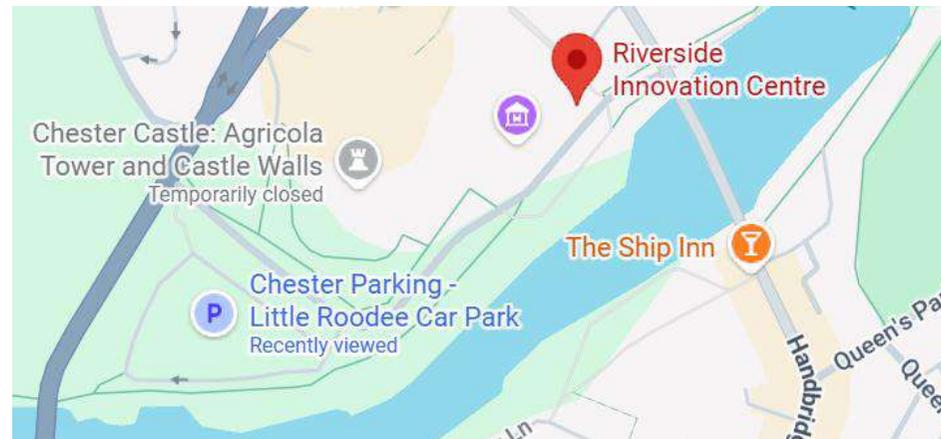


# Meeting of the Board of NHS Cheshire and Merseyside (held in public)

**26 March 2026**  
13:00pm

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



## Public Notice:

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

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

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

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

## Raising Questions:

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

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

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

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

Additionally, these questions will be responded to by the Board in writing (within 20 working days following the date of the meeting where possible) to the individual(s) who submitted the question(s) and will also be published on the ICB website.

Further details can be found at:

<https://www.cheshireandmerseyside.nhs.uk/get-involved/upcoming-meetings-and-events/nhs-cheshire-and-merseyside-integrated-care-board-march-2026/>

# Agenda

AGENDA NO & TIME	ITEM	Format	Lead or Presenter	Action / Purpose	Page No
<b>13:00pm</b>	<b>Preliminary Business</b>				
ICB/03/26/01	Welcome, Apologies and confirmation of quoracy	Verbal	Sir David Henshaw <i>ICB Chair</i>	For information	-
ICB/03/26/02	Declarations of Interest <i>(Board members are asked to declare if there are any declarations in relation to the agenda items or if there are any changes to those published on the <a href="#">ICB website</a>)</i>	Verbal		For assurance	-
ICB/03/26/03	Minutes of the previous meeting: • 26 January 2026	Paper		For approval	<a href="#">Page 6</a>
ICB/03/26/04	Board Action Log	Paper		For approval	<a href="#">Page 18</a>
ICB/03/26/05	Key issues – significant items to raise	Verbal		For discussion	-
ICB/03/26/06	Chairs announcements	Verbal		For information	
ICB/03/26/07	Questions received from members of the public	Verbal		For information	-
ICB/03/26/08	Experience / achievement story	Film		For information	-
<b>13:25pm</b>	<b>ICB Business Items</b>				
ICB/03/26/09 <b>13:30pm</b>	NHS Cheshire and Merseyside Annual EPRR Assurance Report 2025-26	Paper	Jude Adams <i>Interim Executive Director of Transformation &amp; Strategy (Turnaround)</i>	For assurance	<a href="#">Page 19</a>
ICB/03/26/10 <b>13:40pm</b>	5-Year Clinical and Strategic Commissioning Plan (SCP) 2026/2031: Incorporating our Population Health Improvement Plan (PHIP)	Paper	Clare Watson <i>Executive Director of Integrated Health and Care Commissioning</i> & Fiona Lemmens <i>Executive Clinical Director</i>	For approval	<a href="#">Page 30</a>
ICB/03/26/11 <b>14:05pm</b>	NHS Cheshire and Merseyside Single Improvement Plan	Paper	Ben Vinter <i>Executive Director for Corporate Services and Governance</i>	For approval	<a href="#">Page 148</a>

AGENDA NO & TIME	ITEM	Format	Lead or Presenter	Action / Purpose	Page No
ICB/03/26/12 14:20pm	NHS Cheshire and Merseyside Board Assurance Framework and High Scoring Corporate Risks	Paper	Ben Vinter <i>Executive Director for Corporate Services and Governance</i>	For decision	<a href="#">Page 158</a>
ICB/03/26/13 14:35pm	Amendments to the NHS Cheshire and Merseyside Scheme of Reservation and Delegation (SORD) and Operational SORD	Paper	Ben Vinter <i>Executive Director for Corporate Services and Governance</i>	For approval	<a href="#">Page 176</a>
<b>14:40pm</b>	<b>Leadership Reports</b>				
ICB/03/26/14	Report of the ICB Chief Executive	Paper	Liz Bishop <i>Chief Executive</i>	For assurance	<a href="#">Page 210</a>
ICB/03/26/15 14:50pm	NHS Cheshire and Merseyside and System Finance Report - Month 11	Paper	Rebecca Tunstall <i>Associate Director of Finance – Planning &amp; Reporting</i>	For assurance	<a href="#">Page 232</a>
ICB/03/26/16 15:00pm	Highlight report of the Chair of ICB Finance, Investment and Our Resources Committee	Paper	Sue Lorimer <i>Non-Executive Member</i>	For approval	<a href="#">Page 242</a>
ICB/03/26/17 15:05pm	NHS Cheshire and Merseyside Integrated Performance Report	Paper	Jude Adams <i>Interim Executive Director of Transformation &amp; Strategy (Turnaround)</i>	For assurance	<a href="#">Page 254</a>
ICB/03/26/18 15:15pm	Highlight report of the Chair of ICB Quality and Performance Committee	Paper	Tony Foy <i>Non-Executive Member</i>	For assurance	<a href="#">Page 299</a>
ICB/03/26/19 15:20pm	Highlight report of the Chair of the Audit Committee	Paper	Mike Burrows <i>Non-Executive Member</i>	For assurance	<a href="#">Page 306</a>
ICB/03/26/20 15:25pm	Highlight report of the Chair of System Primary Care Committee	Paper	Tony Foy <i>Non-Executive Member</i>	For assurance	<a href="#">Page 309</a>
ICB/03/26/21 15:30pm	Highlight report of the Chair of Shaping Care Together Joint Committee	Paper	Hilary Garratt <i>Non-Executive Member</i>	For assurance	-
ICB/03/26/22 15:35pm	Highlight report of the Chair of North West Specialised Commissioning Services Joint Committee	Verbal	Dr Ruth Hussey <i>Non-Executive Member</i>	For assurance	<a href="#">Page 313</a>
<b>15:35pm</b>	<b>Closing Business</b>				
ICB/03/26/23	Closing remarks and review/reflections of the meeting	Verbal	Sir David Henshaw <i>ICB Chair</i>	For information	-
ICB/03/26/24	Any Other Business	Verbal		For information	-

AGENDA NO & TIME	ITEM	Format	Lead or Presenter	Action / Purpose	Page No
15:40pm	CLOSE OF MEETING				

## Consent items

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

AGENDA NO	ITEM	Reason for presenting	Page No
ICB/03/26/25	Confirmed Minutes of meetings of the ICB Committees: <ul style="list-style-type: none"> <li>• Audit Committee</li> <li>• Finance, Investment and Our Resources Committee</li> <li>• Quality and Performance Committee</li> <li>• System Primary Care Committee</li> <li>• Shaping Care Together Joint Committee</li> </ul>	For assurance	<a href="#">CLICK HERE</a>

## Date and start time of future meetings

**28 May 2026**, 1pm, Liverpool Suite, Holiday Inn, Lime Street, Liverpool, L1 1NQ

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

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

**29<sup>th</sup> January 2026, 2:00pm – 4:30pm**

Held in The Liverpool Suite, Holiday Inn, Lime Street, Liverpool, L1 1NQ

**Draft Minutes**

ATTENDANCE	
Name	Role
<b>Members</b>	
Sir David Henshaw	Chair, Cheshire & Merseyside ICB (voting member)
Liz Bishop	Chief Executive, Cheshire & Merseyside ICB (voting member)
Andrea McGee	Executive Director of Finance (Interim), Cheshire & Merseyside ICB (voting member)
Tony Foy	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Dr Ruth Hussey, CB, OBE, DL	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Janelle Holmes	Partner Member (NHS Trust), Cheshire & Merseyside ICB (voting member)
Adam Irvine	Partner Member (Primary Care), Cheshire & Merseyside ICB, (voting member)
Dr Naomi Rankin	Partner Member (Primary Care) (voting member)
Sue Lorrimer	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Warren Escalade	Partner Member (VCFSE) (Voting Member)
Prof Hilary Garratt, CBE	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
<b>In Attendance</b>	
Jude Adams	Interim Executive Director of Strategy and Transformation
Clare Watson	Assistant Chief Executive, Cheshire & Merseyside ICB (regular participant)
Dr Fiona Lemmens	Deputy Medical Director, Cheshire & Merseyside ICB (regular participant)
Louise Robson	Chair, Health Innovation North West Coast (regular participant)
Prof. Ian Ashworth	Director of Population Health, Cheshire & Merseyside ICB (regular participant)
Sarah Thwaites	Chief Executive, Healthwatch Liverpool
Jennie Williams	Senior Executive Assistant (Note taker), Cheshire & Merseyside
Matthew Cunningham	Associate Director of Corporate Affairs & Governance & Company Secretary, Cheshire and Merseyside ICB

Apologies	
Name	Role
Trish Bennett	Partner Member (NHS Trust), Cheshire & Merseyside ICB (voting member)
Erica Morriss	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Delyth Curtis	Partner member (Local Authority) (voting member)
Andrew Lewis	Partner Member, (Local Authority) (Voting Member)
Prof. Paul Kingston	Chair of ICB Research and Innovation Committee, (regular participant)
Ellen Loudon	C&M Health and Care Partnership Vice-Chair (regular participant)
Mike Burrows	Non-Executive Member, Cheshire & Merseyside ICB (voting member)

## Agenda Item, Discussion, Outcomes and Action Points

### Preliminary Business

#### ICB/01/26/01 Welcome, Apologies and Confirmation of Quoracy

The Chair welcomed the Board to the NHS Cheshire and Merseyside ICB Board meeting in public, apologies were noted, and it was confirmed that the Board was quorate.

#### ICB/01/26/02 Declarations of Interest

Ruth Hussey is now lay member of University of Liverpool council. There were no other declarations of interest made by members that would materially or adversely impact matters requiring discussion and decision within the listed agenda items.

#### ICB/01/26/03 Minutes of the previous meeting of 27<sup>th</sup> November 2025

The minutes of the previous meeting held on 27<sup>th</sup> November 2025 were accepted and recorded as a true and accurate reflection of the meeting subject to amendment – Louise Robson was in attendance at the meeting.

#### ICB/01/26/04 Board Action Log

The Board agreed the actions as listed.

- Action 106 – should be marked as complete
- Action 107 – to be closed

#### ICB/01/26/05 Key Issues – Significant Issues to Raise

There were no key issues raised by Board members.

#### ICB/01/26/06 Chairs Announcements

The Chair advised that he had no announcements.

#### ICB/01/26/07 Questions Received from Members of the Public

The Board received questions from the public in advance of the meeting. The Chair confirmed that written answers would be provided to individuals following the meeting. Questions related to Liverpool Women's Hospital were responded to in writing on 28 January 2026 and can be found at: <https://www.cheshireandmerseyside.nhs.uk/get-involved/meeting-and-event-archive/nhs-cheshire-and-merseyside-integrated-care-board/2026/29-january-2026>

## Agenda Item, Discussion, Outcomes and Action Points

Questions raised were:

### Question 1 -

Does the board believe it is acceptable that the complaints teams at hospitals and Cheshire and Merseyside, do not fully investigate complaints as they know the PHSO will refuse to investigate complaints if escalated, unless someone has come to harm. Therefore, avoiding admitting to errors or making improvements to services. Contrary to the trusts constitution?

### Question 2 -

I'm the director of a not-for-profit organisation working to improve health and wellbeing in one of the most deprived areas of Halton. Since the formation of the ICBs I fear that methods of interacting and communicating with the board regarding policy and delivery has become far more remote than it was with the old CCG structure (which itself was pretty remote). Can you please explain how a very small project like ours can meet with or contact board members or other staff to discuss local and regional health issues?

### Question 3 -

Under the periodic progress report on the Data Info Programme and its links with previous updates on Cyber Security could the Board give local assurance to the near 2.5 million NHS patients in the its footprint area that it is ensuring from routine contract reviews, providers incident alerts and independent verification of any data breaches over that Federated Data Platform operated by Palantir Analytica in some 10 Cheshire and Merseyside NHS Trusts as well as the ICB, including minimising the risks of patient data being leaked, anonymised, stored or inappropriately passed on for commercial or any illicit purposes. This follows recent concerns expressed by the Parliamentary Select Innovation and Technology Committee about outsourcing such a significant data contract to one overseas company with insufficient assurance its data handling and protection processes were sufficiently robust or verifiable.

### Question 4 -

For any NHS bodies within Cheshire & Merseyside

1. Is information on the immigration status of individual patients uploaded to the NHS Spine?
2. Can such information be accessed by the Federated Data Platform (FDP), either currently or as an option in future?
3. Is Message Exchange for Social Care and Health (MESH) used to upload such information to the NHS Spine?
4. Does the FDP have access to NHS communication via MESH, whether or not this information appears on the NHS Spine?

## ICB/01/26/08 Experience / Achievement Story

The board received a video called a [Shaun's story](#), a lung cancer journey as a part of the "what will you miss" campaign, aimed to improve respiratory health and improve lung cancer. It is with gratitude to Sean and his family for sharing the video.

## ICB Business Items

### ICB/01/26/09 Women's Hospital Services in Liverpool – Options Appraisal and Next Steps

James Sumner, Chief Executive of Liverpool Women's Hospital, and Fiona Lemmens presented the slides included within the meeting pack. The purpose of this item was to update the Board on the outcomes of the options appraisal process.

The ICB Chair highlighted to Board members that the item today was just for noting by the Board,

## Agenda Item, Discussion, Outcomes and Action Points

and not for approval, as the approval process was with NHS England.

The Board received an overview of the clinical risks underpinning the options appraisal. Risk 1 relates to the current configuration at the Crown Street site. While the vast majority of women receive excellent care, supported by staff who routinely mitigate risk, two maternal deaths have occurred. In one case, a woman experienced rapid deterioration due to sepsis and required transfer from Liverpool Women's Hospital to the Royal Liverpool Hospital, where she sadly died in intensive care. In the second case, a sudden and unexpected surgical complication in a pregnant woman necessitated urgent transfer to the Royal, and the woman also sadly died. Investigations concluded that the isolated nature of the Crown Street site was likely a contributing factor in both cases, and that earlier access to specialist input may have been possible had services been co-located.

The Board was reminded that this is the fourth comprehensive options appraisal undertaken, each reaching the same conclusion: co-location of maternity and inpatient gynaecology services with adult acute services is the only option that addresses the identified risks. Clinical teams involved in the process have asked that the system now act on these findings rather than repeat the exercise.

The appraisal considered several options. Option 1 (Business as Usual) was included for completeness, but deemed non-viable.

Option 2 ("Do Minimum") was identified as the only feasible medium-term option. It would involve enabling approximately 30 pregnant women with complex medical needs to deliver at the Royal Liverpool site, increasing the number of high-risk gynaecology patients (approximately 75–100) managed at the Royal, and enhancing care at Crown Street through investment in senior clinical staffing, strengthened Flying Squad arrangements, expanded outreach midwifery, and dedicated ambulance provision. It was acknowledged that Level 3 intensive care cannot be delivered at Crown Street to the required standards. While Option 2 would improve the current position, it is estimated to benefit fewer than 1% of women using the service and would not resolve the major risks identified.

Option 6 (Co-location of Services) included three sub-options:

- 6A – Reconfiguration of existing Royal Liverpool buildings to accommodate all services, which is technically feasible but highly complex and would take longer than constructing new facilities.
- 6B – Construction of a smaller new unit with partial integration and co-location.
- 6C – Construction of a fully separate new building to house all inpatient maternity, gynaecology, and neonatology services.

Multidisciplinary clinical teams from Liverpool Women's Hospital, the Royal, Aintree, and lived-experience representatives participated in the appraisal workshops. Scoring consistently demonstrated that only co-location (Option 6) would address the full range of risks for the majority of patients. Although the financial implications are significant, clinicians emphasised that Option 6 should not be discounted on financial grounds alone.

The Board was reminded that failure to progress co-location would perpetuate serious clinical and health inequality risks for women and babies, as highlighted in the Equality and Quality Impact Assessments.

## Agenda Item, Discussion, Outcomes and Action Points

Although there is no statutory requirement for public consultation, the programme team recommended undertaking public engagement due to the high level of public interest, including petitions and active campaign groups. The Board was asked to agree to proceed with this engagement despite the timing challenges associated with the pre-election period.

In discussion, the Board noted -

- Option 2 provides mitigation for only a small number of patients. The Board sought assurance on whether this would meaningfully reduce harm. Fiona Lemmens confirmed that clinicians had undertaken detailed risk stratification and that expanding the cohort further would require levels of equipment, estate, and staffing at the Royal that would be unviable and highly disruptive to other services. Similar findings applied to gynaecology. Option 2 therefore offers only marginal improvement. James Sumner emphasised that while staff at Liverpool Women's Hospital make exceptional efforts in emergencies, the core issue is the inability to meet required specifications for specialist services.
- The importance of public engagement and ensuring the people of Liverpool have a voice.
- Healthwatch confirmed its willingness to support engagement on Option 2 and to contribute to the development of materials.

Sir David Henshaw concluded that this work has been ongoing for many years and that the Trusts need to continue to work with the Region and national bodies on securing long-term capital investment. He emphasised that resolving this issue remains essential and that the Region and centre must be pressed to resource the required solution.

- **Action – ICB Finance Leads will need to be involved with the business case to understand the financial impact of the options. Andrea McGee will become involved and will support.**

**The Board -**

- **Noted the report**

### ICB/01/26/10 Lung Cancer Screening: Phase 5 Procurement Recommendations

John Heyes, Managing Director of the Cheshire and Merseyside Cancer Alliance, presented a paper seeking Board approval to commence Phase 5 of the lung cancer screening (LCS) rollout across Cheshire and Merseyside. Phase 5 will extend the programme to the populations of Cheshire East and Cheshire West, completing full regional coverage.

Lung cancer screening was originally pioneered by clinicians in Liverpool and Manchester before being adopted nationally as a pilot through the National Cancer Programme. Phases 1 and 2 commenced in 2021, covering Liverpool, Halton and Knowsley, with subsequent phases following. The programme is now ready to progress to Phase 5, subject to Board approval.

In June 2023, the National Screening Committee recommended that the Targeted Lung Health Check programme transition to a formal Lung Cancer Screening Programme, mandated under Section 7A of NHS public health responsibilities. This establishes lung cancer screening as the fourth national cancer screening programme, alongside bowel, breast and cervical screening. NHS England has committed to achieving full national rollout by March 2030, with an interim target of 50% coverage by March 2024. Cheshire and Merseyside are performing strongly, currently at 57% rollout, and approval of Phase 5 would enable the region to meet the full population coverage milestone by 2030.

## Agenda Item, Discussion, Outcomes and Action Points

Lung cancer screening is a targeted programme for people aged 55–74 who currently smoke or have ever smoked. Eligible individuals are invited for a Lung Cancer Health Check, and those identified as high risk are offered a low-dose CT scan. Funding is provided directly by NHS England and has been confirmed for the current spending round. The programme has already had a significant impact on early diagnosis and outcomes across Cheshire and Merseyside.

Early-stage diagnosis of lung cancer has increased from 33% to 42%, a nine-percentage-point improvement. For every 120 patients diagnosed earlier rather than later, this equates to a 1% improvement in early diagnosis across all cancers.

If outcomes mirror previous phases, Phase 5 is expected to detect approximately 500 lung cancers in the first two-year cycle, diagnose around 80% at early stage, offer curative treatment to the majority, and generate approximately 4,500 additional referrals to smoking cessation services. The proposal is to deliver Phase 5 through a permitted modification to the existing contract with Liverpool Heart and Chest Hospital (LHCH), which currently provides Phases 1–4. LHCH delivers an end-to-end service, including the MDT model, which is central to the specification.

The Board discussed -

- The strength of the case, while noting the need for assurance regarding the availability of additional two-year funding and alignment with strategic plans.
- The importance of financial scrutiny given current pressures.
- The significance of the programme for Cheshire and Merseyside. A risk was noted in relation to Section 4.3 concerning the potential impact on demand for Liverpool Heart and Chest Hospital's CVD prevention service. Ian Ashworth has been asked to work with finance colleagues to assess and manage this risk. Sue Lorrimer confirmed that the proposal had been reviewed and approved by the Finance Committee, and that funding is confirmed to 2030. The impact on providers was acknowledged, with increased pressure anticipated on surgical cancer lists; however, earlier diagnosis is expected to generate long-term economic benefits.
- Healthwatch's continued support for the programme.
- The strong performance of the smoking cessation element, with quit rates at or above expected levels for a specialist service. Approximately one in two smokers quit, with sustained cessation more likely when support is provided.

**The Board -**

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

## Leadership Reports

### ICB/01/26/11 Report of the ICB Chief Executive

Liz Bishop provided an update to the Board on recent changes to the Executive Team. The Board formally noted the appointment of Andrea McGee as Executive Director of Finance and Contracting, Clare Watson as Executive Director of Health and Integrated Care Commissioning, and Fiona Lemmens as Executive Clinical Director. Professor Rowan Pritchard-Jones and Chris Douglas have now moved on from the organisation, and the Board recorded its thanks for their significant contributions to the ICB and the wider region. The Board also noted that Jude Adams has joined the ICB as Interim Director of Strategy and Integration on secondment, bringing

## Agenda Item, Discussion, Outcomes and Action Points

previous experience from within the Cheshire and Merseyside system.

Changes to the ICB Constitution were presented, and the Board were asked to formally ratify these amendments and note the updated Constitution approved by NHS England.

An update was provided on the voluntary redundancy process, which is currently underway and is expected to conclude by the end of March 2026.

The Board was informed that the ICB and UHLG have supported the establishment of additional palliative and end-of-life care beds at Liverpool Heart and Chest Hospital. These opened in January and represent an important development for the Liverpool system.

The Neighbourhood Health Programme continues to progress, with two pioneer sites in St Helens and Sefton, supported by dedicated funding. A recent national visit was undertaken, and Liz Bishop formally thanked teams for a positive visit and the sharing of good practice.

The Board also noted congratulations to two colleagues recognised in the New Year Honours List: Trish Bennett, Chief Executive of Mersey Care, awarded an MBE for Services to the NHS, and Dr Graham Allan, Volunteer Medical Director at the Southport Macmillan Centre, who was also honoured.

The Board discussed –

- Opportunities to strengthen collaboration with both the Liverpool City Region and Cheshire & Warrington, particularly in the context of emerging Regional Health Innovation Zones. Clare Watson reported that work is already underway across both mayoral combined authority footprints. Liverpool City Region arrangements are well established, and Cheshire & Warrington will form a combined authority following the mayoral election in May. Engagement has taken place with chief executives across the Liverpool City Region, and early proposals for joint committee arrangements are being developed.
- Given forthcoming legislative changes, which will alter the operation of ICPs from April next year, the ICB has agreed to pause its current ICP arrangements while alternative governance models are developed. A draft framework is being prepared and is expected to be presented to the Board in March. The Board noted that the joint committee presents a significant opportunity to shape future collaboration, determine delegated functions, and align with the strategic direction of mayoral combined authorities.
- Palliative and end-of-life care provision - the Board noted that the new beds at Liverpool Heart and Chest Hospital provide an immediate solution. A priority within the commissioning strategy is to review palliative and end-of-life care provision across Cheshire and Merseyside. The beds are commissioned specifically for palliative care and cannot be repurposed. Assurance was provided that sufficient skilled staff are in place to support the service.

**The Board -**

- **Considered the updates to Board and sought any clarification or details.**
- **Formally ratified its endorsement of the changes to the Constitution and noted the approval of the updated ICB Constitution by NHS England.**
- **Noted the report.**

## Agenda Item, Discussion, Outcomes and Action Points

### ICB/01/26/12 Cheshire and Merseyside ICB and System Finance Report – Month 9

Andrea McGee presented the financial update for the end of Quarter 3, beginning with a reminder of the system control total agreed at the start of the financial year. Providers collectively signed up to a £228.6m deficit plan, while the ICB committed to a £50.4m surplus, resulting in a system control total of £178.3m deficit.

To achieve system break-even, the system must deliver the planned £178.3m deficit in order to receive Deficit Support Funding (DSF) of an equivalent value. Based on current forecast positions, the system has only secured Quarter 1 DSF (£44.5m). Subsequent quarters have not been achieved due to the system moving off plan, creating additional financial pressure.

At Month 9, the ICB planned to deliver a £38m surplus and remained on track for the full-year £50m surplus. The actual position is a £31m surplus, £7m adverse to plan. Key risks include prescribing pressures, ADHD activity, acute sector activity, and efficiency plans that were back-loaded and have not materialised. The ICB is now forecasting a £15m surplus rather than the planned £50m.

Across the system, Month 9 performance is £2.8m ahead of plan (excluding DSF, which distorts the position). However, the system has already incurred a £218m deficit and must return to £178m by year-end, leaving a significant gap between the current trajectory and the required position.

Andrea highlighted the challenge this presents for the North West region when allocating DSF, given the system's inability to demonstrate credible delivery of the planned deficit.

A graph was presented showing the system's forecast trajectory since Month 4. The required improvement between Months 11 and 12 to achieve the £178m deficit was described as a "hockey stick" pattern, requiring rapid recovery. Current provider and ICB forecasts do not demonstrate improvement at the required rate. Earlier in the year, the system was trending towards a deficit of over £400m; at Month 9, the forecast is £335m, £156m off plan. If the current rate of improvement continued, the system would still end the year £113m off plan.

Triangulation of workforce and financial plans shows a small reduction in WTE in Month 9, though this may reflect seasonal variation. It is too early to determine whether this represents a sustained trend, and further monitoring is required.

Being off plan and losing DSF has placed significant strain on system cashflow. A total of £259m in cash support has been requested; £150m has been approved nationally, with a further £36m under consideration for February. The system has no access to £111m of DSF, further worsening the cash position.

Although Better Payment Practice Code (BPPC) data was not available when the pack was issued, it was reported that performance is significantly challenged. At Month 9, the lowest BPPC score was 44% against a target of 95% of invoices paid within 30 days, and 10 out of 16 providers are now non-compliant.

All providers and the ICB are required to finalise Board-approved forecast outturns and submit these to NHS England by 4 February 2026, including explanations for non-delivery of plan and immediate recovery actions.

## Agenda Item, Discussion, Outcomes and Action Points

### **The Board –**

**Noted the financial position and metrics reported at Month 9 and the risks to delivery of the financial plan.**

### **ICB/01/26/13 Highlight report of the Chair of the ICB Finance, Investment and Our Resources Committee**

The Board received an update from the Chair of the Finance, Investment and Resources Committee, summarising recent meetings of the Finance, Performance and Planning Committee. The paper included in the pack reflected the meeting held prior to the most recent session, which had focused primarily on approving the initial submission of the ICB plan, with particular emphasis on the financial elements.

It was noted that the ICB is no longer responsible for submitting provider financial plans; therefore, the submission related solely to the ICB's own plan, which aimed for a break-even position. The plan included a 3% cash-releasing efficiency requirement, equating to £75m. The NHS England regional finance lead indicated that this level of efficiency may need to increase.

The Committee also reviewed the Month 10 financial position. However, the subsequent meeting held on 22 January 2026 was considered more substantive in terms of discussing how the system intends to improve financial performance. At that meeting, the Committee received the Grip and Control Report from PWC.

Jude Adams provided further detail on developments within the PMO, noting that the changes align closely with PwC's recommendations regarding how the PMO should support Senior Responsible Officers leading efficiency schemes. The revised model introduces an independent assurance function, enabling the Board to receive objective assessments of governance, delivery progress and risk. This separation of responsibilities ensures the organisation is not "marking its own homework".

Work is underway with PWC to implement the new arrangements. A key focus for the coming year will be strengthening oversight of both large-scale efficiency programmes and smaller, day-to-day savings opportunities within the control of budget holders. This reset will be progressed over the coming months, alongside efforts to improve the current year's financial position

**The Board noted the report.**

### **ICB/01/26/14 NHS Cheshire and Merseyside Integrated Performance Report**

Jude Adams provided an update to the Board, noting that the system had maintained stability over the winter period, with no critical incidents reported to date. Providers successfully reduced bed occupancy to below 90% ahead of Christmas. Vaccination uptake has improved, although further progress is required given its impact on staff sickness absence and overall system capacity.

Formal planned care reporting is pending; however, early indications show strong performance. At the end of December, 48 patients were waiting over 65 weeks, an improved position despite industrial action. The system is participating in an NHS England-funded sprint to reduce long waits and 52-week waiters over the next 12 weeks. Further national sprints are anticipated, including on the Faster Diagnosis Standard and urgent and emergency care.

## Agenda Item, Discussion, Outcomes and Action Points

Performance against the 62-day cancer standard remains strong, though further focus is required on the Faster Diagnosis Standard. Diagnostic performance continues to be strong across Cheshire and Merseyside, and opportunities have been identified to expand the use of Community Diagnostic Centres to support pathway redesign and shift activity out of hospital settings.

There remains a need to decompress acute hospitals by redirecting demand to urgent treatment centres and community services. Several urgent treatment centres remain non-compliant with national specifications, and improvement work has commenced. Work is also underway to maximise the use of community beds to support step-up and step-down care and reduce pressure on emergency departments.

System-wide work is planned to strengthen frailty pathways for people aged 65+, using neighbourhood health models with a focus on risk stratification, partnership with local authorities and adult social care, and supporting people to remain well at home. This improvement work will span the next 12 months across health and care providers.

A meeting with local authority partners took place on 28 January 2026, constructive discussions were held on how the system collectively deploys resources, recognising that community service capacity is funded jointly by the ICB and local authorities. The meeting focused on improving utilisation of community beds and addressing long delays. There was strong support for collaborative working on urgent and emergency care plans, with recognition that local authority involvement is essential to achieving system-wide improvement. The discussion also highlighted the need for alignment in the use of Better Care Fund resources and in managing shared market pressures. The meeting was viewed positively, with clear areas identified for continued joint work.

The Board discussed –

- Ongoing pressures within hospitals, including continued concern regarding the rate of healthcare-acquired infections. Although performance remains comparatively strong nationally, a small number of organisations continue to face significant challenges. The improvement plan at LUHFT remains a central focus of quality contract discussions. The Board reiterated that current patterns cannot continue into the next year and that alternative approaches and stronger levers for improvement must be explored. Reducing healthcare-acquired infections is essential for patient safety and for alleviating pressure on hospital capacity. Fiona Lemmens confirmed that responsibility for this portfolio now sits within the new quality leadership arrangements. As part of the development of the strategic plan, healthcare-acquired infection has been identified as a priority area for enhanced oversight. A proposal will be brought back to the Board. The refreshed System Quality Group will provide a forum for coordinated system-wide action, and work is underway to strengthen the ICB's infection prevention and control function.
- Neighbourhood indicators - which will align to the six core components in the current planning guidance. Work is underway with BI teams, and the indicators will be presented once geographies are finalised in all places.
- Healthwatch engagement, with Fiona Lemmens confirming discussions with Louise Barry regarding visits to A&E departments. Healthwatch has been invited to attend the Urgent Care Board to support patient-voice insight and learning.
- Primary care activity - noting that general practice delivered 1.3 million appointments in the last month, equivalent to contact with approximately one in two residents across Cheshire and Merseyside. The Board observed that despite this significant activity, discussions had focused

## Agenda Item, Discussion, Outcomes and Action Points

predominantly on secondary care. A stronger emphasis on primary care and the 'left shift' could help alleviate pressures in secondary services, particularly in frailty and prevention. The Chair agreed that future Board discussions should place greater focus on general practice and suggested a dedicated Board session.

### Actions

- **A seminar to be held at a future Board meeting focusing on general practice, exploring barriers and opportunities. Naomi Rankin to bring forward a proposal.**

**The Board noted the contents of the report and took assurance on the actions contained.**

## ICB/01/26/15 Highlight Report of the Chair of ICB Quality and Performance Committee

The Chair of the Quality and Performance Committee provided an update to the Board on system pressures, with particular focus on winter demand, bed occupancy, ambulance performance and vaccination uptake.

The Committee reviewed the position on winter pressures and noted significant concern regarding acute bed occupancy, which had reached 96%, exceeding the recommended threshold. Ambulance response times had also begun to deteriorate. The Committee was assured that effective preparatory actions had been taken across the system to respond to increasing demand, with a further review of their impact scheduled for January.

Vaccination uptake among healthcare workers was considered. While most providers met the 50% target, a small number did not. When viewed over a five-year period, all trusts had previously exceeded 70%, with some achieving up to 95%. The Committee recognised the scale of the challenge in improving uptake further, particularly given public expectations for higher vaccination rates among older people and those in care homes.

Significant place-based variation was noted, including differences between areas such as Knowsley and Sefton. Health inequalities were highlighted, particularly low uptake among 18–64-year-olds and pregnant women, although early signs of improvement were reported.

All acute trusts achieved the requirement to reduce bed occupancy below 92% by 24 December. The Committee acknowledged the substantial efforts made across the system to deliver this improvement. No trusts were experiencing sustained ambulance turnaround delays, representing a marked improvement compared with recent years.

The Committee reviewed detailed information on corridor care and noted that the number of instances had reduced over the Christmas period despite an overall increase in A&E attendances. This was viewed as a positive development, indicating that corridor care had not risen in line with demand. A report was received on individual trusts' actions to improve corridor care management. The Committee commended the continued focus on implementing the Red Lines Toolkit, noting that while some trusts were largely compliant, others had demonstrated significant improvements that could be shared across the system.

The Committee held an extended discussion on the fragmented nature of current population vaccination pathways. It was noted that members of the public often do not know where to obtain vaccinations and that services are not always available in locations they expect. Variation in healthcare worker vaccination uptake was also highlighted, with some trusts performing strongly

## Agenda Item, Discussion, Outcomes and Action Points

while others continued to face challenges.

**The Board noted the contents of the report.**

### ICB/01/26/16 Highlight report of the Chair of the Audit Committee

The Chair of the Quality and performance Committee asked the board to approve the amended terms of reference for the audit committee, on behalf of the Chair of the Audit Committee.

**The Board –**

- **Noted the contents of the report.**
- **Approved the changed terms of reference for the committee.**

### ICB/01/26/17 Highlight report of the Chair of the System Primary Care Committee

The Chair of the Quality and performance Committee provided an update on the System Primary Care Committee on the Chair's behalf. The meeting had been particularly challenging due to the depth of detail required. A key theme emerging from the discussion was the financial pressure within the system, with significant overspends, particularly in prescribing, receiving considerable attention. Future meetings will focus on distinguishing demand-driven pressures from operational performance issues.

**The Board noted the contents of the report.**

### Closing Business

### ICB/01/26/18 Closing Remarks and Review / Reflections of the Meeting

The Board reflected on the strong theme emerging throughout the meeting around prevention, immunisation and the importance of the left shift, emphasising the need for early planning for next year's immunisation programme and the importance of strengthening the focus on primary care, acknowledging that limited data visibility has historically led to discussions being weighted towards secondary care. It was agreed that improving the availability of primary care and community data would support better prioritisation and more balanced system oversight.

There is a need to think proactively about managing demand, including opportunities to redirect activity away from emergency departments and ensure alternative services are available and effective.

The Chair concluded by encouraging continued challenge, collaboration and forward planning as the system prepares for the year ahead.

### ICB/01/26/19 Any Other Business

None.

## CONSENT ITEMS

The Board received and noted the items within the Consent Item section of the January 2026 Board.

**ICB Board Meeting Action Log**

Updated: **06.02.26**

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status	Recommendation to Board
ICB-AC-104	27/11/2025	Safeguarding Our Workforce – NHS Cheshire and Merseyside Sexual Misconduct Policy	ICB Sexual Misconduct Policy to be shared with higher education institutions through the deanery	Mike Gibney			ONGOING	
ICB-AC-105	27/11/2025	Board Assurance Framework	Board risk appetite session to be developed	Clare Watson	Q1 2026-25	To be incorporated as part of Board Development Programme in 2026 and as part of single improvement plan	ONGOING	
ICB-AC-108	29/01/2026	Women's Hospital Services in Liverpool – Options Appraisal and Next Steps	ICB Finance Leads will need to be involved with the business case to understand the financial impact of the options. Andrea McGee will become involved and will support.	Andrea McGee	01/03/2026		ONGOING	
ICB-AC-111	29/01/2026	NHS Cheshire and Merseyside Integrated Performance Report ``	A seminar to be held at a future Board meeting focusing on general practice, exploring barriers and opportunities. Naomi Rankin to bring forward a proposal	Naomi Rankin	26/03/2026		ONGOING	

# Meeting of the Board of NHS Cheshire and Merseyside

26 March 2026

## Emergency Preparedness, Resilience and Response Annual Progress and Assurance Report 2025-2026

**Agenda Item No:** ICB/03/26/09

# Emergency Preparedness, Resilience and Response Annual Progress and Assurance Report 2025-2026

## 1. Executive Summary

1.1 The purpose of this report is to inform and provide the NHS Cheshire and Merseyside Board with an overview of the statutory requirements placed on NHS Cheshire and Merseyside which are fulfilled by the Emergency Preparedness Resilience and Response (EPRR) Team and the outcome of the annual NHS Core Standards assurance process.

1.2 Key headlines to note are:

- Consistent increase of the NHS EPRR Core Standards self-assessment score compared to the last 2 years:

<b>2025-2026</b>	91% Substantially Compliant
<b>2024-2025</b>	87% Partially Compliant
<b>2023-2024</b>	40% Non-Compliant

- Leading of the NHS EPRR Core Standards process across Cheshire and Merseyside.
- Plethora of testing and exercises facilitated and participated in at a local, regional and national level.
- Vast array of incident management support (including Industrial Action).

## 2. Background

2.1 The Civil Contingencies Act (CCA) 2004 and the NHS Act 2006 as amended by the Health and Social Care Act 2022, underpin EPRR within health. Both Acts place EPRR duties on the NHS in England. Under the CCA 2004, NHS Cheshire and Merseyside are a Category 1 responder, which are recognised as being the core of emergency response and are subject to the full set of civil protection duties.

2.2 All NHS funded organisations are required to be able to prepare for, respond to, and recover from a wide range of incidents, emergencies or disruptive challenges that could impact on health or patient care.

2.3 Each year, NHS England implements an annual assurance process for the NHS EPRR Core Standards. Each NHS organisation has a varied number of individual standards (ranging from 47 to 62) that they work towards compliance of.

2.4 Part of the Core Standards remit is the requirement to report to Boards on the progress and outcomes of several workstreams. This is the intention of this report.

### 3. NHS Cheshire and Merseyside EPRR Core Standards Self-Assessment

- 3.1 For 2025, due to the success of the process in 2024, the assurance process responsibility was once again shifted to ICBs to lead. The process was moved back to the focus of a self-assessment function with evidentiary requirements.
- 3.2 The Interim Head of EPRR and Head of EPRR (whom returned from maternity leave to support the workstream) completed a review of five randomly selected core standards from each Trusts self-assessment and focused on the evidence supplied for those. Feedback and observations were provided to allow Trusts to verify their position, and review their self-assessment based on the feedback received. This approach was welcomed and feedback received was positive, highlighting open conversations which were supportive and led to strengthening of Trust workstreams, which were recognised.
- 3.3 In line with contractual requirements, NHS Cheshire and Merseyside also provided an annual assurance of compliance with the EPRR Core Standards for 2025-26. This submission consisted of a Statement of Compliance, EPRR Core Standards Self-Assessment, evidence and associated action plan.
- 3.4 The final compliance ratings for all Trusts and NHS Cheshire and Merseyside can be found in Appendix A.
- 3.5 There are 47 core standards applicable to NHS Cheshire and Merseyside which are self-assessed based on 4 levels of compliance.

Full	Substantial	Partial	Non-Compliant
Compliant with <b>all</b> standards	The organisation is <b>89-99%</b> compliant	The organisation is <b>77-88%</b> compliant	The organisation is compliant with <b>76% or less</b>

- 3.6 Based on NHS Cheshire and Merseyside’s self-assessment; 43 standards were declared as full compliance, and four standards were declared as partial compliance. No standards were declared as non-compliance, resulting in an overall EPRR compliance assurance rating of **substantially compliant** (91%) for 2025-26.
- 3.7 NHS Cheshire and Merseyside receiving a rating of substantially compliant, is an increase year on year since the ICBs were established. The EPRR Team are delivering against each Core Standard. It does indicate that there are opportunities for the organisation to further improve over the coming year, through the implementation and monitoring of effective action plans.
- 3.8 Further detail on the EPRR Core Standards, along with action plans can be provided by the EPRR Team if required.
- 3.9 Actions to address the organisations partially compliant standards are in place and will be overseen by the Accountable Emergency Officer.

## 4. EPRR Team annual work programme overview

4.1 In line with the Core Standards requirements, the following is an overview of the work programme ongoing progress and achievements undertaken by the EPRR Team for the period of 1 April 2025 to 31 March 2026 to date.

### Key Activities

4.2 During 2025-2026, the Director of Performance and Planning was and continues to be the organisations Accountable Emergency Officer and is supported by the Interim Head of EPRR and the EPRR Team for the delivery of the EPRR Work Programme. The EPRR work programme for 2025-2026 included:

- Leading the NHS EPRR Core Standards compliance assurance process
- Implementation of a Business Continuity Management System
- Responding to incidents experienced across Cheshire and Merseyside
- The development, testing, and review of the suite of EPRR policies, plans and procedures
- Preparedness, response, and recovery from Industrial Action
- The maintenance of Continuous Professional Development (CPD) portfolios for Commanders and EPRR specialists
- The delivery of EPRR training and exercising across the organisation
- The facilitation of system wide notification and cascade communication exercises
- Engaging in multi-agency exercises with both Cheshire and Merseyside Local Resilience Forums at a local, regional, and national level
- Engaging in multi-agency collaborative planning for mass gathering events
- Leading health sector multi-agency preparedness and planning through the Local Health Resilience Partnership and Local Resilience Forums.

### Incident Response

4.3 Healthcare staff took industrial action throughout parts of 2025-2026. The NHS Cheshire and Merseyside EPRR Team have developed an operational contingency plan to effectively prepare for, respond to and recover from Industrial Action, with an aim to minimise disruption and support patient care. To ensure readiness, NHS Cheshire and Merseyside gained assurance from Trusts and triangulated risks ahead of each day of proposed strike action. On days of Industrial Action, the Incident Coordination Centre was activated with a command-and-control structure in place, which was in addition to the NHS Cheshire and Merseyside’s on-call mechanisms

4.4 To date, in total currently, NHS Cheshire and Merseyside has initiated command and control arrangements, leading the response for Cheshire and Merseyside for 18 days of industrial action during the period of 1 April 2025 - 31 March 2026.

4.5 Other key responses over the reporting period resulting in incident management arrangements being established include:

Water Street incident	May 2025
Level 2 response to WUTH critical incident	Oct 2025

## Training

- 4.6 As of 09 January 2026, all Tactical Commanders have completed the NHS England Principles of Health Commander training with refreshers booked in for those requiring them.
- 4.7 As of 09 January 2026, 89% of Strategic Commanders have completed the NHS England Principles of Health Commander training with refreshers booked in for those requiring them.
- 4.8 The EPRR team have offered and prepared 22 EPRR specific training sessions for both ICB Commanders and system wide EPRR Practitioners, including:
- Strategic Commander Training (localised)
  - Tactical Commander Training (localised)
  - Loggist Training
  - Resilience Direct Training.
- 4.9 In addition, the EPRR Team arranged 15 specific training sessions which were available to all Trusts within Cheshire and Merseyside for their respective Tactical and Strategic Commanders, and EPRR Specialists, utilising the Local Health Resilience Partnership Strategic Contributions. These included:
- Legal Awareness
  - Media Training
  - MACA and Military Awareness.
- 4.10 The EPRR Team created an '[EPRR Awareness and Business Continuity Awareness](#)' eLearning package which is available to all staff via the Staff Hub.

## Exercising

- 4.11 During the 2025-2026 reporting period, NHS Cheshire and Merseyside have developed and delivered three exercises, to test and validate plans. These were:
- Exercise Adversa Tempestas – Tabletop exercise of the NHS Cheshire and Merseyside Adverse Weather Plan (August 2025)
  - Exercise May Day – System wide Communications Exercise out of hours (September 2025)
  - Exercise Paddock – Live Play simulation of the Incident Response Plan, Incident Response Communications Plan and Incident Coordination Centre activation (*initially planned for November 2025 in conjunction with Cheshire Resilience Forum exercise, postponed due to Industrial Action*).
- 4.12 During the 2025-2026 reporting period, NHS Cheshire and Merseyside participated in 25 multi-agency exercises, to test and validate plans. A few examples are:
- Exercise Astra Flame – Control of Major Accident Hazards (COMAH) exercise (May 2025)
  - Exercise Marmoset – CRF Fuel Disruption Plan exercise (June 2025)
  - Exercise Polloi – AHCH Major Incident Plan exercise (July 2025)
  - Exercise Kaus Australis – Regional Business Continuity exercise for national power outage arrangements (July 2025)
  - Exercise Paddock – CRF test of multi-agency plans responding to a Marauding Terrorist Attack (Nov 2025).

**Continuous Learning**

4.13 Following any exercise or incident response, the EPRR Team facilitate a debrief to ensure lessons are identified, good practice is noted, and recommendations are made. Structured debriefs are facilitated by a trained and competent member of staff and a Debrief Report is produced to capture actions, responsible owners, and agreed timescales.

4.14 Examples of debriefs facilitated by the EPRR Team include:

Water Street incident	May 2025
Industrial Action	July 2025
Exercise May Day (Communications Test)	September 2025
Manchester Synagogue Attack (supporting NHS GM)	October 2025
Level 2 Declaration (WUTH Sterile Services incident)	October 2025

4.15 Agreed internal action plan recommendations are recorded on the EPRR Lessons Identified Tracker, which are reviewed and updated bi-monthly by the EPRR Team. This is monitored as part of the EPRR governance process, with assurance provided to the Accountable Emergency Officer and Quality and Performance Committee.

4.16 Where wider health lessons or multi-agency lessons are identified, these will be reported through the Local Health Resilience Partnership (LHRP) Tactical Group governance arrangements via the LHRP Lessons Identified Tracker and to the Local Resilience Forums.

**Business Continuity**

4.17 The NHS Cheshire and Merseyside Business Continuity Policy, Tactical Business Continuity Plan and supporting Annex were created in 2024. The EPRR Team continue to support all Services in the production of their individual Business Impact Analyses and subsequent Service Area Business Continuity Plans. All of this combined contributes to the Business Continuity Management System for NHS Cheshire and Merseyside.

4.18 Due to the complexities of the current restructure of the organisation, progress is slow in the production of Service Area Business Continuity Plans and subsequent exercises following approval and sign off by the Plan Owners. Those who remain outstanding are a priority to complete.

4.19 The following tables show the current position on available plans across NHS Cheshire and Merseyside, and where focus is required within the organisation:

ICB Total	
Total Number of plans	74
Total Number of plans received	69
%	93.24%
Plans Reviewed	69
%	93.24%
Converted to Service Area Plan	69
%	93.24%
Signed off Plans and added to Hub	49
%	66.22%

KEY
0% - 19.99%
20% - 49.99%
50% - 89.99%
90% - 99.99%
100%

### CORPORATE TEAMS

Corporate	Assistant Chief Executives	Finance	Medical	Nursing and Care	People	Performance and Planning
Number of plans	4	2	2	2	2	4
Number of plans received	4	1	2	2	2	3
%	100.00%	50.00%	100.00%	100.00%	100.00%	75.00%
Plans Reviewed	4	1	2	2	2	3
%	100.00%	50.00%	100.00%	100.00%	100.00%	75.00%
Converted to Service Area Plan	4	1	2	2	2	3
%	100.00%	50.00%	100.00%	100.00%	100.00%	75.00%
Signed off Plans and added to Hub	4	0	2	0	2	2
%	100.00%	0.00%	100.00%	0.00%	100.00%	50.00%

### PLACES

Places	Cheshire East	Cheshire West and Chester	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
Number of plans	7	7	7	6	6	6	7	6	6
Number of approved plans	7	7	7	6	3	6	7	6	6
%	100%	100%	100%	100%	50%	100%	100%	100%	100%
Plans Reviewed	7	7	7	6	3	6	7	6	6
%	100%	100%	100%	100%	50%	100%	100%	100%	100%
Converted to Service Area Plan	7	7	7	6	3	6	7	6	6
%	100%	100%	100%	100%	50%	100%	100%	100%	100%
Signed off Plans and added to Hub	4	6	7	6	1	0	7	5	3
%	57.14%	85.71%	100%	100%	16.67%	0.00%	100%	83.33%	50%

4.20 The EPRR Team have created the NHS Cheshire and Merseyside [Business Continuity Portal](#) which is available to all staff via the Staff Hub, to support all services during times of disruption. This one stop shop holds information required for all staff and will support Commanders leading on any incident affecting NHS Cheshire and Merseyside. Along with all relevant documentation to support, there is an EPRR and Business Continuity Awareness eLearning package available for all staff.

- 4.21 Part of the Business Continuity Management System arrangement is the requirement to perform audits on both internal Service Area and external supplier business continuity plans. The EPRR Team audit and review on an annual rolling basis 12 x Service Area Business Continuity Plans and 12 x Supplier Business Continuity Plans.
- 4.22 Service Area Business Continuity Plans need to be signed off by Plan Owners before the necessary audits can be conducted. Due to the complexities of the current restructure of the organisation, progress is slow in the production of Service Area Business Continuity Plans which has affected the ability to conduct the required internal audits.
- 4.23 For Supplier Business Continuity Plans, an Audit Checklist is completed including feedback, which is then sent to the Procurement Team for onward discussion with the Suppliers as required. The Audit Checklist holds 36 salient points to be addressed including, the identification of key roles and responsibilities, prioritised activities identified, incident response structure established, triggers for activation clear, standdown procedures available and testing programme adhered to. The audits for 2025 have been completed as below:

Year:	Plan number:	Supplier:
2025	1	Fairfield Independent Hospital
	2	Care UK
	3	Fairpark Care Limited - Park View
	4	Sanctuary Care - Prince Alfred
	5	Spring Care
	6	HCRG
	7	Quay Healthcare
	8	Bridgewater Family Planning Service
	9	Halton Borough Council
	10	GPHC
	11	St Helens Rota
	12	Willowbrook Hospice

## 5. Next Steps

- 5.1 The NHS Cheshire and Merseyside EPRR Team will maintain the delivery of the agreed action plan to continuously improve the organisations preparedness, whilst also maintaining the organisation’s compliance rating of substantially compliant to September 2026, in anticipation of the next annual assurance submission.
- 5.2 Overall system compliance will be managed by the Local Health Resilience Partnership Strategic Group.
- 5.3 The Interim Head of EPRR is responsible for the EPRR Workplan with overall accountability being the responsibility of the Accountable Emergency Officer.

## 6. Recommendations

- 6.1 The Board are asked to:
- **note** the contents of this report with assurance of delivery of actions and future improved compliance through NHS Cheshire and Merseyside EPRR governance structures.

## 7. Officer contact details for more information

**Nicola Barnes**

Deputy Head of Emergency Preparedness, Resilience and Response

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## 8. Appendices

**Appendix A: 2025-26 Compliance Ratings**

## Appendix A: 2025-26 Compliance Ratings

Core Standard	2024-2025 Percentage	Fully Compliant	Partially Compliant	Non-Compliant	2025-2026 Percentage	Overall Compliance
Alder Hey Children's Hospital NHS Foundation Trust	68%	50	12	0	81%	Partially compliant
Bridgewater Community Trust	81%	48	10	0	83%	Partially compliant
Cheshire and Wirral Partnership NHS Foundation Trust	84%	53	5	0	91%	Substantially compliant
Clatterbridge Cancer Centre	95%	57	2	0	97%	Substantially compliant
Countess of Chester Hospital NHS Foundation Trust	81%	56	6	0	90%	Substantially compliant
East Cheshire NHS Trust	81%	49	13	0	79%	Partially compliant
Liverpool Heart and Chest NHS Foundation Trust	86%	56	3	0	95%	Substantially compliant
Liverpool University Hospitals NHS Foundation Trust	89%	58	3	1	94%	Substantially compliant
Liverpool Women's Hospital NHS Foundation Trust	73%	51	7	1	86%	Partially compliant
Mersey and West Lancashire Teaching Hospitals NHS Foundation Trust	81%	60	2	0	97%	Substantially compliant
Mersey Care NHS Foundation Trust	97%	57	1	0	98%	Substantially compliant
Mid Cheshire Hospitals NHS Foundation Trust	76%	60	2	0	97%	Substantially compliant
The Walton Centre NHS Foundation Trust	78%	37	17	5	63%	Non-compliant
Warrington and Halton Teaching Hospital NHS Foundation Trust	68%	53	9	0	85%	Partially compliant
Wirral Community Health and Care NHS Foundation Trust	86%	56	2	0	97%	Substantially compliant
Wirral University Teaching Hospital NHS Foundation Trust	84%	59	3	0	95%	Substantially compliant
NHS Cheshire and Merseyside	87%	43	4	0	91%	Substantially compliant



Compassionate



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Working Together



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# Meeting of the Board of NHS Cheshire and Merseyside

26 March 2026

## 5-Year Clinical and Strategic Commissioning Plan (SCP) 2026/2031: Incorporating our Population Health Improvement Plan (PHIP)

**Agenda Item No:**

ICB/03/26/10



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Working Together



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# 5-Year Clinical and Strategic Commissioning Plan 2026/2031: Incorporating our Population Health Improvement Plan

## 1. Purpose of the Report

- 1.1 This paper describes the final draft of the ICB's 5-Year Clinical and Strategic Commissioning Plan 2026/2031: Incorporating the Population Health Improvement Plan following the initial endorsement by the Board on the 11 February 2026.
- 1.2 It sets out the detail on the final structure of the plans and outlines the work completed in producing an amended plan for final approval by the Board ahead of publication on 31 March 2026.

## 2. Executive Summary

- 2.1 The presented plans build on the previous submission endorsed by the board on 11 February 2026 and describes the Cheshire and Merseyside plans in response to the national NHS Planning process and priorities. These include:
  - **Five-Year Clinical and Strategic Commissioning Plan** – A strategic document outlining priorities and system-wide plans across all NHS commissioned services (Appendix One)
  - **Population Health Improvement Plan** – A more detailed plan translating strategy into deliverable actions metrics and measures (Appendix Two).
- 2.2 The Cheshire and Merseyside 5-Year Clinical and Strategic Commissioning Plan and Population Health Improvement Plan build on the Health and Care Partnership All Together Fairer Plan, and ICB Joint Forward Plan but refreshes the NHS Cheshire and Merseyside priorities to reflect the NHS 10 Year plan, national medium term planning priorities and the priorities outlined in the published [Cheshire and Merseyside Integrated Needs Assessment](#).<sup>1</sup>
- 2.3 The Integrated Needs Assessment was developed by the ICB Business Intelligence and Population Health Teams and considers a range of information sources in relation to:
  - What residents say matters most to them.
  - Findings from the Population Health Needs Assessment, incorporating the nine Local Authority JSNA's.
  - Identified gaps and concerns in meeting expected quality standards.
  - Areas where current services are not meeting need or demand.
  - Provider insight into clinical, financial and operational pressures.

<sup>1</sup> [https://www.cheshireandmerseyside.nhs.uk/about/cheshire-and-merseyside-health-and-care-partnership/population-health/#interim\\_integrated\\_needs\\_assessment](https://www.cheshireandmerseyside.nhs.uk/about/cheshire-and-merseyside-health-and-care-partnership/population-health/#interim_integrated_needs_assessment)

- Recognition that the system is financially unsustainable and must become more efficient and reduce overall expenditure.
- Delivering the priorities in the NHS 10 Year Plan and “Medium Term Planning Guidance” and statutory national duties (including those areas identified by NHS England as requiring improvement in the ICB through enforcement undertakings in the areas of financial planning, quality, leadership and governance).
- Quality themes identified by the Quality and Performance Committee.
- Intelligence from our providers of NHS Services.

2.4 The Integrated Needs Assessment has been published and shared with partners. This has included a webinar for NHS provider partners to answer questions on the needs assessment and the 5-year Clinical and Strategic Commissioning Plan to support development of organisational plans.

2.5 Since the Board reviewed the draft plans in February 2026 the 5-Year Clinical and Strategic Commissioning Plan 2026/2031 and the associated Population Health Improvement Plan they have been shared widely with our system partners to gather their feedback including:

- Health and Wellbeing Board and Place Partnerships
- Local Authority Chief Executives
- NHS Provider Chief Executives
- Directors of Public Health
- Associate Directors of Transformation and Partnerships
- Provider Collaborative
- Primary Care
- Voluntary Community, Faith and Social Enterprise sector
- Directors of Adult and Children’s Social Services
- Programme leads
- Clinical Network leads.

2.6 Feedback has been widely supportive of the plans and priorities within them. We have completed a full review of the feedback received and integrated this into the final iteration. however, these changes do not materially affect the priorities and plans.

2.7 Feedback continues to be received, and it is important to note that there may be some minor additional revisions ahead of the final publication.

2.8 A key thread of the feedback is the importance of coproduction with partners and our communities in developing the detailed implementation plans and as part of our future ways of working.

2.9 There has also been further work to review and identify the outcomes and metrics which will demonstrate progress in delivering the priorities identified in our 5-Year Clinical and Strategic Commissioning Plan. The measures and trajectories (Appendix Three) will be incorporated into a revised monitoring and reporting framework including the Integrated Performance Report presented to

Board and the Board Assurance Framework and forming part of revised ICB governance arrangements in 2026-2027.

### 3. Ask of the Board

3.1 The Board is asked to:

- **Note** – the consultation and review work completed in producing the final draft, recognising that further ongoing engagement will take place as detailed implementation plans are developed with partners including our communities.
- **Approve** – The publication of both the 5-Year Clinical and Strategic Commissioning Plan 2026/2031 (Appendix One) and the associated Population Health Improvement Plan (PHIP) (Appendix Two) on 31 March 2026.

### 4. Reasons for Recommendations

4.1 The ICB is required to develop the products identified in the Medium-Term Planning Framework specially the development and publication of 5-year plans (an ICB Strategic Commissioning Plan and Population Health Improvement Plan) and to publish the documents by 31 March 2026.

4.2 The planning framework makes clear that Boards are accountable for the development and delivery of plans.

### 5. Summary: 5-Year Clinical and Strategic Commissioning Plan 2026/2031: Incorporating the Population Health Improvement Plan (PHIP)

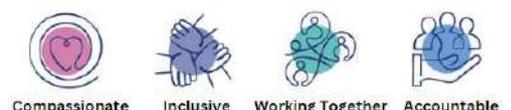
5.1 Responding to the national ICB Blueprint and NHS Strategic Commissioning Framework, as an ICB we are shifting towards becoming a strategic commissioner. This means acting as a system convenor, architect and steward, embracing strategic leadership to shape the future of healthcare services for our residents in line with the NHS 10 Year Plan.

5.2 In developing our plans, we recognise that we are at the beginning of this journey and will need to rapidly strengthen our capability as both an organisation and through working with partners.

5.3 The following principles have been used to develop our plan:

#### Data into Action

- Use of evidence and data platforms (e.g., CIPHA and the Federated Data Platform, including Strategic Commissioning Tool).
- Apply population health analytics: risk stratification and segmentation.
- Enable continuous improvement with dashboards and feedback to teams.



- Adopt systematic evaluation methodologies and Research & Development in our commissioning.

### Financial Sustainability

- Drive productivity and efficiency across pathways and organisations.
- Adopt integrated models of care across primary, community and hospital settings, redesigning and reconfiguring service models.
- Prioritise prevention and reduce unwarranted variation in access and outcomes.
- Decommission low-value interventions and use allocative efficiency to best meet needs.

### Strategic Commissioning Role

- Align with the NHS Operating Model and ICB Provider Blueprint.
- Commission for outcomes, not processes, with clear accountability.
- Integrate services and reduce duplication; use 'do once' opportunities where appropriate.
- Spread good practice rapidly using change and improvement methods.

### Quality, Safety and Experience

- Commission care is safe, effective, sustainable, person-centred, timely, efficient and equitable.
- Set clear quality measures and contractual quality schedules.
- Foster a learning culture with continuous improvement as the default way of working.

### Working with Partners

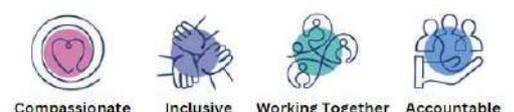
- Co-design/delivery solutions with communities, VCFSE sector, NHS partners and local authorities.
- Work at the most relevant geography - regional, place or neighbourhood - based on population need.
- Share data and insights transparently to build trust and support joint decision-making.

5.4 The 5-Year Clinical and Strategic Commissioning Plan and Population Health Improvement Plan align with the NHS 10 Year Health Plan; the strategy focuses on transforming services to improve outcomes while ensuring long term financial sustainability. It outlines how we will target resources to deliver the three key shifts in care:

- Hospital to community.
- Sickness to prevention.
- Analogue to digital.

5.5 It outlines our belief that these shifts are best achieved through a neighbourhood health model that delivers proactive, preventative care, improves residents' lives and builds on the strengths of our communities.

5.6 The plans outline how we will enable this model; we will transform how we work, aligning with the new NHS operating model and strengthening collaboration with



local government, community, voluntary, faith and social enterprise partners, NHS providers and other key stakeholders. This approach will not only help strengthen local connections, but create a more streamlined, accountable system that reduces duplication, supports agile governance and enables faster, more effective decision making for the benefit of local patients.

- 5.7 The plans outline how we will work differently as we take on our responsibilities as a strategic commissioner. By working in partnership, the ICB will commission based on population need at the most appropriate footprint for the population, service or partnership. Sometimes it will make sense to commission a single consistent approach at a regional or Cheshire and Merseyside level whereas in other situations to work at a more local footprint to reflect the specific needs of a local community.
- 5.8 Aligned with the Model ICB Blueprint, the plans outline how we will act as a system convenor, architect and steward - strengthening collaboration and coproduction to make better use of NHS resources, targeting and investing more in those who need it most.
- 5.9 The plans are built around a life course approach with a priority focus on the following areas:
- Starting Well - Maternity and Neonatal Care and first 1001 days.
  - Growing Well - Children and Young People (CYP).
  - Living Well - Mental Health.
  - Living Well - Proactive and Preventative Care.
  - Living Well - Neurodiversity, ADHD, Learning Disability and Autism.
  - Ageing Well - Frailty and Falls Prevention.
  - Dying Well - Palliative and End of Life Care (PEOLC).
- 5.10 The Population Health Improvement Plan (PHIP) outlines the strategic, data-driven approach to improving the overall health, wellbeing, and health equity of a defined group of people by addressing root causes of illness and promoting wellness across communities, not just within individual clinical visits, but across wider pathways, involving collaboration between healthcare, local government, and community partners.
- 5.11 The PHIP is aimed at improving the health of the entire population. It is about improving the physical and mental health outcomes and wellbeing of people while reducing health inequalities. It includes action to reduce the occurrence of ill health, deliver appropriate health and care services and action on the wider determinants of health. It requires working with communities and partner agencies.
- 5.12 In developing the PHIP priorities we have built from:
- Our Health and Care Partnership Strategy and Joint Forward Plan.
  - Priorities identified in our existing system plans include efficiency, service sustainability and reconfiguration.
  - Our Integrated Needs Assessment (at C&M and Local Authority level).
  - The Cheshire and Merseyside NHS Provider Blueprint.

- 5.13 In addition to this the plan reflects additional priorities outlined in the NHS 10-Year Plan and Medium-term Planning Framework with a specific focus on delivery of the national shifts. The plan provides detail on what we will deliver over the 5 years of the plan, it is heavily weighted to the first two years of delivery. It reflects the current context with a key focus on:
- Preventing and intervening early to prevent ill health; targeting priorities and populations identified through our integrated needs assessment.
  - Commissioning for outcomes and value-based healthcare.
  - Providing more care in our neighbourhoods.
  - Reducing waiting times (Electives, Diagnostics and Cancer (EDC) as well as Mental Health, Neurodiversity and Primary, Community & Urgent Care).
  - Delivering financial and operational efficiency and service sustainability through the opportunities highlighted in our Integrated Needs Assessment.
  - Safe, appropriate and cost-effective use of medicines cuts across our ambitions and is a key enabler of improved outcomes. The medicines management work plan is supporting several key system-wide areas where we are an outlier or have scope to improve, i.e., polypharmacy and frailty, antimicrobial stewardship, pain including opioids, safety and cost effectiveness.
- 5.14 Each section of the plan includes:
- A descriptor or case for change.
  - The key outcomes and ambitions.
  - Key Impacts in relation to:
    - Health Inequalities.
    - Financial costs/benefits.
    - Impact on other services.
  - The commissioning intentions across the five-year period broken down into year 1, year 2 and years 3-5).
  - The key metrics/measures we will use to measure progress.
- 5.15 We describe in the PHIP some of the main activities being delivered to support the priorities in the following areas:
- Digital and Data.
  - Workforce.
  - Estates and infrastructure.
  - Governance and Executive Accountability Summary.
- 5.16 Development of planned governance arrangements has taken place which would see the establishment of a Strategic Commissioning Programme Board to monitor delivery of the priorities in the plan. The final arrangements for the establishment of this forum are being considered as part of the wider review of governance across the ICB and will be agreed by the Board early in the new financial year.
- 5.17 A draft outcomes framework for the priority areas identified in the 5-Year Clinical and Strategic Commissioning Plan has been developed and will be finalised as part of the revised reporting and monitoring process within an updated Integrated Performance Report. This focuses on the “NHS priorities”

contained often within partnership programmes of work and further engagement is ongoing to finalise this framework – See Appendix Three.

## 6. Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities

**Objective One: Tackling Health Inequalities in access, outcomes and experience**

**Objective Two: Improving Population Health and Healthcare**

**Objective Three: Enhancing Productivity and Value for Money**

**Objective Four: Helping to support broader social and economic**

- 6.1 The 5-Year Clinical and Strategic Commissioning Plan and Population Health Improvement Plan builds on the Health and Care Partnership All Together Fairer Plan, and ICB Joint Forward Plan but refreshes the NHS 10 Year plan, national medium term planning priorities and an Integrated Needs Assessment to identify local priorities.
- 6.2 The priorities identified from this assessment in the Strategic Commissioning Plan are:
- Developing a Neighbourhood Health Model
  - Living Healthy Lives - Addressing the wider social determinants of health and delivering prevention and proactive early intervention and care through integrated care delivery supported by a neighbourhood health model
  - Starting Well;
    - Improving the quality and safety of local maternity and neonatal services
    - Focus on the first 1001 days of life
  - Growing Well - Addressing variation in outcomes for Children and Young People
  - Living Well;
    - Proactive and preventative care, delivered in communities wherever possible.
    - Improving outcomes for people with mental health needs
    - Improving care for neurodiverse people
  - Ageing Well - Focusing on supporting people with frailty
  - Dying Well - Focusing on enabling equitable access to good quality end-of-life care.
  - Key enablers to our plan:
    - Workforce, digital and data and estates
    - Provider collaboratives
    - System leadership and partnerships
    - Financial sustainability plans

6.3 For each of these areas the Strategic Commissioning Plan outlines the priority actions to be undertaken focussing on the first 2 years. The Population Health Improvement Plan provides further detail over the 5-year period of the plan.

## 7. [Link to achieving the objectives of the Annual Delivery Plan](#)

7.1 The attached documents will determine our plans as an ICB for 2026-27 and be annually refreshed each year to maintain a focus on key priorities.

## 8. [Link to meeting CQC ICS Themes and Quality Statements](#)

<b>Theme One:</b>	<b>Quality and Safety</b>
<b>Theme Two:</b>	<b>Integration</b>
<b>Theme Three:</b>	<b>Leadership</b>

8.1 The key themes above are included in both of the Plans and will be integral to the ongoing planning process and our commissioning intentions.

## 9. [Risks](#)

9.1 Key delivery risks include:

- Insufficient resources to meet performance objectives, including Referral to Treatment, or for Urgent Care to enable commissioning of out of hospital capacity (left shift) to decompress acute hospital system
- Out of hospital demand pressures exceed planning assumptions in areas such as medicines prescribing, all age continuing healthcare, complex packages of care.
- Demand for ADHD services continues to escalate, partly due to the expansion of Independent Sector providers under Right to Choose.
- Cash Releasing Efficiency Schemes may not deliver the required in-year efficiencies.
- Workforce: Tension between plans for workforce reduction by providers set against ambitious delivery plans, and for ICBs workforce sustainability on reduced cost per head of population, set against programme management resource requirements to deliver plans.

9.2 In reflection of delivering ICB running cost savings and implementing the revised NHS operating model, the programme management resource to support the delivery of the plan and develop our role as a strategic commissioner will need to be embedded in our new operating model and may require further reprioritisation of plans.

## 10. Finance

- 10.1 The financial planning approach for 2026/27 remains anchored on sustainability, including targeted use of non-recurrent items, establishment of an emergency baseline, reflection of performance requirements, and tariff/block deconstruction and convergence to support contract alignment. Final figures will be presented at the extraordinary meeting.

## 11. Communication and Engagement

- 11.1 As part of the Integrated Needs Assessment feedback already gathered from our residents and service users was considered in identifying our priorities. Alongside this, plans were constructed to include intelligence gathered from NHS Providers and through Programme Leads who are working as part of the wider system to build plans.
- 11.2 An ICB Board Reference Group has been formed to help draft and refine content within the 5-Year Clinical and Strategic Commissioning Plan. This included partner member representation.
- 11.3 More recently Strategic Commissioning Group has been established and is now meeting monthly to jointly develop future plans with NHS Provider Chief Executives.
- 11.4 Following Board support for the plan we will continue to share content with wider partners through Health and Wellbeing Boards which will allow feedback to be built into the detail programme delivery plans and to inform the next iteration of the plans.
- 11.5 It is recognised that we need to embed codesign, codelivery and joint working into our revised target operating model to recognise the importance of all partners and have mechanisms at all levels from neighbourhood to whole “Cheshire and Merseyside” and to commence the planning process for 2027-28 as early as possible at the start of 2027-28.

## 12. Equality, Diversity and Inclusion

- 12.1 An overarching Equality Impact Assessment (EIA) has been completed for the ICB plans in line with national guidance.
- 12.2 Individual EIAs will be produced as required to assess the impact of the individual programmes and plans.
- 12.2 A working group has reviewed and refreshed our EIA, and Quality Impact Assessment (QIA), policies, and processes to support effective delivery of the changes that will be delivered through our commissioning intentions.

### 13. Climate Change / Sustainability

- 13.1 The final plans include content on sustainability and net zero alignment, consistent with statutory duties.

### 14. Next Steps and Responsible Person to take forward:

- 14.1 Throughout the remainder of March, the multi-disciplinary Planning Team will:
- Finalise 5-Year Clinical and Strategic Commissioning Plan 2026/2031 and Population Health Improvement Plan for publication on the 31<sup>st</sup> of March 2026.
- 14.2 Work with the Communications and Engagement team to complete accessibility checks ahead of publication on the ICB website.
- 14.3 Complete Work with Executive Senior Responsible Officers and Programme Leads for finalising the 5-Year Clinical and Strategic Commissioning Plan and the Population Health Improvement Plans
- 14.4 A consistent programme management approach will be developed to enable reporting of delivery progress through either a new Strategic Commissioning Committee, or if appropriate through another Board subcommittee. An outline Terms of Reference has been developed to support this. This will be integrated into the single improvement plan to report to the ICB Board as part of the revised governance structures.

### 15. Officer contact details for more information

*Stephen Woods, Head of Strategy*  
 ([stephen.woods@cheshireandmerseyside.nhs.uk](mailto:stephen.woods@cheshireandmerseyside.nhs.uk) or 07813178150)

*Neil Evans, Associate Director of Strategy and Collaboration*  
 ([neil.evans@cheshireandmerseyside.nhs.net](mailto:neil.evans@cheshireandmerseyside.nhs.net) or 07833685764)

### 16. Appendices

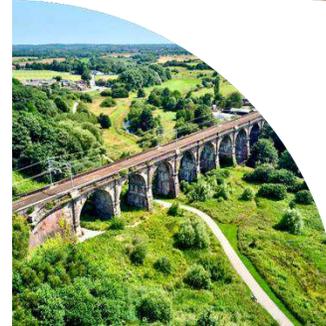
**Appendix One:** Our 5-Year Clinical and Strategic Commissioning Plan 2026/2031

**Appendix Two:** Our Population Health Improvement Plan (PHIP) 2026/2031

**Appendix Three:** Draft Outcomes Framework for priority areas 2026-27.

# 5-Year Clinical and Strategic Commissioning Plan 2026/2031:

*Incorporating our  
Population Health Improvement Plan*



# Contents – Our 5-Year Clinical and Strategic Commissioning Plan

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### Background:

- Introduction
- About Cheshire and Merseyside
- How have we developed our plan
- How we will work differently
- Strategic System Leadership – Working with partners and communities
- Applying the Strategic Commissioning Framework
- Developing our capability as a strategic commissioner

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# Background

- Introduction
- About Cheshire and Merseyside
- How have we developed our plan
- How we will work differently
- Strategic System Leadership – working with partners and communities
- Applying the Strategic Commissioning Framework
- Developing our capability as a strategic commissioner



# Introduction

NHS Cheshire and Merseyside is the statutory body responsible for planning, funding and overseeing NHS services for our 2.7 million residents. Our 2026–31 Clinical and Strategic Commissioning and Population Health Improvement Plans set out our shared ambitions for the years ahead.

While there is much to be proud of, we have unwarranted variation in outcomes, experience and access, and demand for services and the cost of providing them continues to rise. We are currently spending more on care than the resources available to us.

## **Change is essential.**

It is our responsibility to ensure that our £8.2bn annual budget delivers maximum value for local communities. We must decide how best to use this funding to meet the health needs of our population. This is a complex task that requires us to use our role as a strategic commissioner and system convenor to balance competing priorities and address the needs of different groups.

Aligned with the NHS 10-Year Health Plan, our strategy focuses on transforming services to improve outcomes while ensuring long-term financial sustainability. We will target resources to deliver the three key shifts in care:

- **Hospital to community**
- **Sickness to prevention**
- **Analogue to digital**

We believe these shifts are best achieved through a neighbourhood health model that delivers proactive, preventative care, improves residents' lives and builds on the strengths of our communities.

To enable this model, we will transform how we work, aligning with the new NHS operating model and strengthening collaboration with local government, community, voluntary, faith and social enterprise partners, NHS providers and other key stakeholders.

This approach will not only help strengthen local connections, but create a more streamlined, accountable system that reduces duplication, supports agile governance and enables faster, more effective decision-making for the benefit of local patients.



**Sir David Henshaw**  
Chair



**Liz Bishop**  
Chief Executive

# About Cheshire and Merseyside

With a population of 2.7m living across large towns and cities, and more rural areas, Cheshire and Merseyside is a large and complex Integrated Care System

There are many examples of long-standing social, economic and health inequalities, and levels of deprivation and health outcomes in many communities worse than the national average - this drives our commitment to working with partners to address health inequalities and to allocate our funding where it is needed most.:

- A significant proportion of the population live in the 20% most deprived communities – 35.7%
- Projected population growth of 10.8% but this will vary by local authority (2040)
- Over 75 population is forecast to grow by 45% by 2040



## Our Vision

We want everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live healthier for longer.

## Our Mission

We will prevent ill health and tackle health inequalities and improve the lives of poorest the fastest. We believe we can do this best by working in partnership.

## What is different about how we work across Cheshire and Merseyside

As system partners we acknowledge that looking after the health and wellbeing of the 2.7 million people who live in Cheshire and Merseyside provides a unique opportunity for us to collectively consider the added value we can bring by working increasingly closely together. Only then can we ensure our population is enabled to lead healthy and fulfilling lives.

We will support our mission and vision through our strategic objectives:



Tackling health inequalities in outcomes, experiences and access



Improve outcomes in population health and healthcare



Enhancing quality, productivity, and value for money



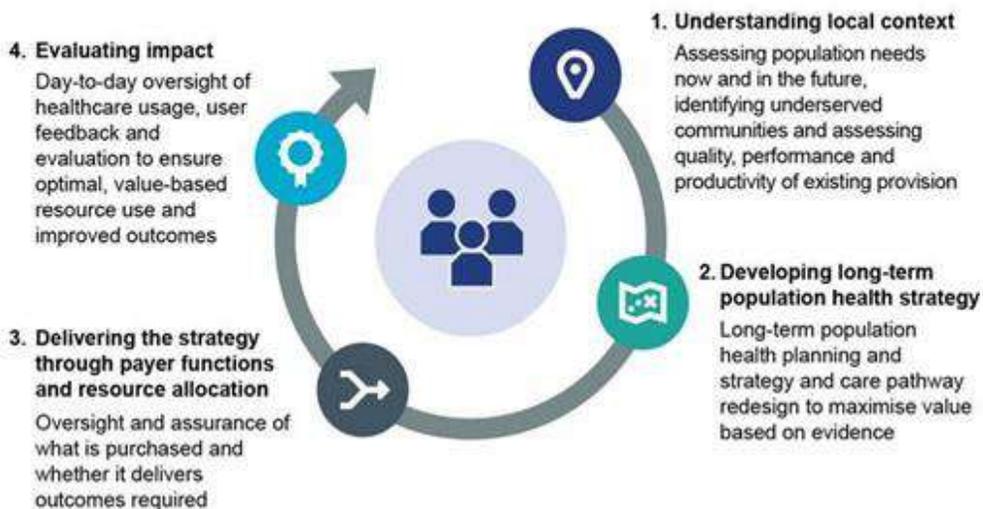
Helping the NHS to support broader social and economic development

# How have we developed our plan

Responding to the national [ICB Blueprint](#) and [NHS Strategic Commissioning Framework](#), we are shifting towards becoming a strategic commissioner. This means acting as a system convenor, architect and steward, embracing strategic leadership to shape the future of healthcare services for our residents in line with the NHS 10 Year Plan.

In developing this plan, we recognise that we are at the beginning of this journey and will need to rapidly strengthen our capability as both an organisation and through working with partners. The diagram below illustrates the key functions of an [NHS strategic commissioner](#):

**Model ICB - System leadership for improved population health**



Our plan is, in part, based on existing Health and Care Partnership and NHS Cheshire and Merseyside priorities but with a refocus based on an updated [integrated needs assessment](#) which considers:

- What residents say matters most to them
- Findings from the Population Health Needs Assessment, incorporating nine Local Authority JSNAs
- Identified gaps and concerns in meeting expected quality standards
- Areas where current services are not meeting need or demand
- Provider insight into clinical, financial and operational pressures
- Recognition that the system is financially unsustainable and must become more efficient
- Delivering the priorities in the NHS Medium Term Plan and statutory national duties (including those areas identified by NHS England as requiring improvement through enforcement undertakings in the areas of financial planning, quality, leadership and governance).

## NHS fit for the future – the three shifts

Hospital to community

Analogue to digital

Sickness to prevention

## To support the scale and pace of change

New operating model

Enhanced transparency of quality of care

Innovation and technology

Workforce and transformation

Financial sustainability

Building partnerships to support Co-design/Delivery

# How will we work differently in Cheshire and Merseyside?

## Working at the optimal footprint to support integration and service transformation:

By working in partnership, the ICB will commission based on population need at the most appropriate footprint for the population, service or partnership.

Sometimes it will make sense to commission a single consistent approach at a regional or Cheshire and Merseyside level whereas in other situations to work at a more local footprint to reflect the specific needs of a local community.



## What does this mean for how our system will work?

- The NHS Operating Model gives ICBs and Trusts greater autonomy, with NHS England taking a more streamlined, supportive role.
- The ICB's role as a strategic commissioner is central to delivering our 5-year commissioning plan and PHIP

## Development of our target operating model:

- The emerging operating model focuses on how we will improve population health and reduce inequalities.
- Our functions, governance, processes, capabilities and culture will enable the ICB to lead as a strategic commissioner while maintaining strong local relationships.

## Our approach to transformation - We will focus on:

- Convening and working with partners to integrate services around local neighbourhood needs.
- Reducing duplication and shifting resources from reactive, hospital-based care towards prevention, early intervention and community-based support.

## To enable this - We will embed:

- Use of data, benchmarking and risk stratification tools, to guide commissioning and decommissioning decisions, targeting investment where it delivers the greatest benefit. Ensuring those with the highest need, such as people with long-term conditions or those who have waited longest, receive proactive support across all care settings.

## We will commission for outcomes:

We will test different ways to enable this through innovative contract frameworks including integrated health organisations through advanced foundation trust and / or neighbourhood-based contracts, including:

- Ambitious plans to work with partners to develop a consistent offer for Children and Young People.
- A five-year transition from activity-based contracts to outcomes-focused approaches, building on existing examples such as diabetes care in Liverpool.

## We will support transformation and reconfiguration:

To improve clinical, workforce and financial sustainability, NHS providers will need to work together to deliver consistent, high-quality care by:

- Forming provider collaboratives - enabling sharing of leadership, estates, clinical and support services
- Delivering agreed programmes for service reconfiguration and consolidation - including women's health and neonatal care.
- Expanding accountable care and lead provider models and enable delegated commissioning to improve care and value - with an initial focus on children and young people and mental health
- Developing service chains hosted by specialist trusts
- Hosting of fragile services across provider groups
- Maximising investment opportunities through commercial and transformational partnerships

# Strategic system leadership; working with partners and communities

## Strategic system leadership:

Aligned with the Model ICB Blueprint, we will act as a system convener, architect and steward - strengthening collaboration and making better use of NHS resources, targeting and investing more in those who need it most.

We will empower clinical and care leaders to drive improvement and make patient-centred decisions. As we mature as a strategic commissioner, our success will depend on trust, devolved responsibility and creating the conditions for proportional leadership to thrive.

## Provider collaboratives:

Provider collaboratives (NHS provider, primary care and VCFSE) will work together to design and deliver creative solutions both within and across sectors. This will enable greater integration of services, increase consistency of access, experience and outcomes for residents, address service fragility and deliver efficiency opportunities:

### We will:

- Work with providers to transform service delivery models including new contractual approaches, such as accountable care approaches for children and young people and mental health.
- Work to develop systems and structures that support alternative service delivery models.

## Working with people and communities:

Our communities face major challenges but also the determination to overcome them. We trust local people and frontline teams to know what matters most to them, we are committed to working with them to improve health, wellbeing and reduce inequalities. Supporting Carers is an essential contribution to narrow health inequalities in access, outcomes & experiences. Support and inclusion of young carers will lead to better chances in life for children and young people.

As NHS partners, we will use community insight and lived experience to help shape better services and outcomes, focusing on removing barriers for vulnerable groups and those with protected characteristics.

**We will:** focus on PLUS groups - who experience poorer than average health access, experience and / or outcomes. Ensure all carers in Cheshire and Merseyside to have the support they need and recognition they deserve to prevent crisis and negative economic impact

## Local, combined authorities and public sector partners:

It is recognised that the NHS plays just one part in the overall health and wellbeing of local residents - with other key factors including education, employment and pay and high-quality housing. We recognise the importance of developing and implementing solutions collectively.

We will work with our nine local authorities to offer improved and more integrated care, and with our two Combined Authorities on public sector reform and investment through Mayoral delegations and levelling up opportunities.

## Embedding the VCFSE sector as an equal delivery partner:

Our Voluntary Community Faith Social Enterprise (VCFSE) sector is large and deeply embedded in communities, with nearly 20,000 organisations, a substantial workforce, and hundreds of thousands of volunteers and informal carers.

Its reach makes it vital to improving outcomes and reducing inequalities. We now have an opportunity to enhance its impact by better connecting services, accelerating prevention-focused reform and reshaping how system partners work with the sector and local communities to address health, social and economic inequalities.

## Utilising our community-based assets:

We will work with partners, including local authorities and the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector, to explore alternative delivery models that make better use of our community assets ensuring community-led engagement and co-production.

### We will:

- Work with our Provider collaboratives to ensure VCFSE is fully embedded as a delivery partner.
- Ensure co-design/delivery and inclusive engagement:
- Create fiscal incentives to create a sustainable integrated care system

# Applying the Strategic Commissioning Framework

The ICB Blueprint and NHS Strategic Commissioning Framework referenced on the previous page outlines four stages of strategic commissioning. Through 2026-27 the ICB will be building on the work we have started to develop our organisational capability in each of these stages.

## Understand the Context

- Identifying the priorities in relation to equity in access, experience and outcomes.
- Commissioning centred on population- and risk-based care, using linked person-level data, health economics and advanced modelling, and lived-experience insight to understand needs, risks, and demand to create an Integrated Needs Assessment.
- This enables identification of underserved communities and assessment of the quality, performance, and productivity of current provision.
- Also identifying where we aren't getting value to inform plans to decommission and reconfigure.

## Develop Long-Term Population Health Strategy

- Use population-health insights, including from the Federated Data Platform Strategic Commissioning Tool, to redesign pathways and allocate, resources for maximum impact on improving priority outcomes.
- Modern Service Frameworks and local insight used to design evidence-based neighbourhood care models and population health plans to deliver:
  - Proactive prevention
  - Complex care and condition management
  - A consistent community offer
  - Integrated pathways enabling step-up/down.

## Payor Function & Resource Allocation

- Incentivise a shift to preventative, proactive care and neighbourhood-based models
- Define and prioritise long-term outcomes through stronger contract management and procurement.
- Work with partners to shape the future market through innovative contract models, including;
  - Delegated and joint commissioning and
  - Collaborative provider arrangements (e.g., Integrated Healthcare Organisations, Neighbourhood Providers, Lead Providers)

## Evaluate Impact

- Rigorously track performance through outcomes, utilisation, clinical risk markers, patient and staff experience, and wider system intelligence.
- Use continuous evaluation to refine interventions and drive population-level improvement.

# Developing our capability as a strategic commissioner

## Our design principles

✔ Clinically led and user informed

✔ Governance and alignment

✔ Integrated Care System

✔ Transformation and priorities

### Clinically led and user informed

Decisions should be underpinned by clinical expertise and informed by the voices of patients and communities.

### Governance and alignment

- Align with the model ICB Blueprint and neighbouring ICBs.
- Ensure transparency, accountability and clear governance structures.
- Retain connections across all Cheshire and Merseyside localities.

### Delivery and structure

- Adopt a lean executive structure that is agile and minimises duplication.
- Embed digital and data driven decision making which includes analytics in planning, prioritisation and redesign to achieve outcomes focused value-based commissioning and contracting.
- Focus on addressing the wider determinants of health and improving health outcomes and tackling inequalities.
- An organisational development programme to build our culture and capability to be a highly effective strategic commissioner.

In support of the changing NHS operating model, we recognise the need to develop our capability as a strategic commissioner. We recognise that this won't happen immediately and will need to develop as we design and implement a revised operating model and build the necessary skills and capability:

### Setting the foundations

New leadership in the organisation.  
 Developing and implementing a new operating model.  
 Clarifying roles and responsibilities (ICB, NHSE and providers).  
 Self Assessment of organisational and staff development needs.  
 Focus on NHS undertakings and enforcement (finances, quality, leadership and governance).  
 Strategic Commissioning development programme with peer ICBs (including best practice analytics, value based commissioning and contracting to achieve improved health and care outcomes).

### Building capability

Embed matrix working with streamlined governance and decision-making.  
 Building the skills and professional identity of commissioners using national tools and targeted local action.  
 Strengthen leadership, management and team performance with practical development and coaching.  
 Work with key strategic commissioning partners to develop jointly including providers (e.g. Accountable Care approaches/ organisations).  
 Establish consistent routines for performance, learning and continuous improvement.

### Transformation

Maintain a high performance culture where continuous learning and improvement are part of everyday practice.  
 Strengthen strategic commissioning partnerships and adopt new contracting models that support the three shifts.  
 Grow capability across the system through shared leadership, collaboration and joint development with partners.  
 Expand and replicate effective approaches by using evaluation and learning insights.  
 Ensure co-design with communities and those with lived experience.

# Key factors shaping our plan

- Building on our shared Health and Care Partnership Plan
- The Case for Change (Our Integrated Needs Assessment)
- The principles that guide our plan



# All Together Fairer: Our Health and Care Partnership Plan

As a key partner in delivering the Health and Care Partnership (HCP) we have committed to making a positive impact on wider determinants of health - the social, economic and environmental conditions in which people are born, grow, live, work and age.

Our [HCP plan](#) is being implemented through the eight themes and system recommendations produced by Sir Michael Marmot and his team from the Institute of Health Equity:

- Give every child the best start in life.
- Enable children, young people and adults to maximise their capabilities and have control over their lives.
- Create fair employment and good work for all.
- Ensure a healthy standard of living for all.
- Create and develop healthy and sustainable places and communities.
- Strengthen the role and impact of ill health prevention.
- Tackle racism, discrimination and their outcomes.
- Pursue environmental sustainability and health equity

In line with the NHS 10-year plan, our HCP plan applies these recommendations through three essential principles:

- Shifting investment to prevention and equity
- Anti-poverty work
- Social justice, health and equity in all we do

# All Together Fairer - Our Headline Ambitions

In developing our plans, and delivering against the eight Marmot themes, we have adopted a set of Headline Ambitions that we will focus on as system partners we will apply the three principles to each of these:

 <p><b>Children and Young People</b></p> <p>We will address the health inequality gap for children living in households with the lowest incomes by focusing on action that will relieve poverty.</p> <p>We will promote good social, emotional and psychological health to protect children and young people against behavioural and health problems.</p>	 <p><b>Physical Activity and Healthy Weight</b></p> <p>We will take action to tackle obesity by focusing on increasing physical activity and promoting healthier diet and food environments, helping adults and children to live healthier lives.</p>	 <p><b>Housing and Health</b></p> <p>We will work with our housing partners to maximise the access to health promoting homes and help improve the service offer for people with complex health needs.</p>	 <p><b>All Together Smokefree</b></p> <p>We will <u>take action</u> to end smoking Everywhere for Everyone.</p>	 <p><b>Work</b></p> <p>We will work with our employers and system partners to help them to create the environments that support our population to start, stay and succeed in work.</p> <p><small>*Work' covers both paid and non-paid activity.</small></p>	 <p><b>Social Value</b></p> <p>We will ensure that the Cheshire and Merseyside Health and Care Partnership member organisations become Anchor Institutions by 2026.</p>
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In line with the HCP headline ambitions, as a key partner NHS Cheshire and Merseyside will focus on supporting:

- Development and delivery of a work and health strategy and implementation plan and partner in the development of the Get Britain Working Plans in Liverpool City Region and Cheshire and Warrington
- Recognising the NHS role as both an employer and key part of local communities and economies we will continue to expand our commitment to social value and supporting the development of the Anchor framework and institutions and prevention pledges.
- Targeted work on housing and health and benefits optimisation.
- Sustainability and delivery of the Green plan – target achieving net zero by 2040, with an ambition to reach an 80% reduction (from 1990 levels) by 2032.
- Alignment with other C&M programmes i.e. All Together Active and Active Cheshire

# The Case for Change – An integrated needs assessment

## What our residents told us

As part of the engagement on the NHS 10-year plan we asked residents what mattered most to them reflecting this in our plans and priorities.

### ✓ A prevention-first approach

Strong health education (schools and social media), alcohol and wider determinants

### ✓ Joined-up, integrated services

One shared patient record

### ✓ Stronger mental health provision

Children and young people

### ✓ Sustainable funding and social care investment

Reduce unmet need, unblock hospital flow, ensure 'right care, right place, right time'

### ✓ Clearer routes and better communication

NHS App expansion

### ✓ More care closer to home

Stronger community services, home-based support

### ✓ Inclusive, safe technology use

Remote health education

### ✓ Faster access and shorter waiting times

Across GP, hospital and mental health services. Smoother patient flow, less corridor care

## Population health needs assessment

- The gap in life expectancy between our richest and poorest areas continues to grow
- Cardiovascular – renal metabolic disease, respiratory disease and cancer remain the leading causes
- Healthy life expectancy continues to reduce in all areas (except Warrington)
- Increasing rates of chronic conditions, multiple chronic conditions and poor mental health are key contributing factors to declining healthy life expectancy
- There has been a growth in need and insufficient capacity to support neurodevelopmental conditions
- Unwarranted variation in outcomes related to frailty

## Impact of demographic projections by 2040



**Diabetes**  
232,669  
+50%



**Atrial fibrillation**  
101,446  
+51%



**Chronic kidney disease**  
103,715  
+34%



**Over 75's**  
+45%



**Dementia**  
31,756  
+45%



**Over 75's**  
+45%

In the next three years we expect there to be **80,000 more people** with long-term conditions, costing an additional **£187m**.

## Quality, safety and experience

In line with our agreed principles and our statutory duties we need to ensure services are Safe, Effective and Sustainable as part of achieving the triple aim:

- Improve the health and wellbeing of our population
- Improve the quality of services
- Make efficient and sustainable use of NHS resources

We have identified areas of concern where quality, safety and experience measures suggest our services need to improve.

These areas have informed the priorities in our plan

## Quality and safety focus

### Infection and prevention control

Healthcare associated infections are above expected levels

Antimicrobial prescribing improve compared with national medians

### Urgent care flow

Ambulance handover delays mean slower response times to 999 calls

"Corridor Care" is happening across all hospitals in C&M  
Delays in people being discharged from hospital and mental health care

### Falls prevention

C&M has the 3rd highest rate of falls nationally

C&M has the highest rate of Polypharmacy in England and high rates of opioid prescribing

### Acute services

The number of "never events" has risen in some of our hospitals

### Maternity

Outcomes are worse in deprived communities

# The Case for Change – An integrated needs assessment

## Demand and capacity

- Demand for GP appointments is rising faster than capacity, increasing the appointments-to-GP/staff ratio.
- Waiting times are growing in some community services, including paediatrics (inc. neurodiversity) and speech and language therapy, with long waits in some Places.
- Mental health referrals are above the national trend.
- Elective activity and waiting times remain under pressure due to capacity, workforce and funding constraints; Independent Sector responsiveness in some specialties leads to inequitable waits.
- Non-elective activity is growing at ~1%, but higher bed day growth signals system flow challenges.
- Incidence of conditions such as diabetes, chronic kidney disease, cancer, atrial fibrillation and dementia is projected to increase.
- Frailty and dementia are expected to drive the largest demand and cost growth over the next 3 years, with an estimated £297m increase.

### Drivers of risk and demand

Risk		Demand	
<b>Biological</b>	Genetics Age Sex	<b>Disease prevalence</b>	Age
<b>Psychological</b>	Personal wellbeing	<b>Health anxiety</b>	Perception of need stigma and shame
<b>Social</b>	Income	<b>Social</b>	Deprivation

### Key messages

- Limited data on genetics currently
- Ageing population - healthy ageing should be a priority
- High disease prevalence
- High service utilisation

## NHS providers and the 'blueprint'

- There are significant clinical, workforce and financial challenges across the Cheshire and Merseyside ICB and the NHS providers across sectors of the ICS.
- This includes fragility of clinical services, duplication of provision, workforce shortages and short and medium-term financial viability of provider trusts.
- Progress had been made in recent years to address some of these challenges, including integration of Trusts, networking of certain clinical services, sharing of assets and consolidation of identified corporate functions however, many of these challenges remain across the ICB.

### Key challenges

#### Financial sustainability

Significant deficits  
Funding allocation changes for ICB and providers impact future sustainability

#### Fragility of clinical services

Fragile services  
Workforce shortages  
Services reconfiguration

#### Number and scale of NHS providers

High number of providers  
Duplication and inefficiencies

#### Variation in community & mental health services

Overlap and variation  
Hospital to community shift

#### Corporate and clinical support functions

Limited consolidation  
Cost savings

#### External factors

Devolution of powers  
Complexity in planning

## Financial sustainability

- The NHS system in Cheshire and Merseyside is spending above its fair-share allocation and continues to face an underlying financial deficit.
- Current service models do not provide sufficient capacity to meet demand, resulting in an over-reliance on costly hospital-based care and limited availability of community-based alternatives.
- A number of clinical services are fragile, with high costs required to maintain them, contributing to unwarranted variation in quality and patient experience.
- There are opportunities to improve productivity and efficiency, both within provider organisations and through the way the ICB commissions and contracts services.

### Financial challenges

#### Underlying Deficit

The Cheshire and Merseyside NHS system is overspending by over £400m

#### Productivity

National benchmarking highlights significant productivity opportunities across the system, including in urgent care, elective and outpatient services, workforce and corporate costs, continuing healthcare, and primary care.

#### Cash flow challenges

The system faces acute cash pressure and is expecting to need deficit and distressed-cash support in 2026-27.

#### Broader public sector financial pressures

There are increasing financial pressures across many of our public sector partners, including local authorities.

# The following principles have been used to develop our plan

## Data into Action

- Use of evidence and data platforms (e.g., CIPHA and the Federated Data Platform, including Strategic Commissioning Tool).
- Apply population health analytics: risk stratification and segmentation.
- Enable continuous improvement with dashboards and feedback to teams.
- Adopt systematic evaluation methodologies and Research & Development in our commissioning.

## Financial Sustainability

- Drive productivity and efficiency across pathways and organisations.
- Adopt integrated models of care across primary, community and hospital settings, redesigning and reconfiguring service models.
- Prioritise prevention and reduce unwarranted variation in access and outcomes.
- Decommission low-value interventions and use allocative efficiency to best meet needs.

## Strategic Commissioning Role

- Align with the NHS Operating Model and ICB Provider Blueprint.
- Commission for outcomes, not processes, with clear accountability.
- Integrate services and reduce duplication; use 'do once' opportunities where appropriate.
- Spread good practice rapidly using change and improvement methods.

## Quality, Safety and Experience

- Commission care that is safe, effective, sustainable, person-centred, timely, efficient and equitable.
- Set clear quality measures and contractual quality schedules.
- Foster a learning culture with continuous improvement as the default way of working

## Working with Partners

- Co-design and co-deliver solutions with communities, VCFSE sector, NHS partners and local authorities.
- Work at the most relevant geography—regional, place or neighbourhood—based on population need.
- Consolidate and share data and insights transparently to build trust and support joint decision-making.

# Our Priorities

- Our plan on a page for 2026-28
- How we are delivering the three shifts
- Neighbourhood health
- Living healthier lives
- Maternity and neonatal care
- Children and Young People
- Mental health
- Neurodiversity, ADHD and Autism
- Frailty and Falls prevention
- Palliative and End of Life Care (PEOLC)



# The NHS 10 Year Plan and Medium-Term Planning Framework

**Our Vision:** We want everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live healthier for longer

**Our Mission:** We will prevent ill health and tackle inequalities and improve the lives of the poorest fastest. We believe we can do this best by working in partnership

Tackling health inequalities in outcomes, experiences and access

Improving outcomes in population health and healthcare

Enhancing productivity and value for money

Helping to support broader socio-economic development

## Our Priorities in 2026-2028 through a life course approach

**Living Healthy Lives** by addressing social determinants and delivering **prevention, proactive early intervention and care** through integrated care delivery and **neighbourhood health models** and working with partners to be **All Together Fairer**

### Starting Well

Improving the quality and safety of local maternity and neonatal services - Focus on the first 1001 days of life

### Living Well

Proactive and preventative care, delivered in communities wherever possible

### Ageing Well

Focussing on supporting people with frailty

### Growing Well

Addressing variation in outcomes for Children and Young People

Improving outcomes for people with mental health needs  
Improving care for neurodiverse people

### Dying Well

Focusing on enabling equitable access to good quality end of life care.

## Our key delivery enablers

Digital and Data

Workforce

Estates and Infrastructure

Quality, Safety and Experience

Clinical and Care leadership

Financial sustainability

Value based commissioning and contracting

Working with collaboratives to transform and reconfigure services (NHS providers, primary care & voluntary community faith and social enterprise)

System leadership and partnerships with local authorities, combined authorities, VCFSE and other key partners

# How our plans support the shifts in care

## HOSPITAL TO COMMUNITY

- Neighbourhood based care models will become the cornerstone of health care delivery, replacing fragmented models with integrated, outcome-focused care built around the holistic needs of the person
- Providers Collaboratives to enhance the quality and sustainability of service delivery (NHS Trusts, Primary Care, VCFSE)
- Achieve consistency in the community services offer to reduce variation and improve quality of care with service provision built around neighbourhoods (with an initial focus on falls, community nursing, care homes and end of life care).
- Focus on best we use our collective estate to support neighbourhood delivery.
- Developing Integrated Health Organisation models with an early focus on Children and Young People and Mental Health to deliver consistency of our universal neighbourhood and hospital and specialist services.
- Supporting workforce development to ensure a skilled, compassionate workforce across all sectors who can support the new models of care required by integrated neighbourhood working

## SICKNESS TO PREVENTION

- Through our neighbourhood model we will improve population health and reduce inequalities through:
- Work to address the social and economic conditions that shape health, working with partners and our population to reduce the risk factors which impact on health and wellbeing; e.g.. obesity, smoking, alcohol consumption
- Optimising uptake of immunisation, vaccination and screening to prevent and identify and treat disease early
- Effectively risk stratify our population to target treatment at those with greatest need and risk of poor health
- Optimizing the treatment and support for long term conditions and frailty to help people better manage their condition(s)
- This will help to improve outcomes in those areas identified as most prevalent in our population including Long Term Conditions (LTC) emphasising better primary and secondary prevention through better management of our key priorities cardiovascular and renal metabolic disease, respiratory and frailty.

## ANALOGUE TO DIGITAL

- A single multi-year digital investment model which considers provider organisations primary care and wider system stakeholders as a single enterprise.
- A digital centre of excellence to coordinate innovation and horizon scanning, overseeing transformation at scale and managing commercial opportunities.
- Timely, secure access to accurate health records across all care settings improving safety and continuity of care.
- Delivery of safe, efficient, and user-friendly digital tools that support clinical workflows, engage and empower patients, enhance staff experience and deliver operational productivity. Whilst ensuring digital literacy is considered and non-digital/vulnerable individuals are supported.
- Data-driven intelligence to inform clinical decisions, improve outcomes, and support research and innovation across the system
- Fully embracing the potential for AI to radically transform how we operate

# Neighbourhood Health

Health and care services including GP, community and social care services are under significant pressure, with disadvantaged communities most affected and acute services consistently operating beyond capacity. A major shift from hospital-based care to more proactive, preventative community support is essential to improve patient experience and outcomes and ensure that demand does not exceed available resources.

Implementing a neighbourhood health model is central to this shift. By working within meaningful neighbourhood footprints, integrated teams across providers will deliver more co-ordinated care, reduce fragmentation and focus on prevention and early intervention.

Successful design of the neighbourhood health model delivery relies on strong integration with local government, the VCFSE sector, housing, education and wider public services, alongside active partnership with communities with local implementation led by our nine Health and Wellbeing Boards - ensuring a holistic, community-centred approach.

Over the next five years, we will shift resources toward prevention and proactive care through a transformation fund developing innovative, outcomes-based commissioning and move towards delegating whole-population budgets, balancing consistent service standards with flexibility for neighbourhood partnerships to tailor support.

We will also continue investing in the infrastructure needed for Integrated Neighbourhood Teams, workforce development, digital tools and the pooling of our collective estates to enable increasingly proactive, personalised, population-level care.

Our Population Health Improvement Plan describes in more detail the steps we are taking to develop this model.

## In developing our neighbourhood model, we will focus on:

### Supporting People with Complex Needs

- Reduce variation including falls, community nursing, care homes, intermediate care, end of life care, mental health, community paediatrics and neurodiversity
- Aligning NHS community services with acute and Place footprints
- Working in partnership with local authorities, social care and the voluntary sector

### General Practice (and wider Primary Care)

- Meet the demand for appointments and reduce variation in access through the use of digital solutions and new ways of working
- Align commissioning of services in primary care with the priorities identified in our integrated needs assessment

### Improving Access to Specialist Opinion & Diagnostics

- Improve the interface between primary and secondary care, through an MDT approach to enhancing access to specialist input and diagnostic tests in the community
- Transformed outpatient care which reduces unnecessary hospital visits

### Improving Health & Wellbeing and Tackling Inequalities

- A whole-system approach involving NHS, local authorities and community partners to ensure meaningful impact on the wider determinants of health
- Use behavioural insights to direct our partner resources at identified priorities

### Increasing Uptake of Prevention

- Work with our partners to focus on public awareness, education and support for the key priorities from our needs assessment
- Reducing avoidable illness, improving functional capacity i.e. by supporting preventative approaches centred on physical activity

### Stratifying our population to focus on those with greatest need

- Identifying which cohorts benefit most and targeting resources at supporting those in most need e.g. people with multi-morbidity, long term conditions, frailty and / or children and young people will result in less need for reactive support e.g. GP, social care or urgent care

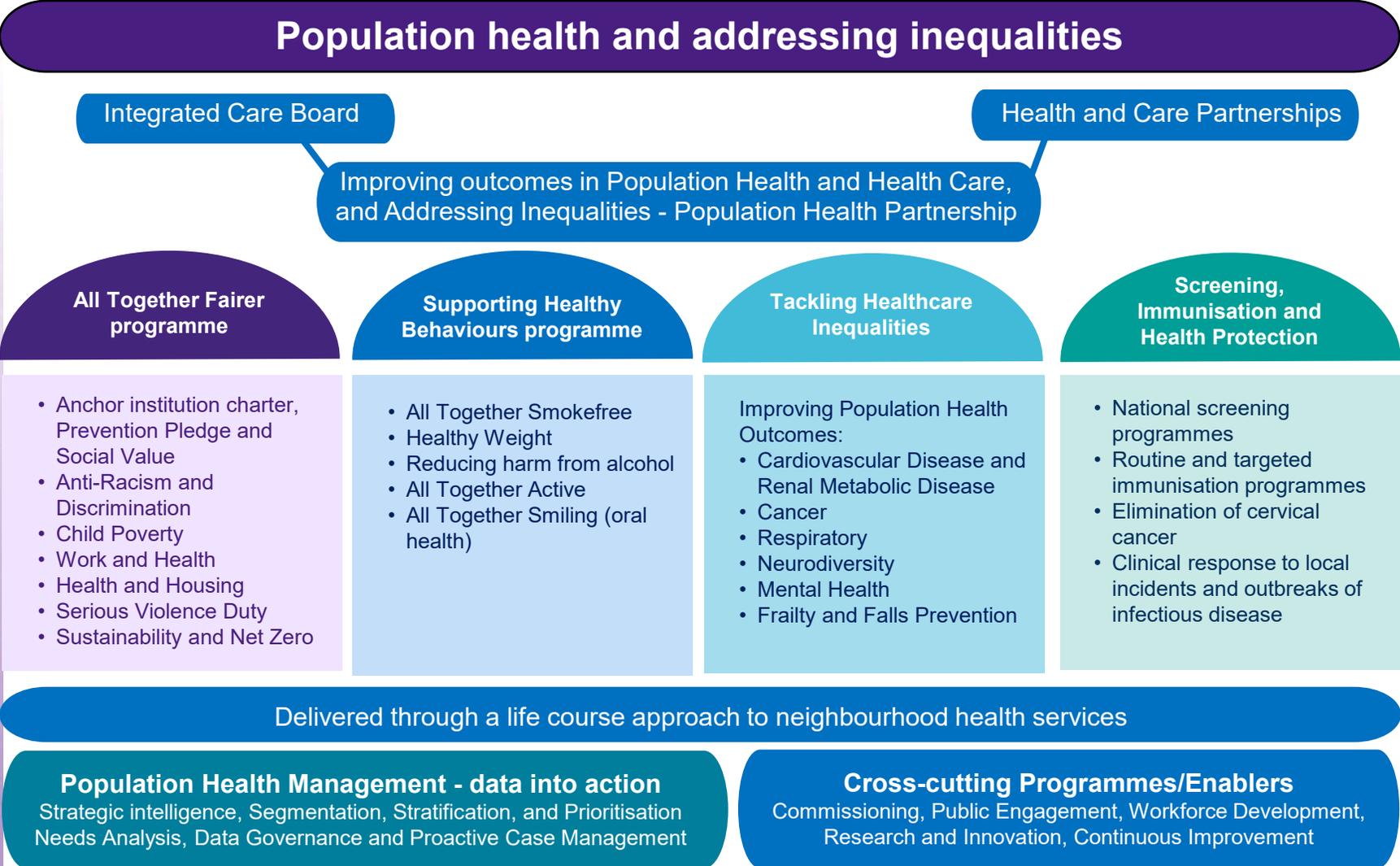
# Living Healthy Lives – Prevention and Proactive Care

## Why is this a priority for us?

- The life-expectancy gap between the richest and poorest is widening, driven by circulatory disease, cancer and respiratory disease. Our needs assessment also identifies neurodiversity, mental health, frailty and falls prevention as areas where we have opportunities to improve.
- Healthy life expectancy is declining across Cheshire and Merseyside, with Warrington the only exception.
- Smoking and unhealthy weight are more common in the most deprived communities, and many people with long-term conditions continue to smoke or live with excess weight or obesity.
- More than a third of the population (35.7%) live in the 20% most deprived areas, with deprivation strongly linked to poorer health outcomes.
- Inequalities are evident across wider determinants of health -including education, housing and employment – varying by age, ethnicity, gender, deprivation and place.
- A disproportionate share of spending goes on treating illness in groups where poor health has not been identified early or effectively managed.
- We have unwarranted variation across communities in those being immunised and vaccinated against disease.

Our Population Health Improvement Plan provides details on our approach to the priorities outlined.

**Our ambition: We will increase the number of years a person can expect to live in good health**



# Maternity and Neonatal Care



## Starting Well

### Our ambition: We will improve the quality and safety of local maternity and neonatal services

#### Why is this a priority for us?

- Improving the quality and safety of maternity and neonatal services is essential to reducing health inequalities reducing variation, avoidable harm, and adverse outcomes.
- A significant proportion of our population live in the most deprived communities, and these women, including women from ethnic minority backgrounds are at higher risk of maternal mortality, stillbirth, and preterm birth
- Maternity and neonatal services are facing changing demographics, rising clinical complexity and persistent inequalities, resulting in more complex care needs and a system that must adapt to meet the needs of a changing population.
- We have several maternity and neonatal units which do not meet national standards in terms of the activity levels, workforce requirements, and estates.
- The cost of delivering the current model is contributing to the lack of system financial sustainability.
- There is a continued national focus on maternity safety, and several national enquiries are expected to publish recommendations during 2026–27 that the system will need to respond to.

#### We Will:

- Undertake a review of maternity and neonatal services across Cheshire and Merseyside to ensure we commission only services that will deliver the national standards of care in a financially sustainable way.
- This will include but is not limited to, achieving the long-term clinical safety and sustainability of women's services in Liverpool.
- Support our maternity and neonatal services to implement national safety initiatives to improve safety, quality and outcomes for women, babies and families
- Work with maternity and neonatal services to develop a detailed understanding of the scale and complexity of co-morbidities, to inform targeted actions to improve outcomes and address inequalities
- Commission and strengthen collaborative clinical networks, including the North West Maternal Medicine Network, Cheshire and Merseyside Preterm Birth Network and the Cheshire and Merseyside Foetal Medicine Network, to develop an improvement plan that addresses poor maternal and perinatal outcomes in our population.

# Children and Young People (CYP)



## Our ambition:

We will improve access and outcomes through a holistic, joined-up system for our children and young people that brings together our partnerships and community, mental health, hospital, and tertiary services

## Why is this a priority for us?

Around 25% of our population are under 19. Some children and young people do not “Start Well” and this translates into poorer outcomes.

As examples:

- We have higher rates than England averages in the percentage of 5-year-olds with visually obvious dental decay.
- 24.0% of year 6 children were obese compared with the England average of 22.7%, with one area in the sub-region as high as 30.7%.
- We are higher than the England averages for teenage conceptions, hospital admissions for asthma and mental health conditions among under 18s.

We know that **access to services** to support children and young people and **outcomes vary widely across communities, this isn't fair or equitable.**

*Note: Specific plans related to children and young people are also reflected in a range of our other priority programmes including mental health and neurodiversity*

## We Will:

- Improve the population health for children and young people including an immediate focus on lung health, healthy weight and oral health and maximising uptake rates of vaccination
- Address unwarranted variation in community and elective waiting times addressing equity of access compared to adults.
- **Work with Local Authority partners to develop plans for a Regional Care Cooperative (RCC) model, building on our Appropriate Places of Care programme.**
- Work with Alder Hey NHS Foundation Trust, and system partners, to develop an Accountable Care Organisation approach to prevention, care and treatment for children and young people, focusing on:
  - Develop a CYP Strategy to improve outcomes, tackle inequalities and maximise resource use, strengthening collaboration across partners and sectors, seizing national opportunities to transform care and deliver in line with the expected national Modern Service Framework.
  - Commissioning of a hosted secondary and tertiary care provider model across NHS Trusts to deliver reduced waiting times in community and hospital-based services.
  - Development of a holistic model for universal community, mental health and neurodevelopmental CYP services.
  - Neighbourhood Multi Disciplinary Health and Care Teams (MDT's) connected to every neighbourhood in Cheshire and Merseyside.



**Our ambition:** We will ensure comprehensive support is provided for people with mental health needs, improving their health outcomes and ensuring access to services meeting their needs.

### Why is this a priority for us?

- There were 26,672 mental health related A&E attendances in 2024/25 we are the 9th highest ICB for emergency hospital admissions for self-harm – rate of 174.6 per 100,000
- Mental health – emergency care costs £9 million annually, delivering a recovery oriented early intervention model of care that supports patients before they experience crisis offers an opportunity to achieve savings.
- It is estimated that 1 in 5 children and young people have a diagnosable mental health problem, and that for many children experiences such as trauma or adversity in childhood have contributed to the development of their mental health condition.
- Highest ICB prevalence rate for depression in England and highest rate of new depression registrations – 7th highest ICB prevalence for severe mental illness – 19th highest prevalence rate for dementia
- A higher proportion of patients on the mental illness disease register live in deprivation quintile one - only 71.7% of patients with severe mental health issues have a comprehensive care plan

### We Will:

- Expand access to timely, community-based services, ensuring mental health support is shaped by a clear understanding of children’s and young people’s needs.
- Ensure all schools and colleges to have access to a mental health support team.
- Work with Mersey Care and Cheshire & Wirral Partnership NHS Foundation Trusts on the development of an accountable care approach to delegated NHS commissioning and care to improve outcomes and cost.
- Reduce admissions to Child and Adolescent Mental Health Services (CAMHS) inpatient beds and crisis attendances at Emergency Departments (EDs) including working with partners to develop “appropriate places of care”.
- Ensure fewer people with a mental health need require inpatient care and reduce presentations to services in crisis.
- Implement community-based mental health services so that more people with a mental health need will be supported to in the community and close to home.
- Improve health outcomes and life expectancy of people with mental health needs.
- Continue to support services that contribute to improving overall mental health and wellbeing for example social prescribing programmes and community based services

# Neurodiversity, ADHD, Learning Disability and Autism



Growing Well and Living Well

## Our ambition:

We will improve the identification and support for neurodivergent individuals, focusing on understanding needs, improving access to earlier support and reducing waiting times for assessment

### Why is this a priority for us?

- The current service models are diagnosis rather than needs led which has led to individuals not getting the early support they need.
- The consistent use of threshold criteria has been variable.
- As awareness of Attention Deficit Hyperactivity Disorder (ADHD) and autism has grown, the number of referrals to assessment services significantly exceeds commissioned capacity leading to long and growing waiting times and there is a lack of clear communication / support while people wait.
- Insufficient NHS capacity has led to growth in independent sector provision with a lack of robust clinical pathways for ongoing support and creating a significant financial pressure (recent costs increased from £12m to £35m).
- Failure to meet individual's needs has wider impacts on individuals and services including associated mental health needs, inability to maintain attendance at school/employment etc
- People with a learning disability are dying on average nearly 20 years younger than people without a learning disability.

### We Will:

- Embed a needs led Neurodevelopment (ADHD and autism) model for Children and Young People that consistently identifies needs early and ensures co-ordinated support to meet need even without a diagnosis, rolling out the Cheshire and Merseyside 'Knowing Me' mapping tool.
- Roll out a Local Enhanced Service for adult ADHD focused on understanding and meeting needs and building capacity in primary care.
- Ensure ALL neurodivergent children and young people have improved access to early and ongoing support and when needed wait no longer than 28 weeks for assessment and diagnosis by 2029.

#### For all ages:

- Explore lead provider models to ensure greater consistency of provision
- Expand the early and ongoing support offer in all places in collaboration with local authorities.
- Streamline the assessment and diagnosis process to reduce waiting times
- Explore the use of digital tools to strengthen access to support.
- Develop effective shared care arrangements that enable those on medication for ADHD to access support closer to home
- Deliver at least a 10% year on year reduction in number of people with Learning Disability and/or Autism in mental health inpatient care.

# Frailty and Falls Prevention



Ageing Well

**Our ambition: We will deliver coordinated, person-centred frailty care**

## Why is this a priority for us?

- We have unwarranted variation in frailty care.
- Our rate of falls is 3rd highest nationally with a third of falls emergency admissions living in the 20% most deprived communities.
- Falls related emergency admissions in over 65s cost £116 million in 24/25.
- Our frailty population consume 10.7% of the healthcare costs in Cheshire and Merseyside. Older people with frailty are more likely to have a delayed transfer of care.
- Our over 75 population is forecast to grow by 45% by 2040, without a change the costs for both acute hospital care and lack of integrated care will continue to rise.
- We want to provide more frailty care in the community and people's own homes supported by neighbourhood health teams

## We Will:

Deliver coordinated, person-centred frailty care that:

- Responds to clinical and social risk stratification of our population.
- Sets out advance care plans for those in last 1000 days of life.
- Shifts the focus from reactive to proactive care, working with partners to move resources aligned with this and to address unwarranted variation across Cheshire and Merseyside.
- Prevents avoidable deterioration and acute hospital admission through early identification and intervention.
- Supports recovery and rehabilitation close to home, independence and quality of life.

# Palliative and End of Life Care (PEOLC)



## Dying Well

**Our ambition: We will enable equitable access to good quality end of life care**

### Why is this a priority for us?

- The number of deaths is projected to rise from 27,000 in 2024 to 34,000 in 2035 due to an ageing population and more people living with long-term conditions.
- Around 80% of those who die could benefit from palliative care.
- Healthcare use increases sharply in the final year of life, yet advance care planning remains below ambition with significant variation across localities and individual GP practices
- A higher proportion of people in C&M die in hospital compared with the England average, and this gap is widening.
- People in more deprived communities are less likely to be identified as being in their last year of life, less likely to be on the palliative care register, and more likely to die in hospital rather than at home or in a care home.
- Specialist palliative-care capacity across hospitals, hospices and community teams is below recommended levels, and generalist staff receive inconsistent training.
- We spend at least £300m each year on unplanned hospital care for people in their last year of life.
- The hospice sector faces sustainability challenges that could impact on provision of PEOLC services.

### We Will:

Develop and deliver a Cheshire and Merseyside strategy based on the findings of the PEOLC Strategic Needs Assessment.

This will:

- Improve early identification and advance care planning across providers, supported by neighbourhood-based models.
- Strengthen workforce capability through consistent learning and development for everyone involved in PEOLC.
- Align commissioning and service models, including specialist PEOLC, hospice provision and transforming CHC fast track into integrated 24/7 support.
- Enable integrated care through technology and shared records to coordinate and honour end-of-life preferences.
- Tackle inequalities by providing equitable access to care and targeting funding to need.

We will work with the Hospice Collaborative to review the model of care and consider the sustainability issues affecting the hospice sector.

# Enablers to achieving our priorities

- Clinical Leadership and Quality Safety and Experience
- Digital and Data
- Workforce
- Estates and infrastructure
- Financial Sustainability



# Enablers: Clinical and Care Leadership

## Our clinical and care leaders will:

- Integrate clinical and care professionals in decision making at every level of the ICS
- Embed a continuous improvement approach across all our functions
- Create a culture of shared learning, psychological safety and collaboration
- Work collaboratively at the Primary-Secondary care interface
- Be data driven and evidence led
- Promote Research and Innovation
- Involve patients and staff in designing, improving and transforming services



# Quality, Patient Safety and Experience

## Quality and Clinical Effectiveness – We will:

Through clinical leadership and engagement, we will improve our capacity and capability to improve all aspects of quality:

- Embed QI methodology across the system
- Develop the System Quality Group to ensure it is an effective forum for sharing risk across the system
- Embed an enhanced, systematic process for Quality and Equality Impact Assessments to be completed for all commissioning and de-commissioning decisions
- Further develop our clinical effectiveness group to ensure it supports the commissioning cycle.
- Improve quality assurance processes for our Primary Care providers
- Use the new NQB quality strategy to improve the quality of care in the highest priority areas locally

## Patient Safety - We will:

- Work with providers of commissioned services to align to national patient safety strategy requirements and embed the Patient Safety Incident Response Framework (PSIRF) with a particular focus on supporting smaller independent providers and primary care organisations to adopt and utilise PSIRF.
- Improve our internal ICB incident reporting rates using the Learning from Patient Safety Events (LFPSE)
- Tackle polypharmacy and reduce our rates of opiate prescribing
- Ensure appropriate Antimicrobial Prescribing to reduce Antimicrobial resistance.
- Support our UEC improvement programme ensuring that patients in the system are managed safely and with privacy and dignity through our Red Lines toolkit.

## Experience - We will:

- Listen to and learn from the lived experience of our patients, residents and service users
- Ensure the findings of national and local patient surveys are routinely considered and inform commissioning plans
- Make co-production our default approach to designing and transforming services.

In addition, we will implement the New Care Delivery Standards and the Modern Service Frameworks as they are launched.



# Enablers: Digital and Data

Our ambition is to create a shared multi-year digital workplan that enables delivery of our strategic commissioning intentions and other system wide priorities through 'collaboration at scale'.

**Goals:** improved patient safety and outcomes, economies of scale through phased consolidation of digital infrastructure and services, and faster routes to innovation adoption.

**Strategic Opportunities:** Large-scale collaboration attracts external investment, especially in AI-driven productivity and healthcare transformation, with opportunities for shared benefits if scaled.

**Core Proposal:** Establish a Digital Centre of Excellence to coordinate innovation and horizon scanning, oversee transformation at scale and manage commercial opportunities.

**Aim:** NHS Providers and Primary Care commit to delivering the 3 strategic aims aligned with ICB strategic commissioning intentions and underpinned by a commitment to disruptive transformation:

- Secure and share patient information - timely, secure access to accurate and up to date health records across care settings to improve safety and continuity of care.
- Enable digital clinical services - safe, efficient, and user-friendly digital tools that support clinical workflows, engage and empower patients, enhance staff experience and deliver operational productivity.
- Harness data for insight and population health - data-driven intelligence to inform clinical decisions, improve outcomes, and support research and innovation.

**Encourage bold innovative thinking - Fully embrace the potential for AI to radically transform how we operate**

**We Will:** Improve health and well-being by weaving our digital and data infrastructure, systems and services throughout our pathways of care.

The 5-year roadmap is anchored in the 3 goals of the ICS Digital and data strategy which has been in place since 2022.

## Goal 1

### Strong digital and data foundations

We will build the strong foundations on which to deliver our digital and data ambitions for Cheshire and Merseyside

#### Levelling Up Digital Maturity

*Ensure all providers meet agreed baseline standards for digital capability*

#### Harmonisation of Digital Systems & Infrastructure

*Reduce duplication and fragmentation through shared architecture and rationalised platforms*

#### Reducing Digital Risks

*Strengthen cyber security and resilience across the system*

#### Rapid Implementation of Digital Technology

*Deliver transformation at pace (e.g. ambient voice technology deployment) with robust assurance*

## Goal 2

### 'At Scale' Digital and data platforms

'At scale' digital and data platforms, tools and services across C&M, to ensure that a sustainable, standardised technical and data architecture is in place to improve consistency of offer, efficiency and interoperability of solutions

#### Driving Productivity & Cost Efficiency

*Optimise resources through shared services, collaborative procurement and economies of scale*

#### Improved Patient Pathways & Experience

*Align co-dependent services and digital tools to reduce risk and improve outcomes including in delivery of neighbourhood health*

#### Optimisation of Digital Workforce and Expertise

*Build a system-wide digital workforce with the right skills and capacity, reducing duplication and pooling specialist expertise where appropriate*

#### Data sharing and shared systems

*Optimise opportunities for the sharing of data and systems*

## Goal 3

### 'At scale' Digital and data platforms, tools and services

Continue to develop and expand its strategic digital and data platforms for use within all health and care providers and at all Places to leverage the benefits of at-scale investment and deliver improved outcomes for the population.

Ensure all parts of our health and care system deliver the digital and data requirements outlined in the NHS Medium Term Planning Framework.



# Enablers: C&M Strategic Workforce Plan

The ambition of our workforce plan:

We Want: Cheshire and Merseyside to be a great place to work and an outstanding place for care; whether in the community, in one of our hospitals or online

The NHS Cheshire and Merseyside ICB system workforce plan frames the workforce as a critical strategic enabler for achieving care closer to home.

It articulates a system-wide ambition to diversify, strengthen and modernise the health and care workforce, enabling a deliberate shift from hospital-centric treatment towards sustained disease management, prevention and personalised, community-based care.

This positions the workforce plan as a catalyst for improving long-term population health outcomes through the:

- Pursuance of affordable workforce models based on supply and demand congruence
- Rationalisation of workforce resources and
- Workforce transformation to support new integrated neighbourhood working models of care.

The NHS C&M ICB System Workforce Plan is supported by the NHS England C&M Workforce Plan: the latter maintaining a specific focus on oversight of acute and secondary care workforce planning.

## Affordability

**Demand analysis based on population health data, the JSNA and wider health intelligence including the CORE20PLUS5.**

**Supply and demand planning to achieve optimal affordability and reduced waste across integrated neighbourhood teams.**

**Workforce gap analysis and remedial action planning to build a futureproof workforce with the capacity and capability to facilitate integrated neighbourhood models of care.**

## Rationalisation

**Rationalisation of non-clinical corporate support services to achieve economies of scale so far as possible.**

**Workforce redesign to integrate and optimise the benefits of AI, digital capability and technology solutions.**

**Efficient and effective management of change to maintain clinical quality and safety and optimal wider workforce productivity.**

## Transformation

**Workforce modelling in collaboration with system partners to cultivate integrated neighbourhood multidisciplinary teams.**

**Workforce innovation informed by epidemiology, public health and the CORE20PLUS5.**

**Workforce capability planning to enable effective risk management of transitioning from existing to new ways of working.**

**As an ICB, we will partner with our staff and system partners to deliberately create ways of working that enable human ingenuity to flourish by:**

- Setting clear accountability for anti racism and social inclusion.
- Ensuring safe and supportive ways to raise concerns about practices that may harm our staff, patients, or the public.
- Taking a population health approach to staff health and wellbeing.
- Putting people at the centre of how we lead and manage.
- Reducing unnecessary bureaucracy so staff at all levels can take part in decision making through networks or engagement forums.
- Embedding Board level oversight of organisational culture and employee experience, aligned with the NHS Constitution and the Nolan Principles for public service.

**To deliver our system workforce plan, we will:**

- Look after the health and wellbeing of our workforce and continue to develop as **Anchor organisations**
- Cultivate antiracist and anti discriminatory ways of working
- Nurture a values-based culture
- Demand personal and communal accountability for health justice
- Create opportunities to learn and continually develop
- Engender civility in the workplace
- Deliver on the NHS People Promise
- Develop psychologically safe places of work where staff can speak up, be heard and challenge without fear of retribution and
- Provide meaningful platforms for staff engagement with organisational decision making.
- Support workforce development across all sectors



# Enablers: Estates and Infrastructure

Estates and Infrastructure is a fundamental driver to the delivery of the 5 Year Clinical and Strategic Commissioning Plan. It will enable the three national shifts:

## Hospital to Community

The estate will support more care in local settings by expanding or enhancing community (neighbourhood) hubs and enabling home-based services exploring opportunities around shared estate

## Analogue to Digital

Estates upgrades will integrate smart technologies that reduce administration and help people to manage their own care needs

## Sickness to Prevention

The estate will create accessible spaces that encourage healthy living and support providing early intervention

The 5 Year Clinical and Strategic Commissioning Plan is anchored to the aims and objectives of the ICS Infrastructure Strategy (2024) .

## Our estates strategy aims to:

Implement a modern, adaptable and futureproof approach to estates and Infrastructure investment; ensuring it supports local delivery, remains flexible and enables new models of working to enhance the integration of services for our population.

### Goal 1

System led development

We will continue to develop and expand the programme; including leadership and governance to enable the delivery of the ICS Infrastructure Strategy

### Goal 2

New models of working

Creating fit for purpose, sustainable physical estate across sectors; system readiness enabling plans that detail the opportunities and investment considerations for delivering neighbourhood health

### Goal 3

Data driven approach

Using digital and data to improve outcomes and services for our population; we will deliver a single source for estates data to support wider medium to long term population health management objectives and enable better decision making and improve operational efficiency.

Ensure all parts of our health and care system produce robust plans to support the delivery of the ICS Infrastructure Strategy.

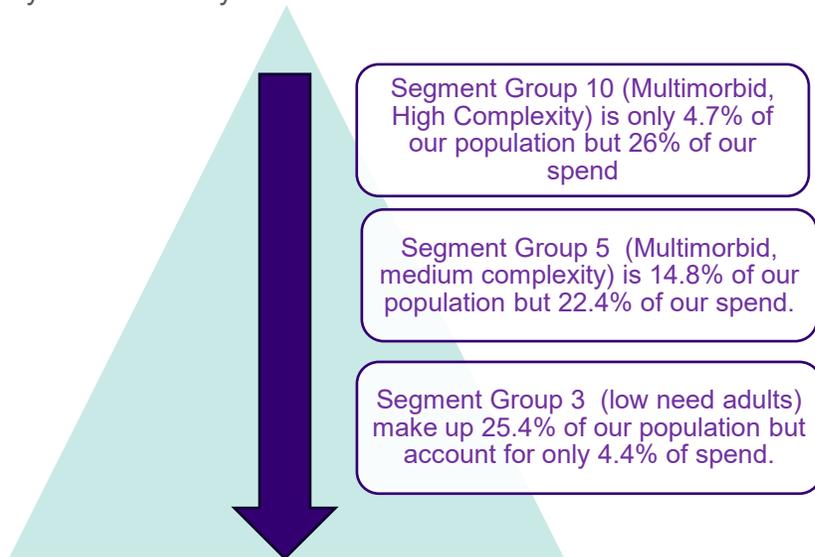


# Enablers: Financial Sustainability

- Too much of our budget goes on treating ill health, pushing care into costly hospital-based services. This is inefficient and contributes to our underlying system deficit of over £400m
- We need to redesign our system to redirect investment towards preventing illness, identifying risk earlier, detecting disease sooner, and helping people with long-term conditions manage their care more effectively as part of a shift of care into neighbourhoods and communities.
- Alongside this we need to ensure that existing services are working productively; this also need a focus on both transformation and reconfiguration to address underlying service fragility, workforce and delivery challenges.
- The enablers described on the previous slides outline the importance on investing in the right workforce, digital and data and estates and infrastructure solutions.

Population segmentation shows that certain groups require substantially greater support and therefore drive higher costs.

Enabling people to remain healthier for longer and preventing escalation in care needs increases overall system efficiency



We will shift resources toward prevention and proactive care through a £29.6m transformation fund in 2026–27 (rising in future years) .

Investment will align with priorities described earlier in this document and informed by our integrated needs assessment.

This also requires system-wide transformation to reduce duplication through integration and reconfiguration

## 1. Allocative Efficiency

Optimising the available resources to ensure greatest impact.

## 2. System Integration & Reconfiguration

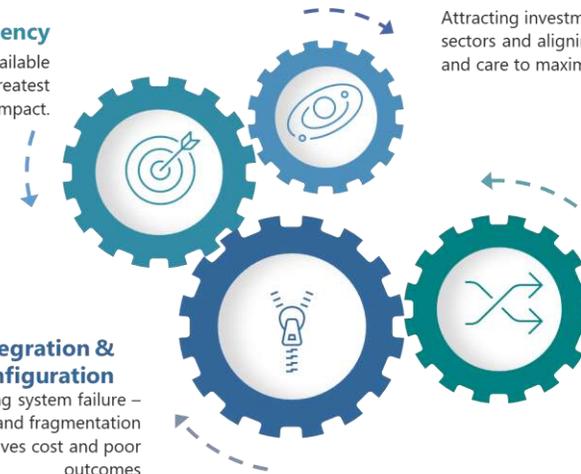
Identifying system failure – duplication and fragmentation which drives cost and poor outcomes

## 4. Wider & Complementary Investments

Attracting investments from other sectors and aligning with health and care to maximise impact

## 3. Resource Realignment

Identifying the parts of the system requiring investment & disinvestment. Using the financial and contractual levers/incentives to drive change



# Population Health Improvement Plan 2026/2031



# Contents – Population Health Improvement Plan

1. What is a population health improvement plan
2. How we have developed the priorities in this plan
3. Our approach to Population Health Management
4. Outcome and Value Based Contracting
5. Investing in the ‘Left Shift’ to provide neighbourhood health
6. Assuring delivery and monitoring of our Plans
7. What are the key risks to our plan

## Our Population Health Improvement Plan

### 8. Living Healthy Lives

- Cancer
- Cardiovascular disease / renal metabolic
- Diabetes
- Respiratory
- Health protection
- Neighbourhood Health
- Neighbourhood health / Community Services
- Routine Immunisations
- Oral Health
- Serious Violence duty
- Smoking cessation
- Weight Management

### 9. Starting Well

- Maternity and Neonatal Care

### 10. Growing Well

- Population Health and Joint Commissioning
- Neighbourhood Health and Accountable Care
- Corporate Parenting
- Mental Health
- Neurodiversity

### 11. Living Well

- Mental Health
- Learning Disability & Autism
- Neurodiversity
- Diagnostics
- Community Pharmacy
- General Practice
- Optometry
- Planned Care
- Primary Care Dental
- Stroke
- Women’s Health

### 12. Ageing Well

- Prevention of Frailty Escalation
- Dementia
- Falls Prevention
- Urgent and Emergency Care

### 13. Dying Well

- Palliative and End Of Life Care

### 14. Enablers

- Digital and Data
- Workforce
- Estates and Infrastructure
- Governance and Executive Accountability

### Glossary (Acronym buster)

There are many acronyms throughout the document - these are explained in the glossary this can be accessed through the link on each slide.

# 1. What is a Population Health Improvement Plan

A Population Health Improvement Plan (PHIP) is a strategic, data-driven approach to improving the overall health, wellbeing, and health equity of a defined group of people by addressing root causes of illness and promoting wellness across communities, not just within individual clinical visits, but across wider pathways, involving collaboration between healthcare, local government, and community partners.

Our PHIP is aimed at improving the health of the entire population. It is about improving the physical and mental health outcomes and wellbeing of people while reducing health inequalities.

It includes action to reduce the occurrence of ill health, deliver appropriate health and care services and action on the wider determinants of health. It requires working with communities and partner agencies.

It includes a focus on **PLUS** groups - who experience poorer than average health access, experience and / or outcomes for example groups like carers ensuring, they have the support they need and recognition they deserve

In delivering our plan we will work with our Provider collaboratives (NHS provider, primary care and VCFSE) to deliver creative solutions both within and across sectors. This will enable greater integration of services, increase consistency of access, experience and outcomes for residents.

**Our vision is to embed a culture of improving population health and reducing inequalities through increasing system collaboration, capacity, capability and intelligence.**

## Our key goals:

- **Improve outcomes:** for all people by using data, intelligence and insight and embedding a population health approach across Cheshire and Merseyside.
- **Reduce inequalities:** in experience, outcome and access to care by increasing collaboration capacity and capability across the system.
- **Address wider determinants:** act on social, economic, and environmental factors influencing health (e.g., housing, education, employment and poverty) helping support broader social and economic development.
- **Enhance care:** Improve patient experience and make care more proactive and personalised.
- **Increase value:** Enhance productivity, efficiency and value for money while improving quality.

Living Healthy Lives

Starting Well

Growing Well

Ageing Well

Living Well

Dying Well

The PHIP is built around our key priorities and follows a life course approach. For each section of the plan we outline:

The case for change

Key outcomes

The key impacts

Our 26-27 commissioning intentions

Our 27-28 commissioning intentions

Our commissioning intentions years 3-5

Our key metrics and measures

Governance route and Exec Lead



**NOTE:** This plan should be read alongside the accompanying 5-Year Clinical and Strategic Commissioning Plan

# 2. How we have developed the priorities in this plan

## In developing our PHIP priorities we have built from:

- Our Health and Care Partnership Strategy and Joint Forward Plan
- Priorities identified in our System Recovery Plans including efficiency, service sustainability and reconfiguration
- Our [Integrated Needs Assessment](#) (at C&M and Local Authority level)
- The Cheshire and Merseyside NHS Provider Blueprint

In addition to this our plan reflects additional priorities outlined in the NHS 10-Year Plan and Medium-term Planning Framework with a specific focus on delivery of the national shifts.

## We have reflected the current context with a key focus on:

- Preventing and intervening early to prevent ill health; targeting priorities and populations identified through our population health needs assessment
- Commissioning for outcomes and value-based healthcare
- Providing more care in our neighbourhoods
- Reducing waiting times (Electives, Diagnostics and Cancer (EDC) as well as Mental Health, Neurodiversity and Primary, Community & Urgent Care)
- Delivering financial and operational efficiency and service sustainability through the opportunities highlighted in our [Integrated Needs Assessment](#)
- Safe, appropriate and cost-effective use of medicines cuts across our ambitions and is a key enabler of improved outcomes. The medicines management work plan is supporting several key system-wide areas where we are an outlier or have scope to improve, i.e., polypharmacy and frailty, antimicrobial stewardship, pain including opioids, safety and cost effectiveness.

## We have recently refreshed our [Integrated Needs Assessment](#):

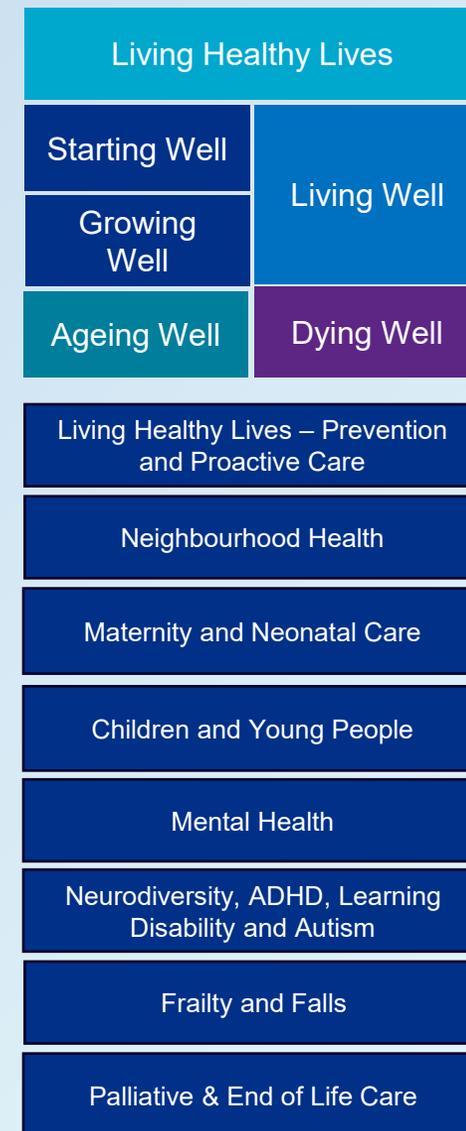
### Current situation:

- The gap in life expectancy between those living in our richest and poorest areas continues to grow
- Cardiovascular Disease, Respiratory Disease and Cancer remain the leading causes of this gap
- Healthy life expectancy continues to reduce in all areas of C&M except Warrington.
- Increasing rates of chronic conditions, multiple chronic conditions and poor mental health are key contributing factors to declining healthy life expectancy.
- Growth in need and insufficient capacity to support neurodevelopmental conditions.

### Future projections:

- Over the next three years in C&M we expect to see an increase of 84,783 people with long-term conditions costing an additional £187 million
- By 2040 - a 50% increase in diabetes, 31% increase in cancer and a 51% increase in atrial fibrillation.
- By 2040 - there will also be a 44% increase in people aged 75+.
- As an area with higher than average rates of frailty and falls this poses another significant challenge.

The PHIP is built around our key priorities and follows a life course approach.



# 3. Our approach to Population Health Management

*Improving outcomes: for all people by using data, intelligence and insight and embedding a population health management approach across Cheshire and Merseyside.*

We will take a [Population Health Management](#) approach to turn Data into Action and identify and then deliver the priorities in our Population Health Improvement Plan by:

Using data and benchmarking tools, including the Federated Data Platform Strategic Commissioning Tool, to inform commissioning decisions and target investment for maximum impact.

Applying segmentation and risk-stratification across NHS providers so people with the greatest need – such as those with long-term conditions or long waits – receive proactive, coordinated support.



### Clinical Risk

Physical health conditions, mental health, medications, complications, episodes of ill health

### Service Interaction

People at risk of being admitted to hospital, missing appointments or not accessing support that could improve their health and wellbeing

## Linked Data: Broader Perspective

### Inequalities

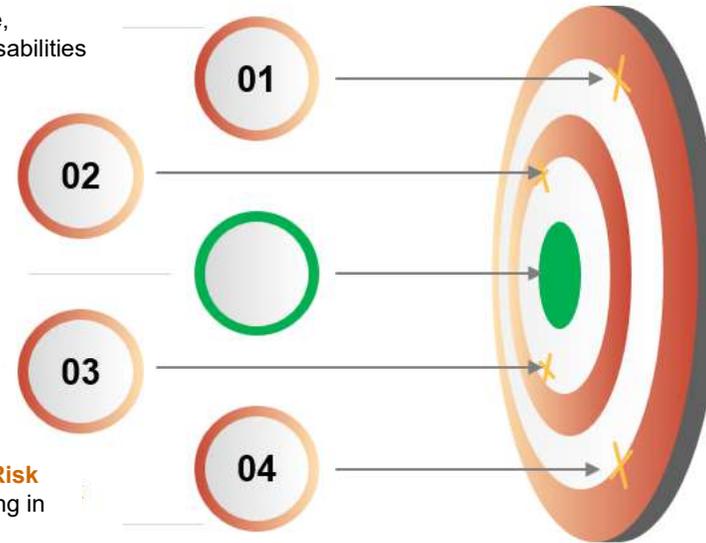
Factors such as age, gender, ethnicity, disabilities and deprivation

### Combination of key factors

Key issues all taken into account to find the people most in need

### Social/Household Risk

Socially isolated, living in poor conditions, fuel poverty, caring responsibilities



[Enhanced case finding](#) to predict population health needs, considering multiple conditions and severity to enable targeted interventions. Developing capability through our [Population Health Academy](#) so staff can use analytical tools to tackle health inequalities locally and lead commissioning and transformation at scale.

*We are using insight from our Integrated Needs Assessment and the Johns Hopkins Model to identify population groups needing support. This shows:*

- 25.4% of residents are “low-need adults” but account for only 4.4% of spend.
- The multimorbid, high-complexity group represents 4.7% of the population but 26% of spend.
- The multimorbid, medium-complexity group makes up 14.8% of the population and 22.4% of spend.

*This approach helps us work with our partners to target support by:*

- Predicting who is at risk of deteriorating health.
- Identifying people not receiving optimal care, such as people who would benefit from a review of the medicines they are taking.
- Highlighting who would benefit from a managed care plan, including people living with frailty or nearing end of life.
- Focusing on residents in the most deprived areas who may be facing a range of challenges.
- Co-ordinating resources to have the most positive impact.

# 4. Outcome and value-based contracting

In line with the principles outlined in our Five-Year Clinical and Strategic Commissioning Plan (see page 15), we have identified a set of commissioning and contracting approaches that will enable our transition toward a strategic commissioning approach centred on improving population health outcomes. These approaches are designed to support collaborative, long-term planning; incentivise outcome-focused delivery; and ensure that all commissioning activity remains compliant with national regulations, statutory responsibilities, and recognised best-practice guidance.

**Neighbourhood Health** is our key delivery vehicle to delivering the 10-year plan. As a commissioner we will develop a consistent framework from which neighbourhoods will be commissioned:

- An outcomes-based commissioning specification that will align with the Neighbourhood Health Framework expected to be published later this year.
- To coordinate proactive and preventative care and urgent and rehabilitative care locally in line with the population priorities identified through our Integrated Needs Assessment.
- Assess how, over time, we might delegate population-based budgets that would be underpinned by clear contractual documentation and expectations and use of financial levers to reflect delivery of key outcomes.

In line with the Provider Selection Regime (PSR), we will **work with partners** to support **market-development** activity that enables accountable care models and creates a more agile, stable care market.

Our priorities are:

- Maximising Alder Hey's role as an early Advanced Foundation Trust, improving outcomes for children and young people through an Integrated Health Organisation (IHO) and planning how we adopt the IHO contract model.
- Implementing lead-provider arrangements in mental health, with the lead subcontracting to capable partners.
- Strengthening provider collaboratives across NHS and VCFSE sectors and developing a Primary Care Collaborative to support neighbourhood delivery.
- We recognise this is a significant shift for commissioners and providers, requiring collective capability-building and realignment of system capacity.

Our plans for **service change** centre on developing neighbourhood health, with partners working to defined geographies and initially using the new Single/Multi Neighbourhood Provider contracts to support delivery at scale.

- NHS providers will realign services to neighbourhood footprints, ensuring consistent access to community care, diagnostics and specialist support.
- Commissioning will move to a single primary-care specification, based on integrated needs-assessment and neighbourhood population-health priorities.
- Provider collaboration will be strengthened through working to single service specifications, building on Modern Service Frameworks and agreed priorities with the ICB.
- We will commission services able to meet national standards for access, quality, safety, outcomes and which are financially sustainable.

We will **shift resources from hospital to community** by commissioning neighbourhood health services based on allocative efficiency, in line with population need and to achieve equitable health outcomes.

- For 2026–27, we have identified a £29.6m transformation fund (with further growth in future years) to drive the “left shift” from hospital to community, analogue to digital, and sickness to prevention.
- This investment will support transitional periods where new models transform from existing services. It will be tied to demonstrable reductions in demand for elective and non-elective acute care and will require providers to deliver additional efficiencies so that core activity can be sustained within a reduced funding envelope.

# 5. Investing in the ‘left shift’ to provide neighbourhood health (1 of 2)

Our 5 Year Clinical and Strategic Commissioning Plan sets out priorities that will drive the 10-Year Plan shifts—from hospital to community, sickness to prevention, and analogue to digital—through a neighbourhood health model.

We have committed significant investment to support this, including a £29.6m transformation fund in 2026–27 (rising in future years) and additional to national Service Development Funding (SDF) and national funding allocations which support a number of areas already included in our plans, such as improved access to mental health services, capital developments, and the expansion of our digital capability.

Our approach focuses on integrating existing services and aligning current resources into new innovative models of care, building support around people, and will actively avoid creating parallel services that add complexity and cost to our system.

The investment areas opposite reflect our initial priorities—those identified through our integrated needs assessment as having the greatest potential to improve population health while reducing pressure and cost in the most challenged parts of the system.

In making these investments we will determine clearly the outcomes which will measure success and how we will ensure plans deliver their intended goals.

**Creating integrated pathways with Primary, Community and Secondary Care Clinicians working together in a “multidisciplinary teams” model to support people to be cared for in their own home or neighbourhood, through:**

- **Diagnose to Refer model:** holistic symptom assessment with rapid access to diagnostics through community diagnostic centres/local testing, reducing unnecessary urgent care and outpatient referrals. Initial pathways will focus on respiratory, CVD risk management and frailty.
- **Single Urgent Care Clinical Assessment Service:** a Cheshire & Merseyside-wide model with community and secondary care clinicians supporting people to receive care at home.
- **Community-based intermediate tier services:** focusing on high-volume elective specialties moving care into community settings/models (initially Gynaecology, Dermatology and ENT).

*Our Population Health Improvement Plan includes further areas of “left shift” where we aren’t immediately planning to make additional investment but will work with partners to maximise existing assets within new care models, including:*

- *Implementing 24/7 mental health neighbourhood crisis centres and community rehabilitation.*
- *Developing an intermediate urgent-care tier, including virtual wards and community beds (including step-up beds), to use existing capacity more efficiently.*

# 5. Investing in the “left shift” to provide neighbourhood health (2 of 2)

## Investing in a consistent universal community services offer for our residents:

- In 2026–27, as part of developing a whole-system frailty offer, we will introduce a Home Assessment service for people who fall, including home-based diagnostics (e.g., X-ray) to avoid unnecessary hospital conveyance.
- We will implement single service specifications and tackle long waits for community services, with priorities including:
  - **Children and Young People:** speech and language therapy, physiotherapy, occupational therapy, community paediatrics and neurodiversity.
  - **Adults:** neurodiversity
- A consistent care-home MDT model (including wider primary-care input such as oral health).
- We will also invest in achieving a consistent end-of-life care model across Cheshire and Merseyside.

## Using Population Health Management intelligence to proactively support those with greatest need in neighbourhoods:

- We will commission Neighbourhood Teams to use population-health-management tools to deliver proactive support and personalised care plans. Until national neighbourhood contracts are available, this will be commissioned through General Practice providers using a Local Enhanced Service (LES) with clear, measurable outcomes. This approach will give partners flexibility to use local assets including VCFSE organisations and NHS provider resources to implement the model.
- Commission a consistent Shared Care neighbourhood based prescribing service to reduce unnecessary outpatient attendances.

### Supporting this:

- We will also commission system wide digital solutions to enable this and other community-based MDT models.
- Neighbourhood priorities will be intelligence-led and focus on key population groups - people with multimorbidity, long-term conditions (including CVD risk management and respiratory), frailty, and children and young people - to prevent escalation in care needs and reduce reliance on secondary care.
- This approach will align with, not duplicate, existing commissioning arrangement, including the national GP Contract.

As referenced earlier it is recognised there are wide ranging opportunities for investment. Over the coming year, we will use the intelligence from our integrated needs assessment to work with partners to agree further priorities for future years as part of a longer-term investment strategy.

## 6. Assuring delivery and monitoring of our Plans

- As part of our new operating model, we will reflect revised and enhanced governance to oversee how we operate, and this will be reflected in our approach to delivery of the priorities in this plan.
  - Each Programme will have an Executive Senior Responsible Officer and Programme Lead who will be responsible for ensuring that plans will deliver against agreed objectives with clear measures of success and timescales.
  - As part of our revised operating model programmes will be assured through a consistent programme management approach, reporting delivery progress through either a new Strategic Commissioning Programme Board or, if appropriate, through another Board sub-committee and then as part of a single improvement plan to the ICB Board.
  - Monitoring of progress against delivery will use strategic trackers of our key priority milestones, metrics and measures (based on outcomes wherever possible) through Board Sub Committees and through a monthly Integrated Performance Report (IPR) to Board.



See Page 64 for a summary of programme governance and executive accountability for each work programme.

The PHIP is built around our key priorities and follows a life course approach.

Living Healthy Lives	
Starting Well	Living Well
Growing Well	
Ageing Well	Dying Well
Living Healthy Lives – Prevention and Proactive Care	
Neighbourhood Health	
Maternity and Neonatal Care	
Children and Young People	
Mental Health	
Neurodiversity and Autism	
Frailty and Falls	
Palliative & End of Life Care	

# 7. What are the key risks to our plan?

Our Five-Year Clinical and Strategic Commissioning Plan and Population Health Improvement Plan have been developed to directly support addressing key risks identified by our Board.

NHS Cheshire and Merseyside has formally accepted 'enforcement undertakings' with NHS England. In response we have committed to delivering rapid improvement work to provide additional assurance in a number of key areas – including financial planning, quality (with particular regard to mental health), leadership and governance.

The service and delivery requirements included in the national planning guidance, alongside local commissioning priorities, may be challenging to achieve given the current financial, performance and capacity context and as such need to be prioritised.

Delivery of the requested reduction in the running cost allocation may have a significant impact on the ICB's ability to deliver against our commissioning intentions. This will become clearer as we begin to understand the details of the revised operating models.

In embedding the new NHS operating model, we will ensure that the ICB has the resources, skills, and abilities to deliver our role as strategic commissioner. It is recognised that the programme management resources we have to deliver our plan are limited, so we will target resources at the priorities in this plan. Progress will be closely monitored by our Executive Team and Board.

***The intentions outlined in both plans will help mitigate these risks.***

## Board Assurance Framework:

- **Quality and Safety Failures in Commissioned Services:**  
Risk that services may not consistently deliver high-quality, safe, and equitable care, especially during the shift from hospital to community-based models.
- **Digital and Cyber Resilience Gaps:**  
Inadequate digital infrastructure, data sharing, and cybersecurity could disrupt care and hinder the transition to a digitally enabled NHS.
- **Failure to Reduce Health Inequalities and Improve Population Health:**  
Risk of not achieving measurable improvements for deprived and vulnerable groups if resources and actions are not sufficiently targeted.
- **Financial Sustainability and Productivity Challenges:**  
Inability to meet mandated savings and productivity targets could limit investment in prevention and digital transformation, and breach statutory financial duties.
- **Failure to Recover Access and Performance Standards:**  
Risk of not meeting national standards for access and performance, undermining public confidence and exacerbating inequalities.
- **System Fragmentation and Provider Sustainability:**  
Potential service loss or fragmentation if provider landscape is not proactively managed during commissioning of integrated, digital-first services.
- **Failure to Deliver Shift to Neighbourhood and Community-Based Care:**  
Risk of insufficient investment, workforce capability, or collaboration to achieve the transition from hospital-centric models.
- **Workforce Capacity, Capability, and Morale:**  
Organisational redesign and headcount reductions may destabilise morale and impede delivery of transformation priorities.

# 8. Living Healthy Lives

- Cancer
- Cardiovascular disease / renal metabolic
- Diabetes
- Respiratory
- Health protection
- Neighbourhood Health
- Neighbourhood health / Community Services
- Routine Immunisations
- Oral Health
- Serious Violence duty
- Smoking cessation
- Weight Management



# Cancer – prevention and early intervention (Inc. Lung Health Checks)

**Case for Change:** Cancer is a leading cause of mortality in Cheshire and Merseyside, with around 7,000 deaths per year. Whilst early diagnosis and cancer survival rates have improved in recent years, cancer incidence and mortality rates remain higher than the national average.

**Health Inequalities:** Each percentage point improvement in early diagnosis rates delivers 731 years additional life expectancy and 454 healthy life years/Quality-Adjusted Life Years (QuALYs) per year. Individuals from deprived communities are disproportionately impacted by cancer. Consistent achievement of the constitutional waiting times for cancer will ensure all patients have equity of access to timely diagnosis and treatment which improves outcomes, especially in fast-progressing cancers. In addition to this, the HPV vaccination programme aims to reduce the incidence of cervical cancer. The NHS aims to eliminate cervical cancer by 2040, emphasising the vaccine's role in preventing HPV-related cancers in both sexes.

**Financial:** Improved prevention, early diagnosis and successful treatment of cancer has a direct positive impact on the health economy. Each percentage point improvement in early diagnosis rates delivers over £2.3m saving to the NHS in Cheshire and Merseyside and £5.6m benefit to the local economy.

**Other Services:** Early-stage cancers require less complex, less intensive diagnostics, treatments and aftercare. However, to detect more cancers early requires an increase in routine diagnostic tests and surveillance programmes. Sufficient diagnostic and treatment capacity will be required to achieve and maintain cancer waiting times.

\*Medium Term Planning Framework (metric/measure or narrative)

**We will:** Reduce lives lost from cancer - Increase the proportion of cancers diagnosed at an early stage and Improve five-year cancer survival rates - Reduce lives lost to cancer by improving the early detection of cancer and reduce cancer-related mortality pertaining to Breast, Bowel and Cervical

Our ambitions are:

- Increase the proportion of cancers diagnosed at an early stage by 3% points each year in line with CMCA ambitions
- Reduce the gap in rates of early diagnosis between the most and least deprived neighbourhoods
- Eliminate Cervical Cancer by 2040

## 2026-27 – Priorities

- Improve HPV vaccination rates (26-28)
- Introduce lung cancer screening to Cheshire, completing 100% coverage.
- Raise awareness of the lifestyle risk factors for cancer and the symptoms of cancer and improve uptake of cancer screening programmes through targeted campaigns and engagement in partnership with VCSFE organisations, focussing on those communities in IMD 1 and 2.
- Implement changes to the bowel cancer screening programme (FIT@80).
- Undertake a strategic review of robotic-assisted surgery.
- Optimise treatment outcomes through prehabilitation and rehabilitation.
- Develop and implement guidance for frailty assessment and management for patients with suspected and diagnosed cancer from initial presentation through to end of life.
- Improve urgent cancer care in line with CMCA's five-year urgent care strategy.
- Reduce the gap in rates of early diagnosis between the most and least deprived areas
- Continue to work with NHSE and partner ICBs on development of NW OPIC ahead of Section 7a commissioning transfer in 2027\*
- Support changes to Cervical screening Programme, i.e. self-sampling

## 2027-28 – Priorities

- Work with system partners to reduce environmental risk factors for cancer.
- Transition lung cancer screening programme into two-year rolling programme for eligible population 2027-31
- Introduce a targeted triage tool to identify early-stage cancers in individuals who have never smoked.
- Implement changes to the cervical cancer screening programme.
- Improve identification of individuals at higher risk of cancer and optimise surveillance programmes 2026-28
- Reduce the proportion of cancers diagnosed in emergency settings, focusing on rarer cancers that cannot be staged.
- Implement the outputs of the review of robotic-assisted surgery.
- Using national and local clinical audits, identify and reduce variations in treatment outcomes.
- Improve urgent cancer care in line with CMCA's five-year strategy.
- Introduce patient-reported outcome measures (PROMs).
- Commission more flexible models of screening delivery

## 2028-31 – Priorities

- Maintain progress in line with the national cancer plan.
- Support patients living with and beyond cancer in the most appropriate setting (at neighbourhood level where possible).
- Strengthen screening workforce and provider resilience and scalability where it makes sense to do so

### Key Metrics and Measures

- Reduce the incidence of preventable cancers by 3% by 2031\*.
- Increase the proportion of cancers diagnosed at an early stage by 3% points each year\*.
- Reduce the number of late-stage diagnoses (age-standardised rate per 100,000 to reduce from approximately 210 to 200, equivalent to 5%, by 2030)\*.
- Improve treatment outcomes (improve five-year cancer survival by at least 1% point per year)\*.
- Reduce health inequalities\*.
- Improved HPV vaccination rates
- Improved screening uptake in all programmes by deprivation quintile

### 2026-27 – Priorities

- Introduce Single Queue Diagnostics for specialist investigations to create equity of access, choice and to achieve shorter average waiting times.
- Fully optimise MDT to improve timeliness of treatment.
- Deliver system pathway approach for skin, lung and gynae pathways, sharing resource where possible, building resilience and adopting best practice.
- Utilise AI and RPA to reduce administrative burden, improve efficiency and reduce errors.
- Expand care pathways which are straight to test (STT) to expedite access to diagnostics and target the non-cancer component of FDS, leading to increased focus on high-risk and diagnosed cancers\*.
- Optimise workforce to ensure roles are continually developed, staff are able to work at the 'top of their licence' to exploit capacity with shared and mobile workforce models to allow scarce workforce resource to operate across organisations.
- Improve visibility and access to data and intelligence to drive improvement through an intelligence strategy.
- Maintain a clear focus on cancer waiting times via a dedicated cancer performance forum and managed collaborative improvement plans and trajectories.
- Develop use of CDCs to increase diagnostic capacity and to support the spread of one-stop service models.
- Develop an SOP for inter-provider transfers to support timely management from diagnostic to tertiary sites, including the development of service contract agreements to facilitate joint care models.

### 2027-28 – Priorities

- Expand Single Queue Diagnostics for specialist cancer investigations and high-impact non-specialist diagnostics to create greater equity of access, choice and to achieve shorter average waiting times.
- Continue to optimise and embed MDT to improve timeliness of treatment.
- Deliver a whole-system pathway approach for breast, LGI and urology pathways, sharing resource wherever possible, building resilience for seasonal impacts and adopting best practice from across England.
- Further development of AI and RPA for example in referral optimisation, diagnostic reporting and information transfer.
- Continue to expand care pathways for cancer which are STT models to expedite access to diagnostics and target the non-cancer component of FDS, leading to increased focus on high-risk and diagnosed cancers.
- Continue to Optimise the cancer workforce and the development of shared and mobile workforce models to allow scarce workforce resource to operate across organisations.

### 2028-31 – Priorities

- Maintain progress in line with the national cancer plan (due to be published in 2026).

#### Key Metrics and Measures

- Maintain performance against the 28-day cancer Faster Diagnosis Standard at the new threshold of 80%\*.
- Achieve 80% performance against the 62-day cancer waiting times standard by March 2027, and 85% by March 2029\*.
- Maintain performance against the 31-day cancer waiting times standard at 94% or above, rising to 96% by March 2029\*.

\*Medium Term Planning Framework (metric/measure or narrative).

## CVD-RM secondary prevention

**The Case for Change:** CVD is the leading cause of morbidity, disability, mortality, and health inequalities in England with inequalities across the pathway from prevention to treatment. It causes around a quarter of all deaths in the UK.

Risk factors for CVD are more prevalent in Cheshire and Merseyside with high blood pressure the leading risk factor. Improving both the identification, treatment and management of atrial fibrillation, high blood pressure and cholesterol (ABC) would have a positive impact on economic productivity, prevent premature mortality and improve the quality of life for individuals and families.

**Impact on Health Inequalities:** CVD is among the largest contributors to health inequalities in life expectancy, accounting for one-fifth of the life expectancy gap between the most and least deprived communities. People living in our most deprived communities are four times more likely to die prematurely.

**Financial and impact on services:** If Cheshire and Merseyside met the 80% blood pressure treatment target ambition, we could prevent 337 heart attacks, saving £3.7m; prevent 502 strokes, saving £8.9m; and prevent 269 deaths in the next 3 years.

\*Medium Term Planning Framework (metric/measure or narrative).

**We Will:** Improve the cardiovascular health of the population by optimising the identification and treatment of those with Atrial Fibrillation, high Blood Pressure (hypertension) and high Cholesterol (ABC)

**Our ambitions are:**

- Target of a 25% reduction in CVD related premature mortality over the next 10 years
- Systematically scale up CVD prevention in primary care focussing initially on those practices furthest away from target

### 2026-27 – Priorities

- Continue to develop evidence-based support for primary care enabling them to proactively identify, monitor and treat high-risk individuals with ABC risk factors at scale, initially targeting practices that are both lowest performers and experience greatest health inequalities.
- Develop a robust response to the CVD Modern Service framework.
- As a CVD Prevention Accelerator site we will work with our partners to test new community-led delivery models for secondary prevention.
- Develop an implementation plan in response to the lipid management mapping exercise including considerations re: lp(a) testing?
- A whole system approach to prevention, strengthening efforts to reduce smoking prevalence and obesity; working with partners in local government and VCSFE to ensure that referrals into pathways reference the impact on CVD.
- Work with North West Kidney Network to support identification of Chronic Kidney Disease (CKD) and optimisation of treatment.

### 2027-28 – Priorities

- Rollout of tools to support primary care and systematically work through practice/ PCNs targeting those with greatest need with the ambition of having a named CVD lead in every practice/ PCN.
- Ensure reference to CVD Prevention in any C&M wide Locally Enhanced Service specification for primary care and consider enhanced payments for results with communities at highest risk of CVD.
- Continued expansion of Prevention Accelerator work completed to establish appropriate outcomes/ metrics.

### 2028-31 – Priorities

- Continued rollout of 2027/28 priorities.
- Supporting the target of a 25% reduction in CVD-related premature mortality over the next 10 years, including testing the NHS Health Check online service\*.

#### Key Metrics and Measures

##### 26-27

- Increase in identification and treatment of ABC

##### 26-28

- Prevention Accelerator outcomes and measures
- Yearly improvement and increase in identification and treatment of ABC

##### 28-31

- Reduction in referrals to secondary care lipid services due to optimisation in primary care

## CVD-RM - Diabetes

**Case for Change:** Diabetes is a major public health problem with diagnoses in the UK having risen from 1.4 million to 3.9 million since 1996. One in ten people over 40 now has type 2 diabetes. Core to Children and Young People (CYP) Core20PLUS5 - Improved access to gold standard care in deprived areas and ethnic minority communities, and more CYP with Type 2 diabetes receiving annual health checks. Delivery of national priority work programmes /Diabetes Prevention Programme (NDPP).

**Inequalities:** Managing patients' health will likely reduce emergency admissions, reducing morbidity and mortality and delays in CVD events and extends life expectancy and support groups who are more at risk of disproportionately adverse outcomes. People with higher risks should be proactively identified and offered screening in accordance with NICE guidance, including people from high-risk groups.

**Financial:** The NDPP is a nationally funded programme. Reduction in diabetes will reduce treatment and social care costs. Maintaining control of diabetes will reduce the burden of disease reducing emergency hospital episodes. Medicines optimisation will reduce overall costs with an initial increase in prescribing costs i.e., use of best value SGLT2i treatments and appropriate and best value CGM and other treatments to offset costs.

**Other Services:** preventing and treating diabetes will reduce demand on primary and secondary care. The demand on social care and treatment costs in the longer term will reduce. People are more likely to remain without diabetes complications for longer, which will prevent the development of cardiovascular, stroke and myocardial infarction disease conditions.

\*Medium Term Planning Framework (metric/measure or narrative)

**We Will:** Slow down the year-on-year incidence of type 2 diabetes as well as increasing the uptake of patients onto prevention programmes and improving the care and outcomes for people with diabetes.

**Our ambitions are:**

- Targeted case finding to identify people at high risk of developing type 2 diabetes (National Diabetes Prevention Programme NDPP)
- Optimising proactive management, targeting those at risk

### 2026-27 – Priorities

- Increase the proportion of people with NDH who had a glycaemic test in the previous 12 months.
- Increase the proportion of people with NDH who have been referred to the NDPP. Including gestational diabetes.
- Increasing the proportion of patients whose last HbA1c record is 42 - 47mmol/mol (at high risk of NDH), without a GP record of non-diabetic hyperglycaemia or diabetes mellitus.
- Improving care and outcomes for Children and Young adults with type 2 Diabetes and variation through GIRFT action plans.
- Improving care for those transitioning from Paediatrics to adult care and addressing poorer outcomes through GIRFT action plans.
- Access to hybrid closed loop/ continuous glucose monitoring (HCL/CGM) for CYP (particularly CORE20+5 populations)

### 2027-28 – Priorities

- Increase the proportion of adults with diabetes receiving all 8 care processes in the preceding 12 months, ensuring increased proportion in the most deprived groups.
- Increase the proportion of people with diabetes meeting all NICE 3 treatment targets.
- Utilise available commissioned places for eligible patients for the NHS T2D Path to Remission Programme.
- Increasing the proportion of people with type 2 diabetes prescribed an SGLT2i except those patients with frailty/other more susceptible groups\*.
- Increase the proportion of people with diabetes who are eligible for CGM or Hybrid Closed Loop who are prescribed this technology. Targeting susceptible ethnic groups and more deprived groups, including pregnancy.
- Increase the rate of referral and attendance of structured education programmes for T1 and T2 diabetes.

### 2028-31 – Priorities

- Tackling diabetes related foot disease and retinal health could be brought into plans.

#### Key Metrics and Measures 27-28 and beyond

- Maintain a year-on-year increase in the number of patients identified for being eligible for NDPP and an increase in the number of eligible patients referred into the NDPP programme.
- Year-on-year increase in the identification, utilisation or referral, with a focus on hard-to-reach groups.
- Year-to-year increase in the identification, utilisation or referral.
- number of people receiving diabetes care processes.
- Major foot amputation rates / surveillance of foot disease.
- Surveillance of retinal screening / retinal screening rate (this is the ninth diabetes Care Process).

# Respiratory Disease

**Case for Change:** Respiratory disease is a leading cause of death and emergency hospital admissions in Cheshire and Merseyside.

**Impact:**

**Inequalities:** Prevalence of respiratory diseases, such as COPD and Asthma, is higher among those living in our most deprived communities and inclusion health groups, such as substance misusers.

**Financial:** Emergency hospital admissions for Asthma, COPD and LRTI cost £33.7 million in Cheshire and Merseyside in 2024/25.

**Other Services:** Respiratory disease impacts on economic productivity through lost productivity, missed workdays and early retirement. Children with Asthma often miss school frequently, leading to educational setbacks and the need for additional support.

**We Will:** - Improve outcomes for all patients living with respiratory disease:

- Reduce the rate of emergency hospital admissions for respiratory disease
- Increase the proportion and quality of respiratory disease reviews
- Reduce the prevalence of smoking among those with a respiratory disease diagnosis

## 2026-27 – Priorities

- Every patient with Asthma or COPD to have a high-quality face-to-face annual review in primary care delivered by an adequately trained practitioner.
- GP practices should review patients based upon agreed risk stratification tools- patients with the greatest need are reviewed at the earliest opportunity.
- All Asthma and COPD patients should have a confirmatory diagnostic test recorded in their primary care record.
- Systems established to maximise people receiving annual flu vaccinations
- Ongoing smoking should be addressed at every clinical interaction, and Ottawa model tobacco dependency treatments provided at every hospital.
- People with COPD who would benefit from pulmonary rehabilitation should receive this within national timelines.

### Key Metrics and Measures

- Inc. the % of face-to-face COPD and Asthma annual reviews in primary care.
- Increase the % of patients with Asthma with a FeNO recorded.
- Increase the % of patients with COPD with spirometry recorded.
- Increase the % of patients with COPD receiving the influenza vaccination.

## 2027-28 – Priorities

- Primary care practitioners conducting respiratory annual reviews should be trained adequately in line with PCRS 'Fit to Care' document.
- Neighbourhoods should case-find COPD amongst high-risk patients, linking in with the Targeted Lung Health Programme.
- Patients with Asthma and COPD who live in cold and fuel-inefficient homes should be referred to appropriate services.
- Implementation of asthma guidance, reducing SABA monotherapy and use of appropriate inhalers in COPD and asthma.

### Key Metrics and Measures

- Increase the percentage of practitioners performing annual respiratory reviews who have appropriate qualifications.
- Increase in the number of patients with COPD in C&M.
- Increase in the number of patients assessed for fuel poverty.

## 2028-31 – Priorities

- Respiratory services should integrate primary, community and secondary care on a neighbourhood footprint.
- Pulmonary rehabilitation teams should proactively case-find people who would benefit from Pulmonary Rehabilitation.

### Key Metrics and Measures

- Respiratory outpatient transformation.
- Increased number of patients completing Pulmonary rehabilitation.

## Health Protection incl. BBV, TB, HCAIs and Outbreak Management

**The Case for Change:** ICBs have a statutory duty under the Health and Social Care Act 2022 to plan and coordinate the NHS response to infectious disease outbreaks, ensuring service resilience, managing resources and collaborating with public health bodies for population health protection.

Healthcare-acquired infections continue to exceed national targets, although there have been improvements in C.Diff. Significant community outbreaks in the past 12 months include: Measles, Respiratory disease in care homes, Avian Influenza, Tuberculosis, Meningococcal and Hepatitis A.

We will work with partners to support strategies which focus on eliminating Blood Borne Viruses and Tuberculosis.

**Impact on Health Inequalities:** As detailed in: [Health inequalities in health protection report 2025 - GOV.UK](#) Health inequalities in health protection have a high human cost across people and Place. In England, those living in the 20% most deprived areas bear the greatest burden, with emergency hospital admission rates due to infectious disease almost twice as high as those in the least deprived.

**Financial and impact on services:** Whilst health protection matters have a high human cost across people and places, they have an impact on health services and economic productivity.

**We Will:** Reduce the number of people harmed by vaccine preventable disease, BBV, TB and HCAI

Our ambitions are:

- Achieve zero new HIV infections, zero AIDS-related deaths and zero new viral hepatitis infections by 2030
- 90% reduction in TB incidence by 2035
- To reduce the harms associated with outbreaks of infectious diseases

### 2026-27 – Priorities

- Continue to review against: [Clinical response to local incidents and outbreaks of infectious disease](#): [Commissioning guidance for ICBs](#) agree a preferred delivery model and commission this in 2026/27.
- Support our LRC partners' ambition to become a HIV Fast Track Cities+ area by including viral hepatitis/TB.
- Consider TB service commissioning arrangements models to ensure future sustainability.
- Continue to work with Providers in relation to reducing rates of HCAIs and the harms associated with them.
- Continued support for BBV testing in Emergency Departments programme.

#### Key Metrics and Measure

- Commissioning cycle for a clinical outbreak response service is complete.
- Increased vaccination rates across all programmes.
- Increase in identification of people in EDs with BBV who go onto a treatment plan.

### 2027-28 – Priorities

- Support mobilisation and/or contract management of outbreak management Provider(s).
- Ensure robust and sustainable commissioning arrangements are in place for TB services.
- Continue to work with Providers in relation to reducing rates of HCAIs and the harms associated with them.

#### Key Metrics and Measure

- Improve vaccination uptake and coverage year on year across all eligible cohorts.
- Increase in identification of people in EDs with BBV who go onto a treatment plan.

### 2028-31 – Priorities

- Continue to review and strengthen ICB and wider system preparedness and responses to known and emerging health threats with key partners including UKHSA and Local Authorities.
- Contract management of outbreak management and TB service provider(s).

#### Key Metrics and Measure

- Improve vaccination uptake and coverage year on year across all eligible cohorts.
- Zero new HIV infections, zero AIDS-related deaths and zero new viral hepatitis infections by 2030.

## Neighbourhood Health

**The Case for Change:** Integrated Neighbourhood Teams (INTs) will become the cornerstone of neighbourhood health delivery, replacing fragmented models with integrated, outcome-focused care. Providers will be expected to organise services around INT footprints rather than historic organisational boundaries. This will prioritise proactive support for residents with high and ongoing needs, ensure continuity of care, and embed collaboration.

The approach will help reduce unwarranted variation in access to GPs and unnecessary non-elective hospital care (inc. for people with frailty or at the end of their life).

**Inequalities:** We have an inconsistent approach to proactively supporting residents across neighbourhoods and Places, use of consistent risk stratification approaches allows us to proactively target support and those with greatest need and reduce inequality of access and care.

**Financial:** Through our risk stratification intelligence we know that we spend disproportionate levels of activity on segments of our population in relation to those with multiple health conditions (high complexity – 26% cost to <5% of population and medium complexity >22.39% against <5% and for those identified as frail 7% for 1% of the population).

**Other Service:** Unnecessary attendances/admissions in both planned and unplanned hospital-based services.

\*Medium Term Planning Framework (metric/measure or narrative).

### 2026-27 – Priorities

- Creating joined-up teams (across health and care) in each neighbourhood in line with Neighbourhood Health Framework\*.
- Use CIPHA to risk-stratify patients most in need of support and continuity of care with General Practice and Neighbourhood Teams delivering care plans.
- Agree Neighbourhood Footprints: Define footprints that are meaningful to local people.
- Reduce variation in GP Access with recovery plans in place where needed\*.
- Improving the Primary - Secondary Interface including improving access to diagnostics and specialist opinion.
- Implementing INTs with agreement on which patient groups (cohorts) to focus on.
- Implementing non-elective plans across multiple neighbourhoods with demonstrable impact on GP appointments, ED attendance and length of stay\*.
- Implementing a Neighbourhood Outpatient Model of Care.

### 2027-28 – Priorities

- An expansion in the cohorts and numbers of patients supported by integrated neighbourhood teams.
- Transfer of service/workforce capacity into “out of hospital settings” to enable more planned and early intervention activity.
- Continue to focus on improving the quality and efficiency of all-age continuing care (AACC) services, addressing unwarranted variation and preparing for full transition to AACC Data Set v2.0 by March 2027\*.

#### Key Metrics and Measures 2026-28

- Reduction in risk profile of our population (CIPHA).
- Reduction in unplanned admissions for chronic ambulatory care sensitive conditions.
- Reduction in emergency admissions due to falls in people aged 65+.

### 2028-31 – Priorities

- Continued expansion of the cohorts being supported and of the community-based services available with a reduction in hospital capacity in prioritised areas.

#### Key Metrics and Measures from 2026-28+

- Prioritised population health indicators show an improvement in health and wellbeing outcomes.

## Neighbourhood Health – Community Services

**The Case for Change:** There are different models for community healthcare provision, and the providers delivering care don't always align to Place footprints, resulting in variation of care, access and outcomes and increased costs. In line with the NHS 10-Year Plan priority to move from Hospital to Community, ensuring sufficient capability is a core component of developing neighbourhood-based services and supporting a movement of clinical services from hospitals into community settings.

Our ambitions are improved outcomes and reductions in:

- Improve population health outcomes
- Emergency admissions (in line with cohorts identified in NHS Neighbourhood Health Framework)
- Hospital length of stay and Delayed Transfers of Care will reduce

**Impact on Health Inequalities:** A consistent offer and access to services will enable earlier treatment, reduce inequalities and improve outcomes.

**Financial:** Through our risk stratification intelligence, we know that we spend disproportionate levels of activity on segments of our population in relation to those with multiple health conditions (high complexity – 26% cost to <5% of population and medium complexity >22.39% against <5% and for those identified as frail 7% for 1% of the population).

**Other Services:** Neighbourhood health models include a range of NHS, Local Authority and Community Partners, and effective models need a shared approach to support communities and prevent escalation of need, including use of hospital and specialist services.

\*Medium Term Planning Framework (metric/measure or narrative).

**We Will: Provide local community-based care that is personalised to meet individual need take a preventative and proactive approach to reduce the need for hospital-based care**

### 2026-27 – Priorities

- Commission neighbourhood partnerships to reduce emergency admissions and other national priority metrics through use of population health management tools with investment targeted through a proportionate universalism approach.
- Implement standard specifications across community services (falls, community nursing, care homes and end of life care) develop specifications for the second phase priorities in 27-28\*.
- Waiting list reduction to increase proportion seen within 18 weeks.
- Holistic model for CYP mental health and community services developed & implementation commences as part of C&M Provider Blueprint.

#### Key Metrics and Measures

- No patients waiting more than 52 weeks for an appointment & st least 78% of people seen in less than 18 weeks\*.
- Reduction in emergency admissions against baseline.

### 2027-28 – Priorities

- Transfer of resources from hospital to community into neighbourhood health models reflective of neighbourhood progress in reducing hospital admissions and outpatient activity.
- Implementation of standard specifications for second phase service specifications and develop timeline and third phase for implementation from 2028.
- Delegation of population budgets to “early adopters” and where all neighbourhood partners agree to contractual model.
- Implementation of holistic C&M model for CYP mental health and community services and development of outcomes-based ACO contract.

#### Key Metrics and Measure

- 79% of people seen in less than 18 weeks.
- Reduction in Emergency Admissions.

### 2028-31 – Priorities

- Year on year transfer of resources from hospital to community into neighbourhood health models reflective of neighbourhood progress in reducing hospital activity.
- Neighbourhood Partners to agree on their agreed contractual model and commencement of delegation of population budgets to agreed “lead” provider\*.
- CYP IHO model (or similar) for programme budget against agreed outcome measures.

#### Key Metrics and Measure

- 80% of people will be seen in less than 18 weeks.
- Reduction in Emergency Admissions.

## Routine immunisations

**The Case for Change:** Vaccination is one of the most effective ways of protecting ourselves and our children against ill health and death. However, if uptake decreases it's possible for diseases to quickly spread e.g. measles is starting to appear again even though the MMR vaccine is the best protection against this. Without improvements:

- Uptake will continue to fall
- Inequalities will widen
- Outbreaks of Vaccine preventable disease will become more frequent
- Pressure on the NHS will increase

We will commission vaccinations as consistent national programmes delivered locally, embedding equity, quality and safety, addressing unwarranted variation across our places.

**Impact on Health Inequalities:** Lower uptake persists for::

- Those from the most deprived quintiles
- Some ethnic minority, migrant & transient populations
- Children missing school & those not registered with a GP

**Financial and impact on services:** Vaccination remains one of the most cost-effective public health interventions. Besides the cost to individuals and their communities, preventing outbreaks reduces pressure on:

- NHS activity including UEC
- Costs associated with outbreak management

\*Medium Term Planning Framework (metric/measure or narrative).

## We Will: Reduce the incidence and associated morbidity and mortality of vaccine preventable disease.

Our ambitions are:

- Reduction in respiratory-related emergency hospital admissions
- Reduction in paediatric ICU admissions associated with vaccine preventable illness
- Commit to achieving and sustaining  $\geq 95\%$  coverage for MMR vaccination to eliminate measles

### 2026-27 – Priorities

- Continue to work with NHSE and partner ICBs regarding development of NW OPIC ahead of Section 7a commissioning transfer in 2027.
- Develop robust systemwide plans to increase uptake in all routine vaccination programmes with a focus on:
  - those in Quintile 1 & 2
  - clinical at-risk groups
  - Pregnant cohort
  - Health Care Workers
- Continue to deliver a C&M response to the national vaccination strategy in collaboration with our key partners including LAs\*.

### 2027-28 – Priorities

- Commission more flexible delivery models, e.g. mobile services, extended access.
- Increase the number of vaccines that can be administered in Community pharmacy\*.
- Continue to deliver a C&M response to the national vaccination strategy in collaboration with our key partners including LAs.
- Strengthen vaccinator workforce
- Strengthen provider resilience and scalability.

### 2028-31 – Priorities

- Continue to deliver a C&M response to the national vaccination strategy in collaboration with our key partners including LAs.
- Continued focus on strengthening vaccinator workforce and provider resilience and scalability.

#### Key Metrics and Measures

- Improve uptake and coverage year on year across all eligible cohorts.
- Improve equality of uptake and coverage in underserved and Core20PLUS populations.

# Oral Health – All Together Smiling supervised toothbrushing programme

## Case for Change:

Tooth extraction due to oral decay is the leading cause of hospital admissions for children aged five to nine in England despite it being largely preventable.

## Impact:

**Inequalities:** Tooth decay disproportionately affects those living in our most deprived communities. Children in these areas are three times more likely to have decay than their more affluent peers. Poor oral health also affects children's ability to sleep, speak, socialise and participate in education.

**Financial:** The cost to the NHS for hospital admissions for decay-related extractions for children aged 0-19 was £50.9 million in 2021/22.

## Governance route and Exec Lead:

The All Together Smiling Programme reports into the Beyond C&YP transformation programme board and the ICB Population Health Partnership.

Exec Lead – Executive Director of Health and Integrated Care Commissioning.

**We Will:** To ensure children and young people have the skills and equipment to brush their teeth

Our ambitions are:

- Increase the number of settings and children participating in supervised toothbrushing
- Increase the number of oral health packs distributed

### 2026-27 – Priorities

- Maintain >50% setting participation in the programme as recommended within national evidence.
- Targeted distribution of oral health packs to: CORE20 General Dental Practices and Community Dental Services, [CORE20 PLUS](#) communities, and CYP within specialist SEND settings/ alternate provisions.
- Enhance programme reach by universal offer for CYP within SEND settings (supervised toothbrushing [STB] and oral health packs).

### 2027-28 – Priorities

- Continued programme alignment to Local Authority commissioned STB programmes, ensuring CORE20 groups remain the focus.

### 2028-31 – Priorities

- Longer-term commissioning intentions to support transition to business as usual in partnership with Health and Local Authority.

#### Key Metrics and Measures

- Number of eligible settings taking part in STB.
- Number of children participating.
- Number of oral health packs distributed.

# Serious Violence Duty

## Case for Change:

The ICB is a statutory partner in the Serious Violence Duty. The ICB plays a key role in the multiagency public health approach to tackling the drivers and impact of serious violence with a focus on prevention and early intervention.

## Impact:

**Inequalities:** Violence disproportionately affects those living in our most deprived communities. We also know that violence against women and girls is a significant driver of gender-based health inequalities. Impacts include direct health burdens as well as impacts on education, employment and quality of life.

**Financial:** The cost of violence to the NHS in England is approximately £921 million, with a further £1 billion in costs associated with violence towards NHS staff.

**Other Services:** The impact on other services will include a reduction in the number of serious violence victims presenting to A&E, the number of serious violence victims being admitted to hospital and ultimately an overall reduction in the number of repeat victims of serious violence presenting to services.

## We Will: Prevent and reduce serious violence across Cheshire & Merseyside

Our ambitions are:

- Increase NHS staff awareness of serious violence and their role in preventing it
- Reduce the number of serious violence victims presenting to A&E
- Reduce the number of serious violence victims being admitted to hospital
- Reduce the number of repeat victims of serious violence

### 2026-27 – Priorities

- Develop a plan for delivering training to all frontline staff on identifying risk of violence.
- Begin delivering training to the staff groups identified as the first priority cohort for training.
- Begin to establish referral pathways for frontline staff who identify at risk patients.

#### Key Metrics and Measures

- Number of staff trained in each NHS Trust.

### 2027-28 – Priorities

- Develop a population health academy training programme on how to use the C&M violence dashboard.
- Consider how the C&M violence dashboard can be developed to encompass additional NHS data.
- Identify a minimum dataset that clinicians within the NHS should be recording to support the development of violence-related data.

#### Key Metrics and Measures

- Number of staff trained in the population health academy from each NHS Trust.

### 2028-31 – Priorities

- Consider how preventing serious violence can be integrated into service specifications and NHS contracts.

#### Key Metrics and Measures

- Number of service specifications and contracts that include duties to reduce serious violence.

## Smoking cessation (Opt out)

**Case for Change:** Smoking is the leading cause of preventable illness, premature death and health inequalities in Cheshire and Merseyside, creating significant pressure on health service demand and costs. The NHS can prevent smoking-related illness by identifying patients who access healthcare services and supporting them to access evidence-based treatment services.

### Impact:

**Inequalities:** Smoking is the leading cause of health inequalities in C&M. Rates of smoking are significantly higher among those living in the most deprived communities and among men.

**Financial:** Smoking costs C&M £1.75 billion each year. The NHS in C&M incurs £75.9 million of these costs each year.

**Other Services:** Smoking has a negative impact on a range of services including social care (cost £598m per year, productivity £1.06bn per year)

**Governance route and Exec Lead:** Each provider requires a Senior Responsible Officer for this work. Progress should be reported to the All Together Smokefree Board and Population Health Partnership.

Exec lead - Executive Director of Health and Integrated Care Commissioning

\*Medium Term Planning Framework (metric/measure or narrative)

## We Will: Ensure all hospital patients who smoke are supported to access tobacco dependency treatment

Our ambitions are:

- 95% of patients have their smoking status assessed when in contact with hospital services
- 75% of patients who are identified as smokers are referred to community smoking cessation services as part of the opt-out pathway
- 60% of referred patients become a treated smoker
- 40% of patients who are a treated smoker quit at 28 days

### 2026-27 – Priorities

- Implement opt-out across all surgical pathways.
- Consider how opt-out can be integrated into the all-new service specifications and existing NHS Trust contracts\*.

#### Key Metrics and Measures

- By the end of 2027 75% of surgical patients who are smokers are referred to community stop smoking services.

### 2027-28 – Priorities

- Implement opt-out across all outpatient clinics\*.

#### Key Metrics and Measures

- 75% of outpatient patients who are identified as smokers are referred to community stop smoking services.

### 2028-31 – Priorities

- Implement opt-out across all other hospital-based planned care.
- Implement opt-out in ED.
- Implement in any remaining hospital departments\*.

#### Key Metrics and Measures

- 75% of planned care patients (excluding inpatients) who are identified as smokers are referred to community stop smoking services.
- 75% of ED patients who are identified as smokers are referred to community stop smoking services.
- 75% of patients (excluding inpatients) who are identified as smokers are referred to community stop smoking services.

# Weight Management Services

## Case for Change:

Unhealthy weight places a significant burden on the NHS in C&M. Currently there are a range of specialist weight management services funded by the ICB, but there are inconsistencies across geographical Places in terms of eligibility criteria, staffing models, capacity and access arrangements.

**Inequalities:** Overweight and obesity disproportionately affect those living in the most deprived communities. This then leads to poorer health outcomes in these groups due to obesity related health conditions. People from certain ethnic groups are also disproportionately affected by overweight and obesity and the associated health conditions. Obesity can then impact on mental health, the ability to work and participation in education for children and young people.

**Financial:** Overweight and obesity cost the NHS around £6.5 billion annually and this is projected to increase to £9 billion by 2050.

**Other Services:** Overweight and obesity can impact on a person's ability to be economically active.

*\*Medium Term Planning Framework (metric/measure or narrative).*

**We Will:** Ensure patients living with obesity can access specialist weight management services.

Our ambitions are:

- 60% of patients lose 5-10% of their body weight
- 75% of patients report an improved quality of life score
- 30% reduction in the prevalence of obesity related comorbidities in this patient cohort

### 2026-27 – Priorities

Establish a service improvement programme for weight management services across Cheshire and Merseyside that:

- Establishes a single service specification for tier 3 services across C&M (including a minimum dataset and management service dashboard to monitor activity and outcomes for these services).
- Continue work around GLP-1 weight management drugs and managing the pipeline of new drugs\*.

#### Key Metrics and Measures

- Increase in the capacity of tier 3 weight management services.

### 2027-28 – Priorities

- Explore alternative operating models to maximise the capacity within tier 3 services in C&M.

#### Key Metrics and Measures

- Increase in referrals for weight management services.
- Increase in patients successfully completing tier 3 weight management interventions.

### 2028-31 – Priorities

- Implementation of identified alternative operating models.
- Contribute to the national target of 250,000 referrals to the NHS Digital Weight Management programme by Mar 2029\*.

#### Key Metrics and Measures

- Increase in the number and proportion of patients losing weight.
- Reduce in the prevalence of obesity related comorbidities.

# 9. Starting Well

- Maternity and Neonatal Care



# Maternity and Neonatal Services:

**Case for Change:** Maternity and neonatal services are facing increasing complexity with more women with co-morbidities, long-term conditions and wider socio-economic factors requiring enhanced care. In addition, there are ongoing workforce pressures, with recent Birthrate Plus reports identifying the need for additional resources to meet care requirements across 8 maternity units with a falling birth rate and national mandates for safety and improvement, which require significant financial resources. Limitations in digital and data capabilities continue to impact service efficiency and hinder effective monitoring. In line with the 10 Year Plan and national reports such as [MBRRACE](#), address disparities in access and outcomes, particularly for women from deprived areas and majority communities, who face higher risks.

Improving services will deliver the following measurable benefits:

- Better health outcomes and patient experience
- Reduced inequalities across ethnicity and deprivation
- Enhanced workforce resilience and retention
- Lower long-term healthcare costs and improved productivity

**Inequalities:** By standardising best practice, protecting high-risk groups, enhancing access through culturally sensitive and personalised care, and preventing complications, this approach delivers measurable improvements in outcomes, patient experience, and long-term system sustainability.

**Financial:** Improving services can deliver significant cost savings and system efficiencies. Preventing complications reduces emergency and acute care costs, while avoiding birth injuries and preterm complications lowers long-term health and social care expenses.

**Other Services:** reduced demand on emergency and acute care by preventing complications, reducing unplanned interventions and neonatal intensive care admissions. Decreasing pressure on paediatric, mental health, and social care services by improving maternal and infant health outcomes.

**\*\*Medium Term Planning Framework (metric/measure or narrative).**

## We Will: Strengthen the quality and safety of local maternity and neonatal services

### 2026-27 – Priorities

- **Implementation of ALL national best practice, safety initiatives and reviews including Maternal Care Bundle\***
- Support maternity and neonatal services to minimise variation in care, ensuring equitable provision, informed by monitoring of outcomes
- Strengthen mechanisms to share learning from adverse events, reducing harm and improving safety
- Development of a transformation plan, incorporating workforce development in line with national recommendations and a review of maternity and neonatal services, to ensure services can sustainably deliver national standards of care.
- Strengthen Maternity and Neonatal Voice Partnerships (MNVPs) via commissioning arrangements
- **Use population health data and JSNA insights to drive population health improvements and access in line with the Maternity/Neonatal Equity Plan\***
- Ensure access to high quality patient information and digital support resources, improving health literacy across services
- Expand the roll-out of the Enhanced Continuity of Carer model for women with increased vulnerability
- Work with the North West Neonatal Operational Delivery Network (NWNODN) to prevent preterm births, reduce requirement for babies requiring cooling and reduce the separation of mothers and babies.

### 2026-27 – continued

- Strengthen pathways for families following bereavement or harm, to ensure families receive timely, compassionate, and consistent support.
- Develop care pathways that meet the needs of women and families with learning disabilities and/or Autism to ensure safe, equitable, and person centred maternity care.
- Commission clinical networks, including Preterm Birth, Fetal Medicine and Maternal Medicine to deliver enhanced care for women with complex long-term and maternal health conditions

### 2027-28 – Priorities

- Support providers to deliver digital transformation that enables improvements in key areas of maternity care, including triage.
- Implement developments in community hub provision, including low-risk pregnancy triage pathways and postnatal care visits.
- Improve integration between maternity services, primary care, health visiting, mental health, and voluntary and community sector partners to ensure the delivery of a seamless, fully integrated maternity pathway.
- **Participate in the Perinatal Equity and Anti-Discrimination Programme to improve culture and practice and implement the Maternity Outcomes Signal System\*.**

### 2028-31 – Priorities

- Transform maternity services by expanding access to community based antenatal and postnatal care and improving the quality of estates, ensuring all women and babies receive high quality care in every setting.
- Commission a sustainable maternity workforce, strengthening resilience and retention and the capacity to deliver safe, high quality maternity care.

### Key Metrics and Measures 26-27

- Reduced stillbirths, preterm births, maternal and neonatal deaths, maternal morbidity, and brain injuries.
- Improved experiences of care across antenatal, intrapartum and postnatal care.

### 27-28 See 26-27 metrics plus –

- Measurable reduction in harm in maternity and neonatal services.

# 10. Growing Well

## Children and Young People

- Population Health and Joint Commissioning
- Neighbourhood Health and Accountable Care
- Corporate Parenting
- Mental Health
- Neurodiversity



# Children and Young People - Population Health and Joint Commissioning

**Case for Change:** Around 25% of the population is under 19. Some Children and Young People in Cheshire and Merseyside do not “Start Well”, and this translates into poorer outcomes. As examples:

- In C&M we see higher than England averages in the percentage of 5-year-olds with visually obvious dental decay.
- 24.0% of year 6 children in C&M were obese compared with the England average of 22.7%, with one area in the sub-region as high as 30.7%.
- In C&M there are higher than England averages for teenage conceptions, hospital admissions for asthma and mental health conditions among under-18s.

**Inequalities:** In our subregion we have 100,300 children living in poverty. This amounts to 22.3% of all children and young people, which is higher than the national average of 19.8% and is reflected in the poorer outcomes.

**Financial:** The cost of the poorer outcomes is not just personal to the children and their families but also costs the health and care system and economy.

**Other Services:** There is a significant opportunity to improve the consistency of services and outcomes across Cheshire and Merseyside through a more holistic model of community and mental health services, as well as developing a service chain model for hospital-based services with an aspiration to create an integrated health organisation (IHO) approach to oversee the health budget for the CYP population. See next slide:

\*Medium Term Planning Framework (metric/measure or narrative).

**We will: Improve access and outcomes through a holistic, joined-up system for our children and young people that brings together our partnerships and community, mental health, hospital, and tertiary services**

## 2026-27 – Priorities

- Work with Local Authority Partners to reduce variation in commissioning by aligning key national policies including NHSE CYP neighbourhood model, Family First and Family Hubs
- Define and develop a consistent health approach into our multi-agency Child-Protection Teams (MAPCTs).
- Implement the Sexual Safety in Health Care Charter and Domestic Abuse Policy.
- Pathway improvements to respiratory care in line with the asthma bundle of care including SABA overuse and appropriate inhalers.
- **Planning for continuation of Complications in Excess Weight Clinic\***.
- Continued delivery of All Together Smiling programme (see Oral Health).
- Work with Providers and other partners to embed GATEWAY & CNEST processes.

## 2027-28 – Priorities

- Implement the key requirements of the Children’s Wellbeing and Schools Bill including our system response to our corporate parenting role.
- Continuation of programmes on asthma, healthy weight and oral health.
- Align models of early identification of need in Early Years pathway across Local Authority footprints.

### Key Metrics and Measures 2026-28

- Reduction in the number of CYP attending A&E due to asthma exacerbations.
- All Together Smiling delivered to a minimum of 50 per cent of early years settings in Core 20 communities.

## 2028-31 – Priorities

- Implement outcomes of CYP Urgent and Emergency Care Review.

### Key Metrics and Measures

- Progress against key national constitutional and international standards.
- Specific population health and wellbeing priorities will be developed based on local population priorities in neighbourhoods.

## Children and Young People – Neighbourhood Health and reducing waiting times

Services for children and young people can feel disconnected, with multiple providers and pathways that are hard to navigate. NHS Cheshire and Merseyside is planning to strategically commission an Integrated Health Organisation (IHO) model to transform services for children and young people. This approach aims to deliver a holistic, joined-up system that brings together our partnerships and community, mental health, hospital, and tertiary services which will complement the expected publication of a national Modern Service Framework for Children and Young People.

### Benefits:

The accountable care approach will enable our neighbourhood health model and provide a range of benefits to our children and young people and their families:

- **Coordinated and Seamless Care:** Health and social care professionals will work together, sharing information across GPs, specialists, social care, and voluntary organisations to provide an integrated experience.
- **Proactive and Preventative Focus:** Early identification and intervention will help address health concerns before they become serious, reducing the need for specialist care.
- **Improved Health Outcomes and Reduced Inequalities:** By adopting a population health approach, the IHO will work with partners to tackle wider determinants of health – such as housing, education, and employment – ensuring targeted support for those with the greatest need.
- **Personalised Care:** Each child or young person will have a care plan tailored to their specific needs, preferences, and goals, ensuring a truly person-centred approach.
- **Enhanced Access to Services:** Integrated neighbourhood teams will make it easier to access community and mental health support closer to home, reducing reliance on specialist or emergency services.

\*Medium Term Planning Framework (metric/measure or narrative).

**We will:** Commission a holistic, joined-up system for our children and young people that brings together our partnerships and community, mental health, hospital, and tertiary services

### 2026-27 – Priorities

- Commission a hosted secondary and tertiary care provider model.
- A single elective waiting list (PTL) with priority on reducing ENT and dental waits.
- A single point of access, including a digital front door.
- Co-design and implement a holistic model for universal community, mental health and neurodevelopmental services, improving access to community paediatrics including neurodisability, speech and language, physio and occupational Therapies, and paediatric audiology in line with national standards.
- Establish an MDT in at least one neighbourhood in each Place.
- Develop a Strategy to improve outcomes, reduce inequalities and optimise resources, strengthening collaboration across partners and aligning with national opportunities\*.

#### Key Metrics and Measures

- Reduction in waiting times in community services and for elective care.

### 2027-28 – Priorities

- Commission secondary/tertiary care services from a Children's Lead provider.
- Commission community and mental health services in line with holistic model.
- Review of C&M wide CYP Urgent and Emergency Care Services and development of a case for change.
- Review of different MDT frameworks and develop outcomes monitoring framework.
- Implement the Paediatric Early Warning System (PEWS) by April 2027 for hospitals with a paediatric inpatient setting, and by April 2028 for all other hospitals\*.
- Have CYP Neighbourhood MDTs rolled out within standard delivery.

#### Key Metrics and Measures

- Reduction in waiting times in community services and for elective care.
- Reduction in A&E attendances and admissions for urgent care.

### 2028-31 – Priorities

- Commission community, mental health, secondary and tertiary care services from an Accountable Care Organisation.
- Implement outcomes of CYP Urgent and Emergency Care Review.
- Development of a consistent MDT framework with funding transitioning into neighbourhoods to reflect need. Each neighbourhood will have embedded delivery of CYP MDTs across a range of needs.
- Develop ringfenced CYP capacity using existing NHS estate by running regular dedicated paediatric surgery days in either a day surgery or hub setting, with an aim to increase CYP activity delivered through surgical hubs\*.

#### Key Metrics and Measures

- Further reduction in A&E attendances and admissions for urgent care.
- Specific population health and wellbeing priorities will be developed based on local population priorities in neighbourhoods.

# Children and Young People – Corporate parenting

**Case for Change:** The number of children in care in the UK has doubled over the past 10 years. In C&M there are circa 7,200 children currently in care. The Children’s Wellbeing and Schools Bill’ legislates the role of corporate parent for the ICB/NHS. We will work with partners regarding our corporate parenting duties, including initial health assessments for Children in Care. We need to ensure we can evidence compliance with the United Nations Convention on the Rights of the Child. In addition, we need to focus on meaningful employment and pathways through the care leavers covenant.

**Impact:**

- Expanded Corporate Parenting duty to the NHS
- Introduction of a Single Unique Identifier (SUI) for children intended to be their existing NHS number
- Young people leaving care to have access to free prescriptions, dental and eyecare services up to age 25
- NHS guaranteed interview scheme and paid internships to break down barriers to opportunity

**Inequalities:** Most children become “looked after” due to various forms of traumatic events, abuse and/or neglect, they may have the same health issues as their peers, the extent of these is often greater because of their past experiences, an estimated half of CECYP have a diagnosable mental health disorder and two-thirds with special educational needs More than one quarter of those leaving care are not told how to get help with their physical health, including registering with a GP or dentist and have much higher rates of being “Not in education, employment or training”.

**Financial:** The cost of the poorer outcomes is not just personal to the children and their families but also costs the health and care system and economy.

**Other Services:** There is a significant opportunity to improve the consistency of services and outcomes through an integrated lens with both ICS and integrated health and care systems.

**Outcome:** "Would this be good enough for my child?"  
**Our ambitions are:**

- To develop an integrated system approach to improving the experience and health outcomes of Care Experienced Children and Young People (CECYP) within Cheshire and Merseyside

### 2026-27 – Priorities

- Clarify the ICB offer regarding corporate parenting duties in line with the proposed.
- Develop ICS response to the corporate parenting role
- Develop an ICS approach to Initial Health Assessments for Children in Care (CiC) (including workforce review of current approach, commissioning intentions and development of integrated dashboards).
- C&M baseline audit of IHA processes, timelines, and outcomes, including Children in care of other local authorities.
- Updated training model and resources for social workers and health professionals.

#### Key Metrics and Measures

- Baseline understanding of Place level offers.
- Promote care experienced as protected characteristic in local policy and practice.
- C&M Corporate parenting workplan (ICB and LA).

### 2027-28 – Priorities

- Collaborate with Regional Improvement Partnership to develop an integrated IHA performance dashboard CECYP led revision of current IHA process ensuring Voice of the child is clear and informs future commissioning practice.
- Scale work under the Good Work Pathway and Care Leavers Covenant building capacity and seeking additional funding opportunities for growth.
- Work with Edge Hill University and CWP to develop a set of NHS corporate parenting principles based on lived experience.
- Workforce redesign to address surge capacity and CECYP access needs.
- Scope where possible integrated/pooled funds to managing all applications for IHA.

#### Key Metrics and Measures

- Dashboard design and development.
- I-Support auditing / pilot / implementation.
- Full implementation of C&M model and service.
- Care leavers covenant in place with positive outcomes including employability/good work pathway.

### 2028-31 – Priorities

- Develop a standardised regional IHA pathway (referral, assessment, follow-up, info sharing).
- Implement digital solutions for referral/tracking and data sharing.
- Remove disparities and standardise entitlements and processes.
- Ensure access to CAMHS, dental, and expedited NHS pathways.
- Ensure all CiC and CECYP have access to support for their Emotional wellbeing and mental health.
- Continue to scale work under the Employability and Good Work Pathway Care Leavers Covenant .
- Support work for transitions into employment for care leavers, CECYP implementing employability offer.
- Targeted work with virtual schools & NEET into training and apprenticeships.

#### Key Metrics and Measures

- Launch and implementation of integrated performance dashboard.
- Review and modernisation of workforce model to include integrated care leaver offer.
- Publish collaboration with Edge Hill.

# Children and Young People – Mental Health

**Case for Change:** At any one time, 1 in 5 children and young people have a diagnosable mental health problem. Most adult mental health illness can be traced back to childhood. The Ten-Year Plan recognises the importance of early intervention and community-based support for children and young people with mental health needs. It also recognises that, when specialist help is needed, it should be available in a timely manner to avoid escalation to more expensive interventions.

**Inequalities:** There is evidence that appropriate mental health support in childhood and adolescence improves life expectancy, outcomes and experience.

**Financial:** reduced spend on expensive clinical interventions, such as inpatient care, will allow for investment in community services. Maintaining children and young people in their own homes, with access to good education and social support opportunities will improve their ability to move into employment in adult life.

**Other Services:** Opportunity to reduce unnecessary attendances at EDs due to breakdowns in care. Enhance Special Educational Needs and Disabilities (SEND) support. Reduce admissions to CAMHS inpatient beds.

\*Medium Term Planning Framework (metric/measure or narrative).

**We Will:** Widen access to services closer to home, reduced unnecessary delays and the delivery of mental health care based on a clear understanding of the needs of children and young people. Our ambitions are :

- All children and young people have timely access to mental health support appropriate for their needs.
- All schools and colleges in Cheshire and Merseyside to have access to a Mental Health Support Team (MHST)
- Admissions to Child and Adolescent Mental Health Services (CAMHS) inpatient beds and crisis attendances at Emergency Departments (EDs) are reduced.

## 2026-27 – Priorities

- Implement refreshed 1-year CYP MH Strategy for 2026/27 and develop future strategy.
- Mobilise waves 15 and 16 of MHST's in schools and colleges.
- Strengthen inclusive mental health pathways so that children and young people with neurodiversity, learning disabilities and autism can access the right support at the right time, aligned with SEND reform.
- Develop alternatives to CAMHS inpatient admission and ED attendance (Appropriate Places of Care and work with Local Authorities to develop plans for a Regional Care Cooperative (RCC) model).
- Ensure that the mental health needs of children and young people are considered in the Neighbourhood Health model and in the roll out of Young Futures hubs.

### Key Metrics and Measures

- 77% coverage of MHST's and teams in training by March 2027\*.
- Reduce long waiting times for access community mental health.
- Increase number of direct/indirect contacts per whole time equivalent practitioner.

## 2027-28 – Priorities

- Implement refreshed MH Strategy
- Mobilise waves 17&18 of MHST's in schools and colleges.
- Continue to improve access, reduce waits, expand early help and strengthen prevention.
- Increase consistent use of clinical outcomes and patient/carer-reported measures to inform improvements.
- Develop integrated 16–25 pathways that support transition, continuity and preparation for adulthood.
- Embed best practice Eating Disorder model, including ARFID pathway.
- Reduce avoidable attendances and inpatient admissions with safe, timely, community alternatives to crisis care.
- Strengthen early identification and intervention for 0-5's focusing on attachment and early development.
- Mobilise Appropriate Place of Care in partnership between ICB and LAs

### Key Metrics and Measures

- 94% coverage of MHST's and teams in training\*.
- Increase the % of CYP receiving first contact within 6/12/18 weeks.
- % CYP mental health episodes with a paired outcome measure recorded.

## 2028-31 – Priorities

- Mobilise waves 19 to 21 to ensure full coverage of MH support teams.
- Create an integrated MH pathway that is easy to navigate, reduces fragmentation, and supports CYP at the right level, at the right time.
- Use digital tools and data to enable proactive, needs-led identification, navigation and delivery of MH support through blended models of care.
- Reduce self-harm and suicide risk through a whole-system approach to prevention and crisis response.
- Build strong lifelong foundations through joined-up perinatal, infant and family mental health support (0–5).
- Address inequalities by ensuring mental health support is equitable, culturally responsive and proportionate\*.

### Key Metrics and Measures

- 100% coverage of MHST's in training by March 2029\*.
- Reduction in CYP emergency department attendances for self-harm.
- Improved uptake of support among families in deprived communities and those under-served by services.

# Children and Young People – Neurodiversity

**We Will:** Ensure ALL neurodivergent children and young people have improved access to early and ongoing support and when needed wait no longer than 28 weeks for assessment and diagnosis by 2029.

**Case for Change:** The current service model is diagnosis rather than needs-led, meaning individuals are not getting the early support they need. The number of referrals to assessment services significantly exceeds commissioned capacity, leading to long and growing waiting times. Right to choose referrals to Independent Sector Providers is increasing, however this offers a variable experience for patients, with some experiencing incomplete pathways and difficulty receiving subsequent support through NHS services.

There has been a lack of investment into NHS provision in terms of capacity for assessment, as well as digital technology to streamline processes and improve communication with parents/carers and families.

Our aim is to improve the identification and access to early and ongoing support for neurodivergent Children and Young People. This includes the roll out of the Knowing Me profiling tool to identify needs early, multi-disciplinary triage of referrals, standardised stratification, streamlined assessment processes and more comprehensive ongoing support.

**Inequalities:** there is significant variation in access and waiting times across Cheshire and Merseyside, in particular when accessing independent sector provision, where waiting times are significantly shorter. This means some of our most complex patients are waiting the longest.

**Financial:** increased noncontract activity on Right to Choose activity, creating financial pressure.

**Other Services:** unmet and delays in meeting need impacts on the NHS (e.g. urgent care/MH demand) and wider society (e.g. school attendance, youth offending behaviour).

## 2026-27 – Priorities

- Continue implementation of needs-led pathway across all Places.
- Complete rollout of Knowing Me profiling tool including digital version.
- Address gaps in early / ongoing support.
- Agree and pilot shared care framework.
- Consistent implementation of stratification tool for waiting lists and streamlined assessment.
- Develop digital tools to support patients while waiting.
- Expand capacity for assessment inc. within CAMHS.
- Develop lead Provider model.

### Key Metrics and Measures\*

- Increase number of staff trained and number of profiling tools completed.
- Increase number of patients accessing early support.
- Reduce number of patients referred on for assessment following triage.
- Reduce numbers on waiting list by 30%.
- Reduce average waiting time for assessment.
- Reduced independent sector spend.
- Eliminate over 52-week waits.

## 2027-28 – Priorities

- Embed new model across all Places including profiling tool.
- Roll out shared care framework and annual reviews in primary care.
- Further enhancements to needs-led community-based support including alternatives to medication.
- Implement digital tools that improve patient access and experience and provider and system efficiency.
- Ensure an integrated offer for patients under MH services with ADHD/Autism.

### Key Metrics and Measures 2026-27 metrics and measures plus

- Reduce number of patients on waiting list by 20%.
- Shared care uptake.

## 2028-31 – Priorities

- Eliminate over 52-week waits.
- Continue to balance needs-led support, primary and secondary care provision.
- Consider further expansion of care model to support wider neurodevelopmental need.

### Key Metrics and Measures Ongoing metrics as outlined 2026-28 plus

- Number of patients triaged for diagnostic assessment.
- Eliminate waits for assessment of over 28 weeks.

\*Note: baselines and targets to be confirmed.

# 11. Living Well

- Mental Health
- Learning Disability & Autism
- Neurodiversity
- Diagnostics
- Community Pharmacy
- General Practice
- Optometry
- Planned Care
- Primary Care Dental
- Stroke
- Women's Health



## Mental Health (Adults Page 1 of 2):

**Case for Change:** In line with the 10 Year Plan we are continuing a programme of reform to transform services with the aim of putting mental health on an equal footing to physical health. The plan continues the expansion of a mental health urgent and emergency care offer and the development of community-based services, aligning this to neighbourhood health. We will apply the proposed modern service frameworks for severe and enduring mental illness and dementia alongside enhanced support to reduce ill-health related inactivity, as well as a focus on digitalisation, prevention and tackling health inequalities.

**Inequalities:** 1 in 4 adults experiences at least one diagnosable mental health problem in any given year. People in all walks of life can be affected at any point in their lives. Mental health problems represent the largest single cause of disability in the UK.

**Financial:** reduced spend on clinical interventions, such as inpatient care, will allow for investment in community services. Talking Therapies and Individual Placement and Support, along with community and preventative services, will support people to remain as economically active as possible.

**Other Services:** Reductions in unnecessary attendances at A&E and improved access to primary care support and preventative care helping support more people in community settings with access to social care and housing support when needed.

\*Medium Term Planning Framework (metric/measure or narrative).

**We Will:** Ensure support is provided for people with mental health needs, improving their health outcomes and ensuring access to services meeting their needs.

Our ambitions are:

- Fewer people with a mental health need will require inpatient care and present to services in crisis.
- More people with a mental health need will be supported to in the community and close to home.
- The health outcomes and life expectancy of people with mental health needs will be improved.

### 2026-27 – Priorities

- Build on existing mental health Urgent and Emergency Care (UEC) plan to scope single offer for C&M.\*
- Improve the care and treatment of individuals who require an intensive and assertive approach from health services.
- Ensure parity on discharges to reduce numbers who are Clinically Ready for Discharge (CRFD) in MH inpatient beds.
- Use ring-fenced funding to support the delivery of effective courses of treatment within Talking Therapies and expand Individual Placement and Support (IPS).

#### Key Metrics and Measures

- Reduce the number of Mental Health A&E attends by 50% from 24/25 base.
- 50% reduction in >12 hour and > 24 hour MH waits in A&E.
- No inappropriate out-of-area placements.\*
- Reduce length of stay and delayed discharges (50% reduction).
- Increase Reliable Improvement Rate for Talking Therapies to 69% and Reliable Recovery to 51%.\*
- Increase access to IPS based on agreed recovery plan.\*

### 2027-28 – Priorities

- Continue to develop single health UEC offer.\*
- Assertive outreach care and treatment expansion.
- Maintain focus on reducing CRFD and lengths of stay.
- Expand NHS Talking Therapies and Individual Placement and Support in line with planned growth.

#### Key Metrics and Measures

- As a minimum, subject to further guidance, maintain delivery in reduced A&E attendances and achieve MH waiting time standards, out of area placements, length of stay and CRFD.\*
- Increase Reliable Improvement Rate for Talking Therapies to 70% and Reliable Recovery to 52%.\*
- Increase access to IPS in line with trajectories (as determined by future guidance).\*

### 2028-31 – Priorities

- Implement single Cheshire and Merseyside mental health UEC offer.\*
- Assertive outreach care and treatment expansion.
- Expand NHS Talking Therapies and Individual Placement and Support in line with planned growth.
- Implement capacity management software and digitised Mental Health ACT (MHA) pathways by 2030.

#### Key Metrics and Measures

- Comprehensive mental health UEC offer to support system, including for Type 1 Emergency Departments.
- Expand NHS Talking Therapies and Individual Placement and Support in line with planned growth.\*
- 100% coverage of Assertive Outreach Care and Treatment.
- Increase Reliable Improvement Rate for Talking Therapies to 71% and Reliable Recovery to 53%.
- Increase access to IPS in line with trajectories.\*

## 2026-27 – Priorities

- Develop a model for an integrated inpatient and community mental health rehabilitation offer.
- Implement the personalised care framework.
- Develop 24/7 Neighbourhood Mental Health Centre in Cheshire West.
- Review HACT housing recommendations and co-produce plans to implement where possible without additional resource.
- *Develop a common approach to management of complex mental health and s117 cases.*
- *Develop a C&M plan to respond to the Modern Service Framework for mental health when published.*
- Ensure mental health practitioners across all providers undertake training and deliver care in line with the *Staying safe from suicide* guidance.
- Improve control of “slow stream” Acquired Brain Injury (ABI) and neurorehabilitation pathways to reduce clinical and financial risk.
- Develop options to reduce reactive spend on mental health secure transport.

### Key Metrics and Measures

- Reduction in out of area, spot purchased and locked rehabilitation placements for mental health rehabilitation.
- Establish first 24/7 neighbourhood mental health centre.

## 2027-28 – Priorities

- Commence delivery of integrated inpatient and community mental health rehabilitation model.
- Develop a further four 24/7 Neighbourhood Mental Health Centres.
- Deliver a common approach to management of complex mental health and s117 cases across Cheshire and Merseyside.
- Commence implementation of Cheshire and Merseyside plan to deliver the Modern Service Framework for mental health.
- *Staying safe from suicide* embedded in provider’s training offer.
- Enhance collaborative approaches for improved control of “slow stream” Acquired Brain Injury (ABI) and neurorehabilitation pathways.
- Implement options to reduce reactive spend on mental health secure transport.

### Key Metrics and Measures

- Sustained reduction in out of area and spot purchased rehabilitation placements for mental health rehabilitation. Move to zero locked rehabilitation placements.
- Establish next four 24/7 neighbourhood mental health centres.

## 2028-31 – Priorities

- Full implementation of integrated inpatient and community mental health rehabilitation model.
- Develop a further four 24/7 Neighbourhood Mental Health Centres to ensure one in every place by March 2029.
- Common approach to management of complex mental health and s117 cases across Cheshire and Merseyside fully implemented.
- Continue implementation of Cheshire and Merseyside plan to deliver the Modern Service Framework for mental health.
- Responding to impact of MHA Reform.

### Key Metrics and Measures

- No out of area, spot purchased and locked rehabilitation placement for mental health rehabilitation.
- Establish final four 24/7 neighbourhood mental health centres.

# Learning Disability and Autism:

**Case for Change:** Improving care and support for people with a learning disability and autistic (LDA) people is part of a national programme known as Transforming Care. It covers people with a learning disability and autistic people of all ages. Reducing inpatient numbers through increased discharges and admission avoidance, through improved community support. Improved access to health checks, primary care services, and appropriate prescribing will improve outcomes. There is also learning from the lives and deaths of people with a learning disability and autistic people (LeDeR).

### Impact:

**Inequalities:** People with a learning disability and autistic people too often experience avoidable health inequalities and can also be inappropriately admitted to mental health hospitals for long periods. People with a learning disability are dying on average nearly 20 years younger than people without a learning disability. Almost 2 in 5 deaths are avoidable.

**Financial:** reduced spend on expensive clinical interventions, such as inpatient care, will allow for investment in community services.

**Other Services:** Improved access to primary care and prevention. More people maintained in community settings with social care and housing support as appropriate.

\*Medium Term Planning Framework (metric/measure or narrative).

**We Will:** Ensure comprehensive support is provided for individuals with autism and learning disabilities, improving their health outcomes and ensuring access to necessary services.

Our ambitions are:

- Fewer people with a learning disability and autistic people will need mental health inpatient care.
- More people with a learning disability and autistic people will be supported to in the community and close to home.
- The health outcomes and life expectancy of people with a learning disability and autistic people will be improved.

## 2026-27 – Priorities

- Reduce longest lengths of stay in mental health hospitals.\*
- Reduce admissions to mental health hospitals for LDA & Autism.\*
- Improved management of packages of care in community settings.
- Develop an integrated inpatient and community rehabilitation offer within transition.
- Adult Dynamic Support Databases to be fully established to meet revised Mental Health Act (MHA).
- C(E)TRs fully coordinated to meet MHA.
- Agree new delivery model for LeDeR.
- Establish agreed CYP LD Pathway
- Establish new units of LDA Crisis Accommodation.
- Implement and embed Green Light Toolkit.

## 2027-28 – Priorities

- Reduce longest lengths of stay in mental health hospitals.
- Reduce admission rates to mental health hospitals.
- Continue to develop a Community LDA Crisis /Respite provision.
- Develop integrated community Rehabilitation model for LDA.
- A DSD to be fully commissioned for people with Autism.
- Implement new delivery model for LeDeR.

## 2028-31 – Priorities

- Reduce longest lengths of stay in mental health hospitals.
- Reduce admission rates to mental health hospitals.
- Established integrated inpatient and community rehabilitation offer.
- To have a fully commissioned/implemented community offer for LDA crisis provision.

### Key Metrics and Measures 26-27

- Min 10% year on year reduction in number of people with LDA in mental health inpatient care.\*
- Deliver on 75% of Annual Health Checks and complete 100% of Health Action Plans.
- Meet Length of Stay targets for CYP, restricted and unrestricted patients.

### 2028-31

- Delivery on the Annual Health checks and Health Action Plans.
- Deliver on LOS target for CYP, restricted and unrestricted patients.

# Neurodiversity – Adults

**Case for Change:** Our aim is to improve the identification and support for neurodivergent individuals with an initial focus on a needs-led Attention-Deficit/Hyperactivity Disorder (ADHD) model. The current model is diagnosis rather than needs-led, meaning patients are not getting the early support needed. This drives growth in demand for assessments when not all patients referred for assessment meet a formal diagnosis threshold. The number of referrals for assessment exceeds commissioned capacity, leading to long and growing waiting times.

There are many NHS and Independent Sector organisations providing assessments, which is leading to inconsistencies in the way care is accessed and provided, including provision of partial pathways of care.

**Inequalities:** there are significant variations in access and waiting times specifically when accessing independent sector provision, where waiting times are significantly shorter, meaning some of our most complex patients are waiting the longest.

**Financial:** The rising right to choose referrals are driving significant increases in spend on adult ADHD services – from £11 million in 2023/24 to £35 million in 2025/26.

**Other Services:** unmet and delays in meeting need impacts on the NHS (e.g. urgent care / Mental Health demand) and wider society (e.g. economic inactivity and offending behaviour)

**We Will:** improve the identification and support for neurodivergent individuals our initial focus will be around a needs led model for those with Attention-Deficit/Hyperactivity Disorder (ADHD).

## 2026-27 – Priorities

- Continue implementation of needs-led model across all Places, including new primary care service.
- Agree and launch revised shared care framework.
- Consistent implementation of local specification and diagnostic assessment referral criteria.
- Commence repatriation of ongoing treatment to primary care service.
- Revise secondary care provision and stratify secondary care waiting lists.
- First phase of enhancements to needs led community-based support.
- Set Indicative activity plans with providers of assessment services.

### Key Metrics and Measures

- 92% of patients referred for diagnostic assessment have their first appointment within 52 weeks of referral.
- 75% of patients report they understand their needs and that they are better met.
- 75% of patients report a positive experience of adult ADHD services.
- 95% of ADHD activity is provided by locally commissioned providers.

## 2027-28 – Priorities

- Conclude implementation of new model across all Places.
- Shift patients on secondary care waiting lists to primary care service.
- Further repatriation of ongoing treatment to primary care service.
- Further enhancements to needs-led community-based support including alternatives to medication.
- Set Indicative activity plans with providers of assessment services.
- Implement digital tools that improve patient access and experience and provider and system efficiency.
- An integrated offer for patients under MH services with potential ADHD.

### Key Metrics and Measures

- % of PCNs operating primary care model.
- Number of patients referred for diagnostic assessment.
- Number of patients on waiting lists.
- Average waiting time for assessment.
- Independent sector activity / spend.
- Shared care uptake.
- Reduction in ADHD treatment costs.

## 2028-31 – Priorities

- Reducing over 52-week waits.
- Continue to balance needs-led support, primary and secondary care provision.
- Consider further expansion of primary care model to support wider neurodevelopmental need.

### Key Metrics and Measures

- As per 26-28 metrics

# Diagnostics

**Case for Change:** We know it is important to our residents to reduce the length of time people wait to be diagnosed and treated and that addressing long waits will support improved outcomes and deliver greater system resilience and performance on behalf of our population.

Rapid access to locally delivered diagnostic services will support earlier intervention and decision making for patients requiring planned care, cancer and treatment for long-term conditions.

**Impact:** Access to diagnostics is a major source of health inequality, with deprived groups, minorities, and rural populations facing barriers like distance, cost, digital exclusion, and discrimination, leading to later-stage diagnoses, worse outcomes, and underdiagnosis

**Financial:** Early diagnosis offers significant financial benefits by enabling less intensive, cheaper treatments, reducing the need for costly emergency care, delaying expensive long-term care and unlocking crucial government benefits and support for patients and caregivers, ultimately saving money for individuals, families, and healthcare systems

**Other Services:** Work to implement straight-to-test pathways will help to reduce avoidable Outpatient appointments. Rapid access to locally delivered diagnostic services will support earlier intervention and decision making for patients requiring planned care, cancer and treatment for long-term conditions

Improving access as part of a multidisciplinary team approach with clinicians from primary, community and secondary care will provide more effective, timely treatment.

\*Medium Term Planning Framework (metric/measure or narrative).

**We Will:** Improve performance against diagnostic waiting times working towards diagnostic services being delivered as a single provision, ensuring service consolidation for critical diagnostics tests whilst ensuring local provision.

## 2026-27 – Priorities

- Straight to test pathways to reduce avoidable outpatient appts.\*
- New service models to minimise risk, maximise efficiency and ensure services are delivered in line with activity and performance and best practice guidance i.e. interventional radiology, phlebotomy, pathology hubs and integration of paediatric and neuro pathology.\*
- Deliver the recommendation outlined in the high-level Phlebotomy review including maximum waiting time KPIs.
- Improve the early and accurate diagnosis of respiratory conditions, promote the use of technology and enable more care to move from hospitals to community settings.
- Prioritise diagnostic (including CDC) and treatment capacity for urgent suspected cancer (USC) pathways, stratifying referrals in primary care, identifying alternative pathways and diverting lower-risk people to more appropriate access routes for their condition.\*

## 2027-28 – Priorities

- Service consolidation for critical diagnostic tests to be provided in several sites to ensure local provision but hosted by a single provider.
- Implement networked C&M service model for Interventional Radiology to minimise patient risk, maximise efficiency and ensure that service development in line with guidance.
- Implement recommendations of the review for phlebotomy (inc. standardised commissioning across primary and acute care and standardised Key Performance Indicators (KPI) of max waiting times of 2 weeks for routine patients & 2 days for urgent patients.
- Implement 3 hub pathology service and phased approach of integration for Paediatric and Neuro pathology to ensure maximum efficiency and resilience.
- Implement hub model for Imaging services to fit with Provider Collaborative Blueprint and LAASP plans. Will network services to allow great efficiency.

## 2028-31 – Priorities

- Move to Diagnostic Services being delivered as a single provision across C&M to include single-hosted services; Hubs could be run by wholly owned subsidiaries.
- Implement a single PTL and diagnostics waiting list across which will be embedded in contracts and coordinated through our collaborative embedding risk stratification to prioritise based on clinical risk and broader population health priorities.
- Mitigate demand growth in excess of agreed growth assumptions, increasing the role of neighbourhood health teams over time.\*

### Key Metrics and Measures

- Continue to deliver performance of 95% of patients seen within 6 weeks Targeting tests below 95%.\*
- 80% of cancer biopsies processed within 10 days.
- 70% of cancer biopsies are processed within 10 days and imaging is reported in line with national guidelines.

# Community Pharmacy

**Case for Change:** Position community pharmacy as the front-line prevention and early intervention service. Described in the 10-year plan, 'from hospital to community' positions the Neighbourhood Health Service, to which community pharmacy will be integral. Contribute to the traditional model of outpatient care and take on new roles in relation to secondary care prescribing – consistent with a shift left approach.

**Impact:** Pharmacies are flexible health anchors, tackling inequalities, supporting ageing populations, and adapting to growth pressures.

**Inequalities:** Inequalities concentrated in Core20PLUS5. Rising CVD, cancer, respiratory and mental health burden. Local PNAs highlight different priorities depending on population needs.

**Financial:** Annual budget £96 million – potential for reduced demand on pressured services.

## Other Services:

- CVD: Hypertension case-finding and management, statin adherence, lifestyle support.
- Contributor to weight management and alcohol brief interventions
- Cancer: Early symptom recognition, smoking cessation, mould/mask checks
- Respiratory: Inhaler technique checks, rescue pack optimisation
- Mental Health: Medication adherence, physical health checks
- Neurodiversity: Sensory-aware consultations and tailored medication support
- Pharmacy Needs Assessments (PNA) determine the commissioning of community pharmacy, and the PNA is a Health and Wellbeing Board function.

\*Medium Term Planning Framework (metric/measure or narrative).

**We Will:** Position community pharmacy as the front-line prevention and early intervention service for Cheshire & Merseyside.

## 2026-27 – Priorities

- Increase Pharmacy First Consultations.\*
- Continue developing the relationships between general practice and community pharmacy to support access to pharmacy services.\*
- Introduce prescribing-based services into community pharmacies during 2026/27.\*
- Develop and shape role of Community Pharmacy in Neighbourhood health Services.\*
- Preventing ill health and supporting wellbeing
- Providing clinical care for patients and system resilience.

### Key Metrics and Measures

- Plan total 456,151 consultations (2.9%).
- Clinical Pathway – 155,881 (5.0%).
- Oral Contraception – 57,779 (10.0%).
- Blood pressure – 242,490 (0.0%).

## 2027-28 – Priorities

- Become the primary access point for prevention.
- Deliver high-volume contact points for underserved groups.
- Act as clinical risk-detector for CVD, cancer, respiratory, mental health.
- Become trusted community anchors in deprived areas
- Act as data-rich contributor to population health management.
- To contribute to the traditional model of outpatient care, and to take on new roles in relation to secondary care prescribing.
- Expand access to emergency contraception through community pharmacies.\*

### Key Metrics and Measures

- Plan total 464,495 consultations (1.8%).
- Clinical Pathway - 161,337 (3.5%).
- Oral Contraception - 60,668 (5.0%).
- Blood pressure 242,490 (0.0%).

## 2028-31 – Priorities

- Lead for hypertension case-finding.
- Lead for smoking cessation.
- Contributor to weight management and alcohol brief interventions.
- Provider of rapid access advice for minor conditions.
- Key partner in medicines optimisation and polypharmacy reduction.\*
- Single neighbourhood provider and multi-neighbourhood provider contracts referenced in 10-year plan align with refreshed contract for community pharmacy services.

### Key Metrics and Measures

- Plan total - Increase
- Clinical Pathway - Increase
- Oral Contraception - Increase
- Blood pressure – Maintain/Increase

## General Practice (Primary Medical Services)

**Case for Change:** Increasing demand for general practice services and gaps between demand and capacity, acknowledging workforce challenges.

Variation of patient experience and key indicators for measuring access to general practice results in an unequal offer for our residents, including in our most deprived wards.

Increasing patient complexity and needs are compounded by remaining barriers between system provider and patient pathways.

**Clinical areas:** Focus driven by population health data: CVD, Respiratory, Diabetes, Frailty/Falls, Cancer, Immunisations.

**Inequalities:** Current variation linked to deprivation with both access and clinical outcomes including mortality.

**Financial:** SDF allocation, local noncore spend, digital and estates spend.

**Other Services:** Reduction in unnecessary attendances at A&E; referrals to Pharmacy First maximised.

\*Medium Term Planning Framework (metric/measure or narrative).

**We will:** Ensure Primary Care first model of delivery as part of a neighbourhood health offer / Timely access to services for the whole population via a consistent commissioned approach / Harnessing/maximising digital technology to support and improve all outcomes, patient experience and productivity / High quality care driven by measurement of and improvements in continuity particularly for our most vulnerable patients

### 2026-27 – Priorities

- Complete review of investment streams (SDF/Noncore) and Enhanced Services.
- Establish a consistent, outcomes-based contractual framework of local enhanced services aligning contracts with population health needs.\*
- In line with national policy to prioritise the use of Advice and Guidance and/or locally agreed referral protocols.\*
- Implement national contract / policy asks, including red tape challenge recommendations.\*
- Identify GP practices where demand is above capacity and create a plan to reduce variation in access.\*
- Support/underpin neighbourhood working
- Review work to align prescribing incentives in key areas of financial efficiency, medicines safety and antimicrobial stewardship.

#### Key Metrics and Measures

- 2.2% growth in appointments (Planning guidance) (16,691,997).\*
- 90% of appointments within 2 weeks min.
- Measurement of continuity indicators with improvement in-year.
- Number of clinically urgent appts. and % seen same day (Indicative 90%).
- QOF/local quality clinical indicators.
- Patient Experience measures via GPSS and ONS data.\*

### 2027-28 – Priorities

- First full commissioning year of new enhanced offer for PC.
- General practice/neighbourhood health ambitions formalised into an ongoing arrangement, full realisation of impact of new contractual forms implemented during 26/27.
- Delivery/contract methods fully in place to deliver at scale solutions.

#### Key Metrics and Measures

- 2% growth in appointments.\*
- Agreed care plans for patients with complex needs.
- Developing measurement for proactive personalised care.
- Key metrics from new enhanced service offers including clinical targets/areas.
- Developing digital targets.
- Revised June 2025 plan access. variation targets including stretch access targets in deprived areas (TBC).
- Equalisation of access entry modes.
- Shift of £ resources from secondary to primary care.
- Improvements in continuity measures.
- Progress against patient experience measures.\*

### 2028-31 – Priorities

- Digitally-enhanced, team-based model with increased workforce.
- More patient choice in consultation methods (digital/in-person) – including management of medicines online.\*
- Focus on complex care and continuity.
- supported by digital methods for triage, and models which better manage growing demands with new technology and tools.
- Realisation of primary care at scale ambitions.

#### Key Metrics and Measures

- Mix of appointments.
- QOF and local quality clinical indicators.
- Demand and referrals between services as part of NH models.
- Shift of £/f resources from secondary to community/primary services.
- Routine measurement of proactive, personalised care leading to improved outcomes and reduction in avoidable admissions.
- Progress against patient experience measures.\*

# Optometry

**Case for Change:** Pressure on hospital eye services and GPs – Reducing unnecessary hospital / GP visits

Prevalence of age-related eye conditions such as glaucoma increasing overall demand for eye care services.

Inconsistency of enhanced services throughout Cheshire and Merseyside leading to disparities based on geographic location.

Underutilisation of key optometry skill set and supporting more preventative work.

**Impact:**

**Inequalities:** disparities in eye health outcomes / access to care equalised.

**Financial:** Local enhanced services, Special Education Settings Services (SES) allocation, General Ophthalmic Services (GOS) budget flexibilities.

**Other Services:** Unnecessary attendances at A&E, referral pathways into Secondary Care, and reduced presentations at GP surgeries.

**Governance route and Exec Lead:** System Primary Care Committee Executive Lead Clare Watson.

**We Will:** Further enable optometrists as first-contact practitioners and expand access supported by high quality eye health pathways delivering better care – with a focus on prevention and early detection.

## 2026-27 – Priorities

- Improving access to GOS services and delivery quality of care maximising national and local contract opportunities.
- Embed optometry as key part of neighbourhood health plan and priorities.
- Review and expand services for homeless and other vulnerable groups including SES for children.
- Review and embed outcomes and learning from CVD pilot.

### Key Metrics and Measures

- SES services outcomes and measures within spec year 1.
- Reduction in GP eye-related consultations.
- Reduced acute presentation for eye-related symptoms in emergency care.
- Specific patient pathway rollout – Glaucoma Enhanced Referral Services (GERS) measurements.

## 2027-28 – Priorities

- First full commissioning year of enhanced eye care services offer.
- Optometry/neighbourhood health ambitions formalised and in place.
- Implement national contract/policy asks (TBC).
- Year 2 of commissioned schemes for SES and other vulnerable groups.

### Key Metrics and Measures

- Eye tests for vulnerable groups.
- SES numbers year 2.
- Reduction in GP eye related consultations.
- Reduction in acute presentation for eye related symptoms.
- Specific patient pathway target (e.g. glaucoma monitoring pathways across all hospitals in Cheshire and Merseyside).

## 2028-31 – Priorities

- Digitally integrated, community-focused service, shifting more care from hospitals to high streets.
- Expanded roles for optometrists, advanced diagnostics (e.g. remote monitoring), integrated electronic systems (EERS).
- Focus on prevention, supported by better workforce planning and training for a wider scope, including enhanced prescribing and specialist pathways to tackle increasing demand and reduce hospital pressure.

### Key Metrics and Measures

- Equitable Access: Reduction in geographic variation for core and enhanced services.
- Reduced Hospital Referrals: Decrease in unnecessary referrals for minor eye conditions to hospital.
- Chronic Disease Management: Improved outcomes in glaucoma/medical retina managed in primary care.

## Planned Care

**Case for Change:** Our NHS Providers are leading work with partners to address clinical, workforce and financial challenges across C&M ICB, reducing the fragility of clinical services and unwarranted variation of quality in care, improving health inequalities across populations and making services more sustainable for the future. This will see us develop and implement a system capacity management process (for adults and CYP) that will significantly increase the level of inter-organisational support provided for elective care, improve utilisation of system assets (mainly elective hubs) and enable the development of a 'business as usual' model for the longer term.

Appropriately manage waiting lists, including thorough validation and the application of referral to treatment guidance and local access policies.\*

To implement clinical pathway changes at the point of referral to safely reduce the level of demand on acute services by increasing self-care and utilisation of primary and community-based services to deliver care closer to home.

**Inequalities:** The consistency of offer and use of analytics to target interventions to those with the greatest clinical benefit will help address current inequalities.

**Financial & Other Services:** Through streamlining pathways, the total costs of treatment will start to reduce as well as a transfer of resources to prevention and early intervention. This will include the integration of clinical teams across hospital, community and primary care teams to support prevention and early intervention.

\*Medium Term Planning Framework (metric/measure or narrative).

### 2026-27 – Priorities

- Undertake pathway optimisation of Gynaecology, Ophthalmology, Musculo Skeletal (MSK), Pain, Dermatology and ENT, including community-based options and implementing Single Point of Access and Referral Triage.
- Implement a single elective and diagnostics waiting list for agreed pathways.\*
- Delivery of national efficiency measures including outpatients digital first, patient led model; expanding the use of Advice and Guidance and digital triage tool and follow-up care including access to patient-initiated follow-up (PIFU), remote consultations and digital monitoring.\*
- Commissioning a North West Complex Termination of Pregnancy Service.
- Specialised Services specification review.

#### Key Metrics and Measures

- Every trust delivering a minimum 7% improvement in 18-week performance or a minimum of 65%, whichever is greater (to deliver national target of 70%).
- Reduce the number of people waiting over 52 weeks.
- An increase Advice and Guidance rates baseline to be confirmed.\*
- Outpatient follow-up rates improve in line with national standards.\*

### 2027-28 – Priorities

- Expand whole pathway optimisation to further specialties.
- Implement a single PTL and diagnostics waiting list for agreed priority pathways.
- Implement recommendations from Specialised Services specification review.
- Significantly reduce the number of routine, clinically low- value follow-up appointments.\*
- Conduct comprehensive reviews of clinic templates and standardising these in line with GIRFTs. specialty-level good practice and job planning guides.\*

#### Key Metrics and Measures

- Achieving the standard that at least 92% of patients are waiting 18 weeks or less for treatment.
- Reduce the number of people waiting over 52 weeks.

### 2028-31 – Priorities

- Expand whole pathway optimisation to remaining specialties and pathways to have single standard model across C&M.

#### Key Metrics and Measures

- Improvement in defined population health outcomes in line with our population health needs assessment.
- Maintain delivery of national waiting time standards.
- Upper quartile delivery of NHS efficiency standards across C&M Providers.

# Primary Care Dental

**Case for Change:** NHS dental access remains a major challenge. Contract reform needed to unlock dentistry's role in prevention and Neighbourhood care. Oral health integration supports wider system dividends.

**Impact:** Improvement of oral health and related benefits to the Cheshire and Merseyside population.

**Inequalities:** 31.2% of 5-year-olds have tooth decay. Oral health inequalities concentrated in Core20PLUS5. Links to rising CVD, cancer, respiratory and mental health burden.

**Financial:** £15m ring-fenced dental budget; potential for local "shift left" funding.

### Other Services:

- Early oral cancer detection and digital referrals.
- GP cancer referrals routed to urgent dental care.
- Dental homes for vulnerable groups.
- Trauma-informed pathways for SMI; sensory-adapted care for neurodiverse patients.
- Improved outcomes in diabetes and COPD.

\*Medium Term Planning Framework (metric/measure or narrative).

**We Will:** Transform NHS dentistry into a population health prevention platform, expanding access, embedding oral health into neighbourhood models, and shifting resources to where need is highest.

## 2026-27 – Priorities

- Deliver 46k additional urgent dental appointments against baseline
- Ensure routine access and vulnerable groups.
- Implement dental reforms. Review Units of Dental Activity (UDA) rates to create a fairer system, but with caveats attached for providers\* where their UDA rate is increased.
- Implement locally driven quality improvement approaches for dentistry.\*
- Prevention and integration of oral health within Neighbourhood services.
- Data Dashboard to encompass end-to-end pathway.

### Key Metrics and Measures

- 85% units of Dental activity delivered.\*
- 42% of resident population seen by an NHS Dentist (Adults).
- 64.41% of resident population seen by an NHS Dentist (Children).
- 46,617 Urgent Care appointments.\*

## 2027-28 – Priorities

- Deliver 46k urgent dental appointments.
- Ensure routine access and vulnerable groups.
- Develop Dental as a Neighbourhood frontline provider.
- Integrate Dentistry into the Neighbourhood MDT model.
- Develop local PDS contract with core outcome framework.

### Key Metrics and Measures

See 26-27

## 2028-31 – Priorities

- Build shared data flows and shift from "services" to "platforms" driven by population health management.
- Commission through a single provider model, not separately from GP Pharmacy and Optometry.
- Dental as the Neighbourhood's proactive outreach engine.
- Dental to contribute to Neighbourhood level inequalities reduction\*

### Key Metrics and Measures

- An increase in units of Dental activity
- An increase % of resident population seen by an NHS Dentist (Adults).
- An increase % of resident population seen by an NHS Dentist (Children).
- Outcome measures from local PDS contract.

# Stroke

**Case for Change:** Stroke is a major health challenge in the UK with 152,000 strokes annually, with 1.2 million survivors. It is among the top four causes of death and a leading cause of adult disability. Current care is fragmented, creating health inequalities and inefficiencies. Key Solution: Integrated Community Stroke Service (ICSS) Early Supported Discharge (ESD): Enables specialist rehabilitation at home, reducing disability and improving outcomes. ICSS provides rapid access to hyper-acute units, consistent inpatient therapy, and robust community rehabilitation.

Our ambitions are:

- Improvement of patient-reported experience measures
- Reduction in length of stay in acute inpatient setting.
- Reduction in secondary stroke
- Improved survival and functional independence for patients.
- Faster access to thrombectomy and thrombolysis
- Embed digital imaging and AI (e.g. Brainomix) to support rapid diagnosis and equitable access.

**Inequalities:** ICSS addresses disparities by proactive screening for high-risk groups (e.g. ethnic minorities, cardiometabolic disease, severe mental illness, learning disabilities).

**Financial:** ESD can halve inpatient stays, saving ~£325 per patient. ICSS is highly cost-effective (£10,000–£18,000 per Quality-Adjusted Life Year QALY), reducing long-term dependency and admissions.

**Other Services:** Reduces pressure on acute stroke units and emergency departments. Improves continuity of care, lowers complications, and prevents unnecessary residential placements. Provides psychological and vocational support, reducing mental health referrals. Streamlines therapy provision, minimising duplication and gaps.

\*Medium Term Planning Framework (metric/measure or narrative).

**We will:** Enhance quality of life, reduce long-term disability, and deliver substantial cost savings through integrated, standardised stroke care and delivery of a consistent, high-quality 24/7 thrombectomy and hyperacute stroke pathway across Cheshire and Merseyside in line with the 2023 guidelines.

## 2026-27 – Priorities

- Establish consistent thrombectomy and hyperacute stroke pathways across all sites.
- Secure commissioning of AI-enabled imaging and review standardised SOPs.
- Gap analysis of current post-discharge rehabilitation services to understand the services better and where inequalities etc. are. Work up of existing “Case for Change” paper.
- Commission a sustainable NROL model to bolster current post-discharge rehab offer.
- Pre-hospital video triage and remote follow-up in selected sites.
- Increase use of best value and correctly dosed DOACs across the system.\*

### Key Metrics and Measures

- NROL available at all post-discharge rehabilitation teams across Cheshire and Merseyside.
- Increase in mechanical thrombectomy %.
- SSNAP (Stroke Sentinel National Audit Programme).

## 2027-28 – Priorities

- Expand community rehabilitation services with equitable access.
- Strengthen secondary prevention programmes (AF detection, hypertension).
- Develop regional workforce plan for stroke specialists.
- Pan ICB-Workforce planning and hub integration.

### Key Metrics and Measures

- 10% increase in access to community rehab.
- Prevention KPIs (AF/hypertension) tracked across all sites.

## 2028-31 – Priorities

- Integrate stroke rehabilitation into ICS community hubs.
- Pilot virtual MDTs for complex cases.
- Implement virtual monitoring with wearables across ICB.
- Scale up digital-first pathways (tele-rehab / NROL, remote monitoring).
- Embed patient-reported outcome measures (PROMs) into routine care.
- Achieve region-wide equity in thrombectomy access and outcomes.
- Deliver measurable reduction in stroke-related disability. Publish regional outcomes report.

### Key Metrics and Measures

- 50% of community teams delivering stroke rehab / ICSS.
- Workforce gaps identified and recruitment underway.
- PROMs embedded in 80% of stroke pathways.
- 20% reduction in readmissions.
- Equity in thrombectomy access.
- Reduction in avoidable hospital admissions by 10% by 2031.

# Women's Health Services

We will: Ensure timely and equitable access to diagnosis and treatment for key women's health conditions across the life course, addressing health inequalities and informed by women's experiences and needs.

**Case for Change:** Women make up over half the UK population and live longer than men yet spend **25% more of their lives in poor health**. Systemic gaps persist – only **7% of healthcare research** focuses on women-specific conditions. Women also face longer waits for care, with those in deprived areas waiting the longest. Gynaecology waits remain among the **second highest in England** (RCOG Elective Recovery Tracker), leading to worsening physical and mental health.

- **Health Equity:** Women experience conditions such as endometriosis, heavy menstrual bleeding, and menopause that are frequently underdiagnosed or undertreated, affecting overall wellbeing.
- **Economic Impact:** Poor health limits participation in work and education, reduces productivity, and increases financial pressures.
- **Quality of Life:** Women spend more years in poor health, affecting their ability to work, care for families, and maintain independence.
- **Systemic Efficiency:** Early diagnosis and preventive care reduce long-term healthcare demand and costs.
- **Social Justice:** Meeting women's health needs is fundamental to fairness and societal progress.

**Financial:** Reduced resource demand: Long waits (18+ weeks) increase GP visits, prescriptions, and hospital use. System-wide savings: Neighbourhood women's health hubs offer more cost-effective care than reliance on acute secondary services.

**Other Services:** Less outpatient demand through care in neighbourhood hubs. Fewer A&E attendances through faster diagnosis and treatment. Reduced non-elective admissions via improved clinical pathways.

\*Medium Term Planning Framework (metric/measure or narrative).

## 2026-27 – Priorities

- Develop neighbourhood hub model to increase the proportion of diagnosis, treatment, and care of women's health conditions managed in the community.
- Expand training for primary care and community professionals supporting early diagnosis, reducing delays, improving co-ordination and quality of care.
- Implement, evidence-based pathways across primary and secondary care (Inc. Endometriosis), to reduce variation, support timely referral, streamline diagnostics, co-ordinated care, and faster access to treatment to improve outcomes and experiences for women.
- Support delivery of the National Equity Framework for Menopause and Heavy Menstrual Bleeding.
- Strengthen collaboration and accelerate improvements in women's health by sharing best practice and learning through the C&M Gynaecology Network.
- Optimise theatre utilisation across the system to reduce waiting times, increase productivity and improve patient outcomes.
- Support delivery of the National Equity Framework for Menopause and Heavy Menstrual Bleeding
- Implement women's health group consultations, expand the use of digital platforms / virtual clinics and Advice and Guidance
- Ensure access to high quality patient information and digital support resources

## 2026-27 – continued

- Support continuous quality improvement by implementing the 15 Steps Challenge across Trusts, enhancing the experience of women, girls, and families accessing gynaecology services.
- Use Population health data and JSNA insights to drive improvements that reduce the life-expectancy gap for women and girls

## 2027-28 – priorities

- Increase access to specialist menstrual health and gynae service provision within the community, starting with national 'pioneer' areas for the development of neighbourhood health.
- Strengthen the 'train the trainer' model for primary care and community health professionals.
- Develop and implement a collaborative model to improve the mental and emotional health of women with key women's health conditions, to address psychological and emotional impacts alongside physical symptoms.
- Improve health literacy to promote prevention and access to services to help close gaps in health inequalities.
- Support the roll-out of national and local integrated clinical care pathways developed for key women's health conditions to enable prompt diagnosis and management.

## 2028-31 – Priorities

- Increase access to specialist menstrual health and gynae service provision within the community.
- Deliver a model of care in which health maintenance becomes 'business as usual', ensuring that women with specific women's health conditions are referred to the right service and seen by the right clinician to optimise outcomes and quality
- Align local services with the national ambition to halve violence against women and girls (VAWG) by 2035, adopting a whole system, trauma informed and prevention focused approach that strengthens support for survivors, tackles inequalities and improves coordination.

### Key Metrics and Measures 26-27

- Increased HPV and cervical screening rates to achieve national targets.
- Increased utilisation of Advice and Guidance for gynae conditions.
- Reduced number of patients on elective waiting lists for gynaecology.
- Reduced average wait to first appointment for gynae conditions.
- Reduced the proportion of patients waiting over 52 weeks for treatment.
- Meet the 18-week referral to treatment standard by March 2029 for gynae conditions.
- Increased proportion of patients diverted to neighbourhood hubs to receive care.

# 12. Aging Well

- Prevention of frailty escalation
- Dementia
- Prevention of falls
- Urgent and emergency care



## Prevention of frailty escalation

**Case for Change:** Older people living with frailty are the highest users of health and social care services and have the highest levels of emergency admissions. Our over-75 population is forecast to grow by 45% by 2040.

### Our Ambitions:

- Shifts the focus from reactive to proactive care.
- Prevents avoidable deterioration through early identification and intervention.
- Enables timely crisis response when required.
- Supports recovery and rehabilitation close to home, promoting independence and quality of life.

**Inequalities:** The highest percentage of people living with moderate or severe frailty lives in deprivation quintile one.

**Financial:** Our frailty population consume 10.7% of the healthcare costs in Cheshire and Merseyside. Older people with frailty are more likely to have a delayed transfer of care. Federated data platform projections identify 45,000 patients at risk of transitioning to high frailty by 2027 at a cost of £266.1m and 106,000 patients at risk of transitions into intermediate frailty by 2027 at a cost of £260.9m.

**Other Services:** People with frailty are likely to require significant health, social and informal support over a considerably longer period than those dying of a single condition.

\*Medium Term Planning Framework (metric/measure or narrative).

### 2026-27 – Priorities

- Develop the target operating model for system frailty services.
- Map out frailty services across Community and Acute providers, including falls pick-up services, *frailty-at-the-front-door* and care home services.\*
- Collect quantitative and qualitative evidence about the impact of existing services.
- Implementation of the polypharmacy strategy – rapid polypharmacy reviews for the top 200 high-risk patients as per development and deployment of ICB polypharmacy dashboard.\*
- Strengthen discharge-to-assess by prioritising frailty cases with reablement needs and embedding discharge planning across the patient journey.

#### Key Metrics and Measures

- An increase in the percentage of polypharmacy reviews completed for high-risk cohort.
- A reduction in the rates of readmission within 30 days.
- A reduction in people aged 65+ being discharged into long-term care after an acute hospital stay.

### 2027-28 – Priorities

- Implement standardised frailty screening in primary care, community, ambulance, and acute settings.
- Introduce a frailty 'flag' in the shared care record, accessible to all providers.
- Provide frailty training for all front-line staff in ED, ambulance, primary care, and community teams.
- Develop, agree, and commence implementation of frailty assessment and management guidance for patients with suspected or diagnosed cancer.
- Improve identification of people who may be in their last year of life, increasing the number of end-of-life patients with care plans in place.

#### Key Metrics and Measures

- An increase in the number of patients screened for frailty within 30 mins of arrival.
- An increase of 15% in the number of people who die who had an end-of-life care plan in place (EPACCS or ACP).
- A reduction in non-elective admissions for patients on gold standards framework (GSF).

### 2028-31 – Priorities

- Establish co-located multidisciplinary teams delivering prevention, assessment, and ongoing support.
- Ensure universal access to strength and balance programmes, nutrition support, and loneliness interventions.
- Implement real-time frailty data dashboards to track performance, outcomes, and health inequalities.\*
- Redirect a proportion of acute expenditure to early intervention and prevention programmes.
- Complete phased roll-out of frailty assessment and management guidance for patients with suspected or diagnosed cancer.

#### Key Metrics and Measures

- Achieve a 10% reduction in non-elective admissions for patients 65+ with frailty.
- Achieve a 15% reduction in length of stay for patients 65+ with frailty.
- A reduction in patients 65+ being discharged onto pathway 3 after an acute hospital stay.

## Dementia

**Case for Change:** In line with the NHS Long Term Plan and the C&M Dementia Strategy (2025–2030), we are continuing a programme of reform to transform mental health and dementia services, ensuring parity between mental and physical health. Dementia is a growing public health challenge, with over 35,000 people currently living with dementia in C&M and prevalence projected to rise significantly over the next decade.

Our ambitions are:

- Fewer people with dementia will require inpatient care or present in crisis, through proactive support, virtual wards, and urgent community response.
- More people with dementia will be supported in the community and close to home, via integrated neighbourhood teams, social prescribing, and assistive technology.
- Health outcomes and quality of life for people with dementia will be improved, reducing inequalities and enabling people to live well with dignity and purpose.

**Inequalities:** Significant disparities exist in diagnosis and support, particularly for deprived communities, global majority populations, LGBTQ+ individuals, and those with Young Onset Dementia. Rural isolation and digital exclusion further widen gaps.

**Financial:** Investing in prevention, early diagnosis, and community-based support will reduce reliance on costly inpatient care and avoidable hospital admissions.

**Other Services:** Plans will reduce unnecessary A&E attendances and improve urgent care through virtual wards and UCR services. Integrated neighbourhood teams will strengthen links with social care, housing, and voluntary sector support, enabling people to live well in their communities.

### 2026-27 – Priorities

- Improve Diagnosis and close diagnostic gaps through Dementia 100 toolkit analysis, expand timely care home diagnosis using DiADeM, standardise physical checks and neuroimaging.
- Enhance Access and Involvement – providing clear guidance on dementia services and establishing Place-level involvement groups for people with dementia and carers.
- Strengthen Post-Diagnostic Support – Implement shared care protocols and minimum standards and promote NHS Talking Therapies for ongoing support.
- Improve Hospital Care and Transitions – Deliver delirium protocol training and embed improved hospital discharge and transition planning.

#### Key Metrics and Measures

- Achieve ≥67% Dementia Diagnosis Rate.
- Increase timely diagnosis in care homes.
- Ensure person-centred care plans for all diagnosed individuals.
- Reduce avoidable hospital admissions.
- Embed dementia risk messaging in NHS Health Checks.
- Operational Place-level involvement groups and complete Equality Impact Assessments.

### 2027-28 – Priorities

- Training – Roll out tiered training across health, social care, and the third sector, with targeted programmes for unpaid carers, palliative care staff, and Young Onset Dementia support.
- Prevention – Embed messaging into NHS Health Checks and campaigns, supported by an ICB dashboard to identify at-risk populations and targeted monitoring through frailty pathways.
- Personalised Care – Improve development and annual review of personalised care plans, ensuring consistent standards.

#### Key Metrics and Measures

- Achieve 80% workforce completion of tiered dementia training across health and social care.
- 100% of NHS Health Checks include dementia risk messaging.
- 90% of people with dementia have an annually reviewed care plan.
- Reduce social isolation among people with dementia (Place-level surveys).

### 2028-30 – Priorities

- Promote engagement in dementia research and embed NICE guidelines.
- Commission services for underserved populations and implement health inequality plans.
- Awareness campaigns in schools, universities, and public events, alongside peer-led storytelling and counselling initiatives.
- Grow Dementia Action Alliance, deliver inclusive toolkits, and host cross-sector summits to strengthen partnerships.
- Prepare for disease-modifying treatments, embed integrated palliative care models with seamless end-of-life coordination and bereavement support.

#### Key Metrics and Measures

- Growth in Dementia Action Alliance and dementia-inclusive organisations.
- Equality Impact Assessments and tailored services for underserved groups.
- Increased participation in research and readiness for disease-modifying treatments.
- Reduction in emergency admissions for dementia-related crises and improved end-of-life care.
- Annual audit of performance and equality metrics – strategy refresh for post-2030.

## Prevention of falls

**Case for Change:** Falls in over-65s creates a significant burden on both the individual, their family and the health and care system through loss of independence, injury and death, hospital admissions and a precipitating factor for a person going into long-term care. Need to develop a single pathway for frailty and falls across Cheshire and Merseyside with a clear plan for commissioning these services consistently across C&M in partnership with local authorities and the VCFSE sector

### Impact:

**Inequalities:** People aged 65 and over have the highest risk of falling, with around half of those aged 80 plus falling once a year. A third of falls emergency admissions live in the 20% most deprived communities.

**Financial:** Falls-related emergency admissions in over-65s cost £116 million in 24/25. Opportunity to improve case finding to ensure at risk patients are identified and receive interventions to prevent progression. FDP projections identify 45,000 patients at risk of transitioning to high frailty by 2027 at a cost of £266.1m and 106,000 patients at risk of transitions into intermediate frailty by 2027 at a cost of £260.9m.

**Other Services:** Falls increase a person's risk of losing their independence and can therefore create a significant burden on both informal care demand and formal adult social care services. Taking this approach is key to improving patient outcomes, reducing demand on secondary care and releasing funding to invest in community.

## We will: Reduce falls-related hospital admissions –

Our ambitions are:

- To ensure all patients 65+ opportunistically have their history of falls assessed
- 100% of patients with a history of falls receive a comprehensive falls risk assessment
- Increase the number of patients referred to falls prevention interventions

### 2026-27 – Priorities

Identify programme management capacity and through this capacity:

- Establish a task and finish group to agree the contents of a comprehensive falls risk assessment.
- Map the commissioning of falls prevention services across C&M.
- Develop a standard service specification for falls prevention exercise interventions in C&M.
- Implement a consistent approach to responding to falls and diagnosis in the community.

### 2027-28 – Priorities

- Develop a standard service specification for falls prevention services in C&M.

### 2028-31 – Priorities

- Commission integrated community-based falls prevention services across C&M.

### Key Metrics and Measures

- Increase in comprehensive falls risk assessments.
- A reduction in falls related emergency hospital admissions.

## Urgent and Emergency Care

**The Case for Change:** Urgent and Emergency Care demand continues to rise earlier in the year, with increasing acuity, complexity and health inequalities. Hospital-centric models are no longer sustainable. Performance challenges in ED waits, ambulance handover delays and delayed discharges reflect system flow constraints rather than isolated provider issues. A step-change is required to shift care upstream, strengthen neighbourhood and community capacity, and deliver safe, timely urgent care.

### Impact:

- Improved patient experience and safety.
- Reduced avoidable ED attendances and admissions.
- Improved ambulance response and handover performance.
- Better flow through acute, community and social care.
- Reduced health inequalities and unwarranted variation.

### Inequalities:

- Targeted approaches for frailty, Children and young people and high intensity users. Improved access to urgent care alternatives in deprived and rural communities.

### Financial and other services:

- Reduced non-elective length of stay. Improved productivity through reduced escalation and stranded patients. Better use of community and intermediate care / virtual capacity.
- Reduced reliance on premium escalation measures.
- The Shaping Care Together Programme remains a key priority, reviewing urgent and emergency care (UEC) services across Southport, Formby and West Lancashire.

\*Medium Term Planning Framework (metric/measure or narrative).

### 2026-27 – Priorities

- Stabilise 4-hour and 12-hour ED performance through early senior decision-making, SDEC-first pathways, redirection and streaming.\*
- Strengthen urgent care alternatives (UTC, NHS 111 CAS, mental health crisis response) to reduce avoidable ED demand.\*
- Enhance early decision-making and same-day options for CYP, including improved front-door streaming, paediatric advice/assessment outside ED, and clearer CYP mental health crisis routes.\*
- Improve Category 2 ambulance response times and reduce handover delays
- Deliver proactive joint health-and-care risk assessment for frail populations.\*
- Optimise intermediate care capacity, prioritising home-first and reducing acute/community length of stay.\*
- Embed system-wide UEC leadership and shared data discipline.
- Implement a single North West Adult Critical Care Transport Service.
- Agree and plan implementation from Shaping Care Together Review.

#### Key Metrics and Measures

- $\geq 82\%$  4-hour A&E by March 2027 (no month below 80%).\*
- Reduce patients >12 hours in ED by 20%.\*
- Reduce paediatric Type 1 attendances by 5% and achieve  $\geq 80\%$  of CYP streamed to an age-appropriate pathway/same-day assessment.
- Category 2 mean response time  $\leq 25$  minutes.\*
- Reduction in corridor care by 50%.
- Reduced adult G&A occupancy trajectory aligned to <92%.
- Reduce NCTR to 12%.

### 2027-28 – Priorities

- Shift from stabilisation to sustained improvement.
- Deliver whole-pathway frailty models at scale, including prevention, same-day assessment and community follow-up.\*
- Scale neighbourhood urgent care to support left shift. Fully integrate urgent care, intermediate care and community services within neighbourhood teams.\*
- Redesign UEC for CYP, expanding same-day assessment and age-appropriate alternatives to ED.\*
- Embed home first and discharge to assess as standard practice.
- Strengthen integrated working with local authorities and VCSFE partners.
- Reduce reliance on escalation beds and reactive surge responses.
- Embrace new standards and guidance including Model Emergency Department and clinical operational standards for the first 72 hours in hospital.\*

#### Key Metrics and Measures

- 85% 4-hour standard as the annual average.\*
- Reduce patients spending >12 hours in ED by further 20%.\*
- Reduced delayed discharges and stranded patients.
- Category 2 mean response time <20 mins\*
- Reduce NCTR to 10%.
- Intermediate care bed base LOS in line with best practice (<21 days).

### 2028-31 – Priorities

- Deliver a fully left-shifted, neighbourhood-led urgent and emergency care model with hospital care reserved for those who need it most.\*
- Prevent avoidable crisis through proactive, neighbourhood-based care.
- Embed personalised urgent care for frailty, CYP and high-intensity users
- Deliver resilient, equitable urgent care aligned to population need.
- Operate UEC as one system, using shared data, improvement discipline and system accountability to sustain performance.
- Move from recovery to high-performing, sustainable UEC services.
- Accelerate the transition to a more structured, digital-first model, with appointments and scheduling according to clinical prioritisation.\*

#### Key Metrics and Measures

- Sustained  $\geq 85\%$  4-hour A&E performance.\*
- Category 2 mean response time  $\leq 18$  minutes, with 90% within 40 minutes.\*
- Reduced emergency admissions per 1,000 population.
- Reduced inequalities in urgent care access and outcomes through a reduction in attendances from patients in IMD 1-4 (To confirm %).\*
- Consistent system resilience with minimal escalation periods.

# 13. Dying Well

- Palliative and End of Life Care (PEOLC)



# Palliative and End of Life Care (PEOLC)

**Case for Change:** The number of people who die each year is expected to rise from around 27,000 to 34,000 by 2035. Most people die from long-term health conditions such as cancer, dementia, heart failure, or liver disease, and rates are expected to rise.

Rates for identifying people likely to be end of life and agreeing Advance Care Plans are below ambition. Rates vary greatly from locality to locality and practice to practice.

The proportion of people dying in hospital is higher than the national average – and the gap is getting wider. Cheshire and Merseyside is the 7th highest area (out of 42) for this key metric.

Unplanned hospital activity in the last 3, 6 and 12 months of life is higher than the national average. Put simply, too many people attend A&E and are admitted unnecessarily.

**Inequalities:** There are significant differences in life expectancy, outcomes and experience dependent on deprivation, ethnicity, disability and learning disability.

**Financial:** Each year Cheshire and Merseyside ICB spends at least £300m on unplanned hospital care for people in their last 12 months of life.

**Other Services:** Unnecessary attendances at A&E: We know that the 27,000 people who died in C&M in 2023 attended A&E around 60,000 times in their final 12 months of life. Non-Elective Admissions (NEL): The number of people admitted, and admitted multiple times, is higher than the national average.

\*Medium Term Planning Framework (metric/measure or narrative).

**We will:** Enable access to good quality end of life care equitably across Cheshire & Merseyside

**Our ambitions are:**

- 60% of people who die to have been on a palliative care register (referred to as Gold Standards Framework or GSF).
- Our ambition is for 60% of people who die to have had an Advance Care Plan or discussion.
- Our ambition is to reach the England average of proportion of deaths in hospital (currently 42.7%).
- 10% reduction in A&E attendances and Non-Elective Admissions by people in the last 12 months of life by year 5 of the plan.

## 2026-27 – Priorities

- Development of a C&M PEOLC Strategy.
- Improve early identification and advance care planning.\*
- Work in partnership with providers to support and strengthen the learning and development for all staff involved in palliative and end-of-life care.
- Refresh and align commissioning for specialist palliative and end-of-life care, including a review of hospice provision.
- Implementation of aligned ICB contracts and palliative drug stock holding in community pharmacy.

### Key Metrics and Measures

- By 2031 60% of people who die to have been on a palliative care register. Year 1 target 37% (Current performance 33%).
- By 2031 60% of people who die to have had an Advance Care Plan or discussion. Year 1 target 44% (Current performance is 40%).

## 2027-28 – Priorities

- Address inequalities in end-of-life care outcomes as outlined in the Population-based Needs Assessment.\*
- Transform All Age Continuing Health Care Fast Track pathways into a fully integrated, proactive model offering coordinated 24/7 support.
- Work with General Practice to embed early identification and advance care planning.
- Incorporate babies', children and young people's care in service design: early identification, 24/7 access, and family choice of care setting.

### Key Metrics and Measures

- By 2031 60% of people who die to have been on a palliative care register. Year 2 target 41% .
- By 2031 60% of people who die to have had an have an Advance Care Plan or discussion. Year 2 target 48%.
- Place of Death – England average 42.7% year 2 target 45.5% (currently 47.5% of people die in hospital in C&M).

## 2028-31 – Priorities

- Shared Care Record for PEOLC to be fully interoperable to co-ordinate the wishes of people who are at end of life.
- Ensure palliative care is fully integrated into developing neighbourhood models providing single points of access, treatment escalation plans, and co-ordinated touch points.

### Key Metrics and Measures

- 10% reduction in unnecessary A&E attendances by year 5 of the plan.
- Non-elective, and admitted NEL multiple times, is higher than the national average. Our ambition is to meet the national average by year 5 of the plan. (target 60.3% and 6.2%).

# 14. System Enablers

We have identified the following system wide enablers that support the delivery of our population health plan

- Digital and Data
- Workforce
- Estates and infrastructure
- Governance and Executive accountability



# Enablers: Digital and Data

We have identified a number of system wide enablers that support the delivery of our population health plan. Innovation and technology and specifically, Digital and Data is a significant contributor.

The Cheshire and Merseyside Provider Collaborative (CMPC) reset and the creation of a shared multi-year Digital workplan will be a key enabler for the collaborative's priorities. It will enable significant economies of scale; Support a phased consolidation of digital infrastructure and Digital support teams and allow us to organise and deploy our transformation resources more effectively by innovating and scaling faster and more consistently to deliver measurable benefits.

The five-year digital and data roadmap is anchored in the three goals of the Cheshire and Merseyside Digital and Data Strategy which has been in place since 2022.

**We Will:** Improve health and well-being by weaving our digital and data infrastructure, systems and services throughout our pathways of care.

The five-year digital and data roadmap is anchored in the three goals of the C&M ICS Digital and Data Strategy which has been in place since 2022.

## Goal 1

**Strong digital and data foundations**

We will build the strong foundations on which to deliver our digital and data ambitions for Cheshire and Merseyside

## Goal 2

**'At Scale' Digital and Data Platforms**

'At scale' digital and data platforms, tools and services across C&M, to ensure that a sustainable, standardised technical and data architecture is in place to improve consistency of offer, efficiency and interoperability of solutions

## Goal 3

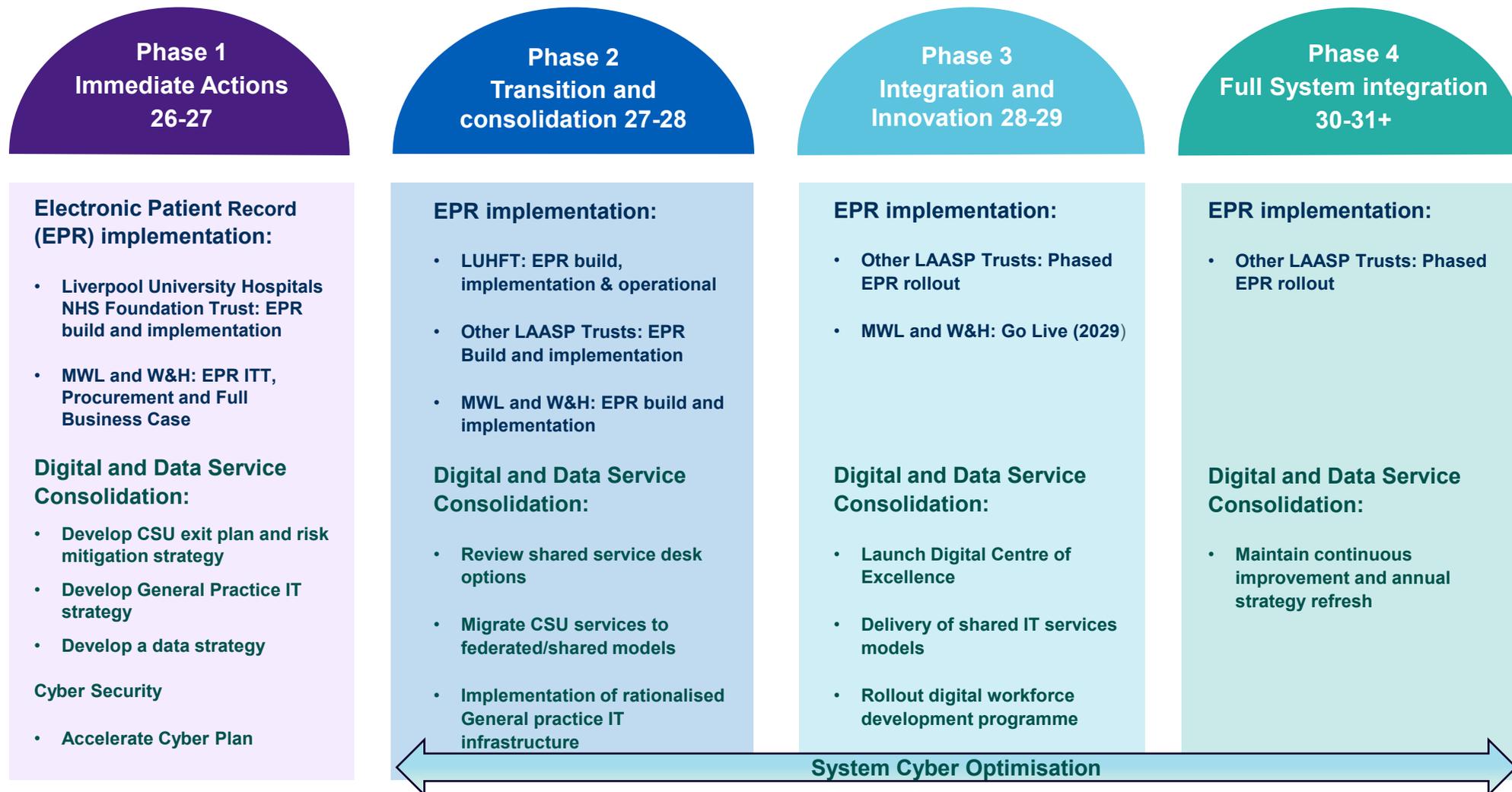
**'At scale' Digital and Data Platforms, Tools and Services**

Continue to develop and expand its strategic digital and data platforms for use within all health and care providers and at all Places to leverage the benefits of at-scale investment and deliver improved outcomes for the population.

Ensure all parts of our health and care system deliver the digital and data requirements outlined in the NHS Medium Term Planning Framework.

# Enablers: Digital and Data

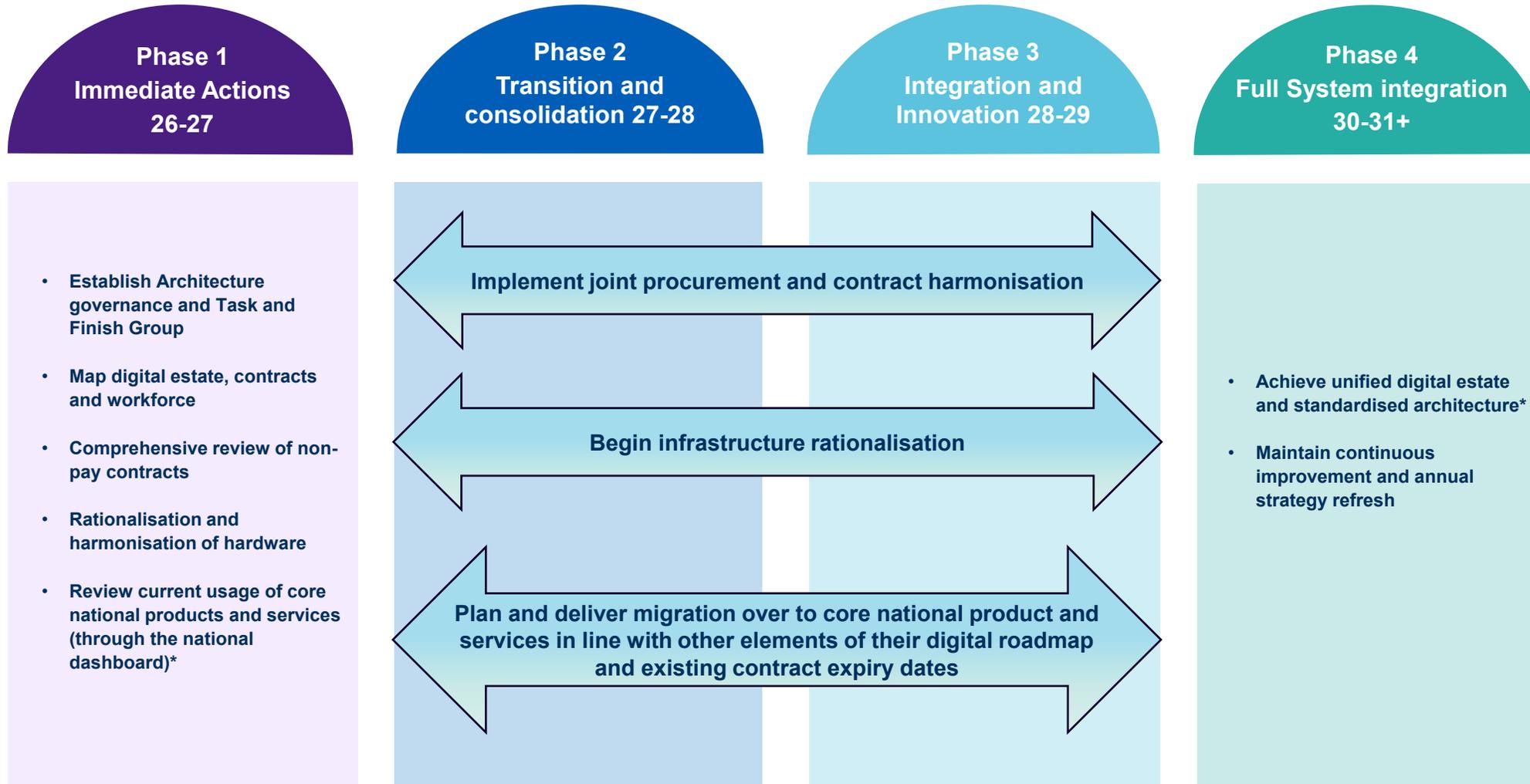
## Goal 1. Build Strong Digital and Data Foundations



# Enablers: Digital and Data

\*Medium Term Planning Framework (metric/measure or narrative)

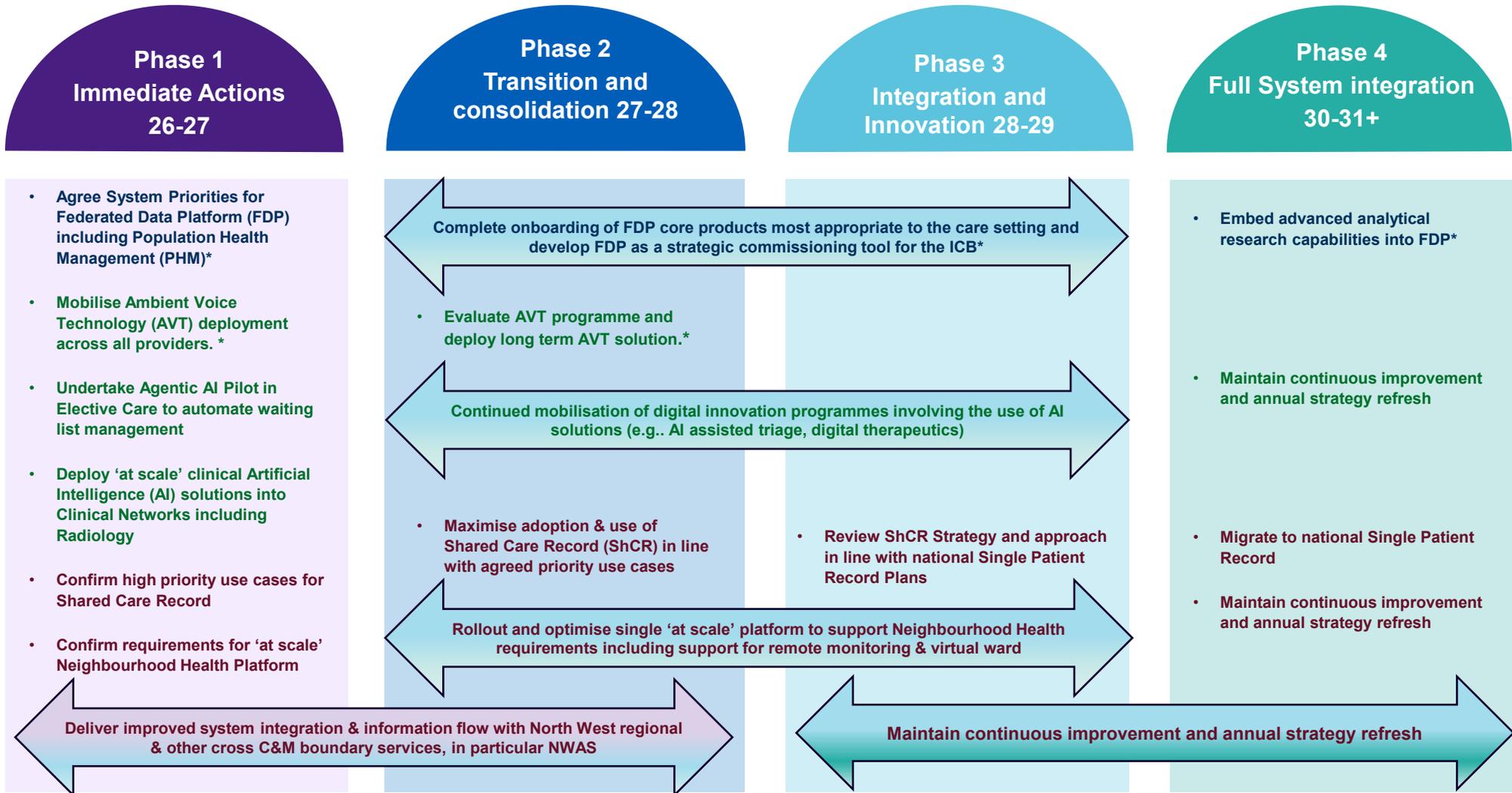
## Goal 2. Design and deliver 'at scale' digital and data architecture and infrastructure



# Enablers: Digital and Data

\*Medium Term Planning Framework (metric/measure or narrative)

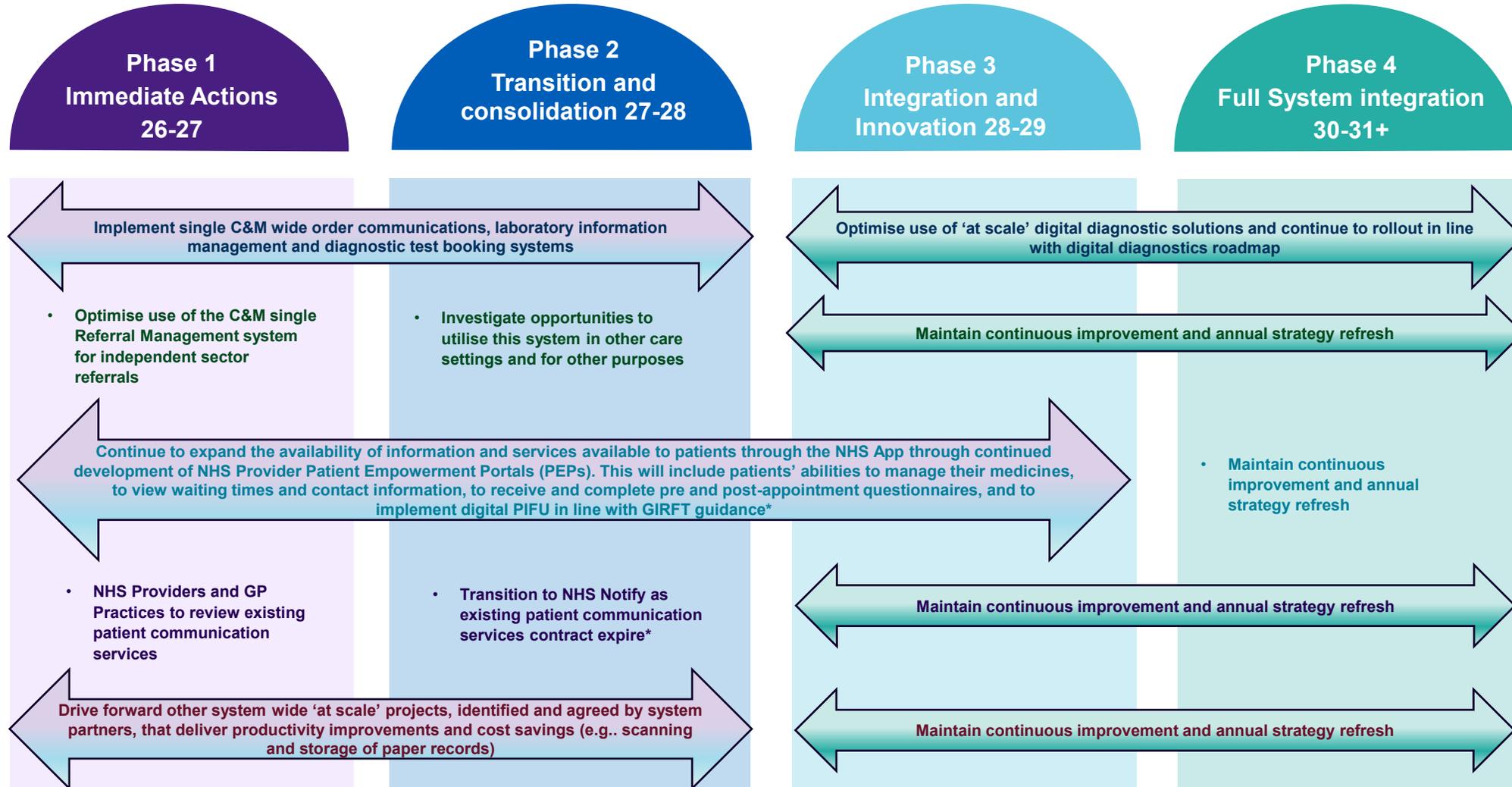
## Goal 3. Deploy 'at scale' digital and data platforms, tools and services



# Enablers: Digital and Data

\*Medium Term Planning Framework (metric/measure or narrative)

## Goal 3. Deploy 'at scale' digital and data platforms, tools and services





# Enablers: C&M Strategic Workforce Plan

The NHS Cheshire and Merseyside ICB system workforce plan frames the workforce as a critical strategic enabler for achieving care closer to home.

It articulates a system-wide ambition to diversify, strengthen and modernise the health and care workforce, enabling a deliberate shift from hospital-centric treatment towards sustained disease management, prevention and personalised, community-based care.

This positions the workforce plan as a catalyst for improving long-term population health outcomes through the:

- Pursuance of affordable workforce models based on supply and demand congruence
- Rationalisation of workforce resources and
- Workforce transformation to support new integrated neighbourhood working models of care.

The NHS C&M ICB System Workforce Plan is supported by the NHS England C&M Workforce Plan: the latter maintaining a specific focus on oversight of acute and secondary care workforce planning.

The ambition of our workforce plan:

We Want: Cheshire and Merseyside to be a great place to work and an outstanding place for care; whether in the community, in one of our hospitals or online

## Affordability

Demand analysis based on population health data, the JSNA and wider health intelligence including the CORE20PLUS5.

Supply and demand planning to achieve optimal affordability and reduced waste across integrated neighbourhood teams.

Workforce gap analysis and remedial action planning to build a futureproof workforce with the capacity and capability to facilitate integrated neighbourhood models of care.

## Rationalisation

Rationalisation of non-clinical corporate support services to achieve economies of scale so far as possible.

Workforce redesign to integrate and optimise the benefits of AI, digital capability and technology solutions.

Efficient and effective management of change to maintain clinical quality and safety and optimal wider workforce productivity.

## Transformation

Workforce modelling in collaboration with system partners to cultivate integrated neighbourhood multidisciplinary teams.

Workforce innovation informed by epidemiology, public health and the CORE20PLUS5.

Workforce capability planning to enable effective risk management of transitioning from existing to new ways of working.

As an ICB, we will partner with our staff and system partners to deliberately create ways of working that enable human ingenuity to flourish by:

- Setting clear accountability for anti racism and social inclusion.
- Ensuring safe and supportive ways to raise concerns about practices that may harm our staff, patients, or the public.
- Taking a population health approach to staff health and wellbeing.
- Putting people at the centre of how we lead and manage.
- Reducing unnecessary bureaucracy so staff at all levels can take part in decision making through networks or engagement forums.
- Embedding Board level oversight of organisational culture and employee experience, aligned with the NHS Constitution and the Nolan Principles for public service.

To deliver our system workforce plan, we will:

- Look after the health and wellbeing of our workforce
- Cultivate anti-racist and anti-discriminatory ways of working
- Nurture a values-based culture
- Demand personal and communal accountability for health justice
- Create opportunities to learn and continually develop
- Engender civility in the workplace
- Deliver on the NHS People Promise
- Develop psychologically safe places of work where staff can speak up, be heard and challenge without fear of retribution and
- Provide meaningful platforms for staff engagement with organisational decision making.

**We want:** Cheshire & Merseyside to be a great place to train, work & be an outstanding place for compassionate care; whether in the community, in one of our hospitals or online.

**Immediate Priorities:  
Operational Planning  
26-27**

- Affordable workforce planning based on supply & demand forecasting, focusing on temporary staffing spend efficiencies & agility.
- Harmonising corporate services & HR&OD through re-design of corporate support functions & incorporating digital solutions for greater efficiency & effective management of resources
- Exploring and understanding root causes of absence – aiming to reduce sickness absence by 1% in 26/27.
- Conducting workforce capacity reviews to understand current ways of working and potential areas of waste, distraction, duplication or efficiency to inform and contribute to delivering 2% average annual productivity growth in 2025/26 and over the Spending Review Period.
- Streamlining People Services across the health economy to achieve economies of scale wherever possible.

**Foundational  
Priorities: 27-28**

- Embedding the new National Management and Leadership framework and programmes which actively contribute to delivering the strategic ambitions laid out in the 10-year Health plan.
- Creating close alignment and collaborative working with quality improvement teams and Professional Leads to ensure clinical and professional standards and safe staffing thresholds are met, with a particular focus on Maternity workforce and Mental Health investment standards.
- Overseeing accountability for the performance of the NHS People Promise to ensure we care for those who care.
- Ensuring understanding and quantification of reasonable workloads and that longer term effects on individuals and teams are recognised and addressed within financial recovery plans.

**Foundational  
Priorities: 27-28  
Continued...**

- Generating good employment opportunities for our local populations through apprenticeship pathways in hard to fill roles.
- Understanding future skills requirements and building responsible talent and progression pathways.
- Protecting student and learner placement opportunities, and appropriate trainer/supervision and education & training capacity required for longer term staffing needs.
- Adapting skill mix and accelerating functional redesign activities, maximising the utility of new and non-medical consultant roles.
- Conducting robust workforce establishment reviews and demonstrating robust establishment control measures.
- Accelerating robust Job Planning and rostering practices to enhance sustainable and agile deployment. Building in flexibility and ownership for staff as well as enhanced pay cost forecasting.

**Longer Term  
28-31+**

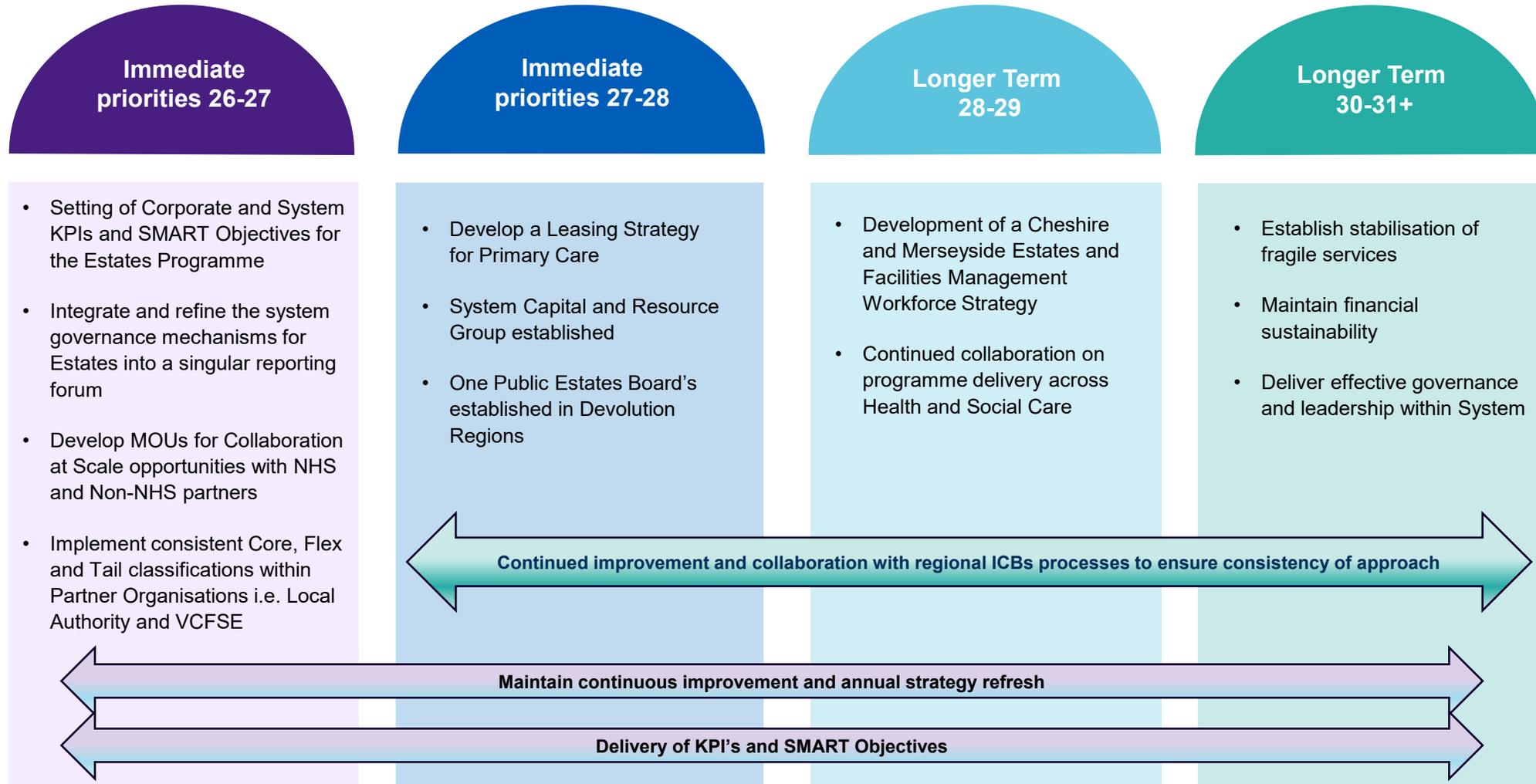
- Delivering national ambitions to enhance employment from local communities and reduce international recruitment to <10% by 2035.
- Embedding skills aligned to digital and technological capabilities & innovation to support efficiency ambitions.
- Translating digital transformation and AI (Artificial Intelligence) integration programmes into readiness and capability programmes for staff.
- Embedding new ways of working, including integrated workforce models, cross-sector, and collaboration across system networks.
- Developing system level solutions to address workforce challenges - prioritising workforce diversity as a key asset in achieving health justice
- Strengthening the interface between hospital and community care pathways, sustaining the transition from hospital to community, treatment to prevention and analogue to digital.

**NHS Medium Term Plan - Operational headline targets:**

- Trusts to reduce agency and bank use in-line with individual trust limits as set out in planning templates, working towards zero spend on agency by 29/30.
- Annual limits will be set for trusts individually based on a national target of 30% reduction agency in 26/27 and 10% year on year reduction in spend on bank staffing.

# Enablers: Estates and Infrastructure

Goal 1 – We will continue to develop and expand the programme; including leadership and governance to enable the delivery of the ICS Infrastructure Strategy



# Enablers: Estates and Infrastructure

## Goal 2 – Creating fit for purpose, sustainable physical estate

### Immediate priorities 26-27

- Outline Business Case Submission of new Neighbourhood Health Centre proposals including, Knutsford, Aintree, Maghull and Handbridge
- Refine the System Estates and Infrastructure Investment Strategy to include Neighbourhood Hub opportunities including identified Pioneer and future Neighbourhood development sites
- Creation of an Estates Asset Management Plan to support better utilisation and cost improvement proposals via disposals
- Develop an Improvement Plan for Modern General Practice where access to the physical Estate is a prevailing factor
- Develop a Utilisation and Optimisation Plan for NHS Property Services and Community Health Partnerships

### Immediate priorities 27-28

- Evaluate Full Business Cases for new Neighbourhood Health Centre proposals including, Knutsford, Aintree, Maghull and Handbridge
- Comprehensive review and implementation of a LIFTco End of Concession strategy for our CHP Portfolio
- Support the development of Decarbonisation Plans within Existing Estate
- Develop an ICS Design and Development Standards for New Builds
- Review opportunities for rationalisation and optimisation because of vertical integration (Community to Acute)

### Longer Term 28-29

- Deliver New Neighbourhood Health Centres in Key Service Areas including but not limited to: Knutsford, Aintree, Maghull and Handbridge.
- Reduce the level of Tail Estate by 10-15% via rationalisation, optimisation or new investment.
- Support the Full Business Case Submission of a New Hospital for Mid Cheshire Hospitals Foundation Trust (MCHFT)
- Review opportunities for increasing the capacity and provision of existing Community Diagnostic Centres to support more outreach services

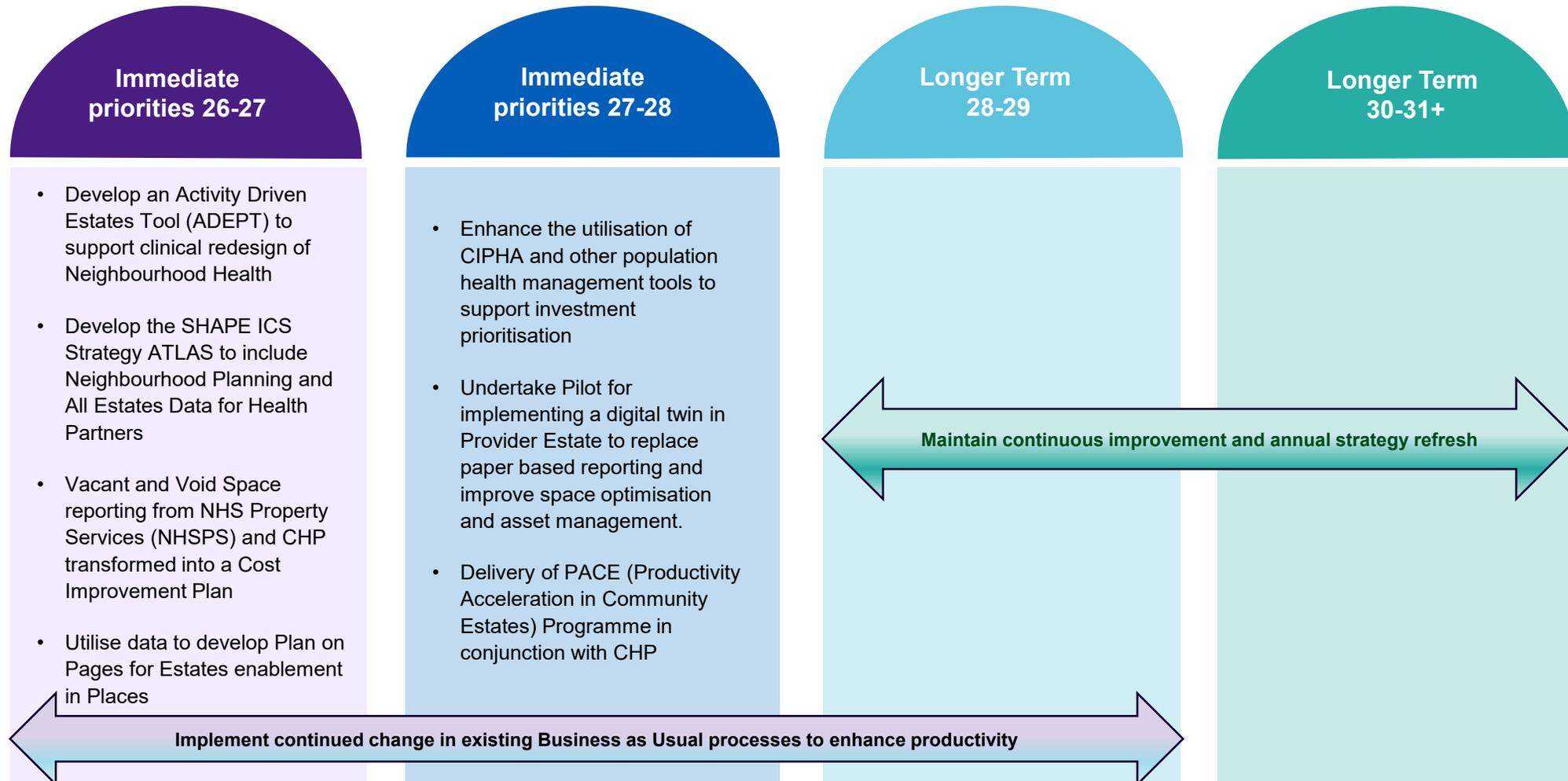
### Longer Term 30-31+

- Refresh System Estates and Infrastructure Investment Strategy
- Continue improving access to service and health outcomes
- Completion on construction on the New Hospital for Mid Cheshire Hospitals Foundation Trust (MCHFT)

Deliver Neighbourhood Health Centre's (existing or new)

# Enablers: Estates and Infrastructure

## Goal 3 – Data Driven Approach



# Governance and Executive Accountability Summary

Life Course Stage	Programme	Committee (Programme Board reporting through to ICB Board Sub Committee)	Accountable Executive Director
<b>Living Healthy Lives</b>	<ul style="list-style-type: none"> <li>Cancer</li> <li>Long Term Conditions (Cardiovascular-Renal Metabolic, Respiratory Disease)</li> <li>Healthy Behaviours</li> <li>Screening and Immunisation</li> <li>Outbreak Responses</li> </ul> <ul style="list-style-type: none"> <li>Serious Violence Duty</li> </ul>	<p>Cancer Alliance Board into Strategic Commissioning Committee.</p> <p>Programmes reporting to Population Health Board into Strategic Commissioning Committee.</p>	<p>Clinical Director</p> <p>Director of Health and Integrated Care Commissioning</p>
<b>Starting Well</b>	<ul style="list-style-type: none"> <li>Maternity and Neonatal Care</li> </ul>	Programme Board into Strategic Commissioning Committee.	Clinical Director
<b>Growing Well</b> (Children and Young People)	<ul style="list-style-type: none"> <li>Neighbourhood Health and accountable care approaches</li> <li>Mental Health</li> <li>Neurodiversity</li> <li>Joint Commissioning and Partnerships</li> </ul>	<p>Programme Board into Strategic Commissioning Committee.</p> <p><i>(Review to be undertaken for system CYP Governance including development of ACO)</i></p>	Director of Health and Integrated Care Commissioning
<b>Living Well</b>	<ul style="list-style-type: none"> <li>Mental Health (including community)</li> <li>Learning Disability &amp; Autism</li> <li>Neurodiversity (Adults)</li> <li>Integrated Neighbourhood Teams</li> <li>Community Services</li> <li>Elective (Planned) Care</li> <li>Diagnostics</li> </ul> <ul style="list-style-type: none"> <li>Primary Care (General Practice, Dental, Optometry and Pharmacy)</li> </ul> <ul style="list-style-type: none"> <li>Stroke</li> <li>Women's Health</li> </ul>	<p>Programme Board into Strategic Commissioning Committee.</p> <p>Primary Care Committee.</p> <p>Programme Board into Strategic Commissioning Committee.</p>	<p>Director of Health and Integrated Care Commissioning</p> <p>Clinical Director</p>
<b>Ageing Well</b>	<ul style="list-style-type: none"> <li>Prevention of Frailty Escalation</li> <li>Dementia</li> <li>Falls Prevention</li> <li>Urgent and Emergency Care</li> </ul>	Programme Board into Strategic Commissioning Committee.	Director of Strategy and Transformation
<b>Dying Well</b>	<ul style="list-style-type: none"> <li>End of Life and Palliative Care</li> </ul>	Programme Board into Strategic Commissioning Committee.	Clinical Director
<b>Enablers</b>	<ul style="list-style-type: none"> <li>Digital and Data</li> </ul> <ul style="list-style-type: none"> <li>Workforce</li> </ul> <ul style="list-style-type: none"> <li>Estates and Infrastructure</li> </ul>	<p>Programme Boards to Strategic Commissioning Committee.</p> <p><i>Notes: ICB role in Workforce has changed and arrangements need confirming from April.</i></p> <p><i>Capital decisions via Finance Investment and Resources Committee</i></p>	<p>Clinical Director</p> <p>TBC</p> <p>Director of Finance and Contracting</p>

# Glossary

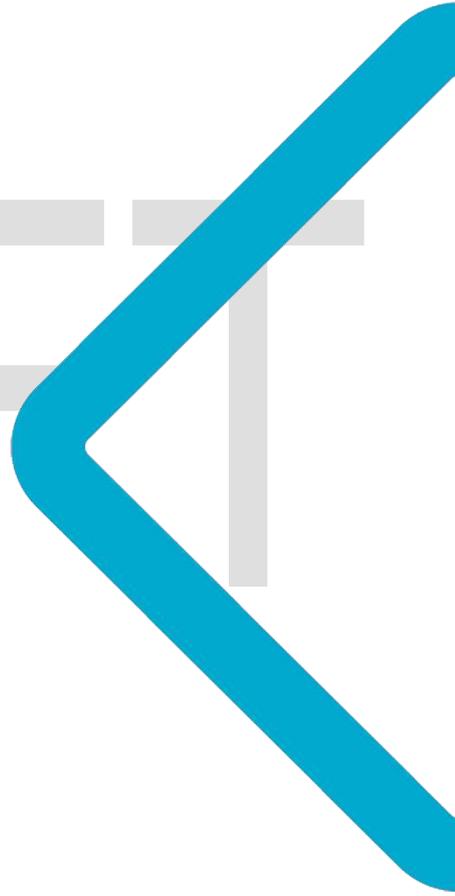
- ABC = Atrial fibrillation, high Blood pressure and Cholesterol
- ACO = Accountable Care Organisation
- ADHD = Attention Deficit Hyperactivity Disorder
- AI = Artificial Intelligence
- AIDS = Acquired immunodeficiency syndrome
- ATLAS = Part of the Strategic Health Asset Planning and Evaluation Tool
- BBV = Blood Born Virus
- CAMHS = Child Adolescent Mental Health Services
- CDC = Community Diagnostic Centre
- CETR = Care Education Treatment Review
- CDif = Clostridioides difficile
- CGM = Continuous Glucose Monitoring
- CHC = Continuing Health Care
- CHP = Community Health Partnerships
- CIPHA = Combined Intelligence for Population Health Action
- CMCA = Cheshire and Merseyside Cancer Alliance
- COPD = Chronic Obstructive Pulmonary Disease
- CVD = Cardiovascular Disease
- CSU = Midlands and Lancashire Commissioning Support Unit
- CYP = Children and Young People
- DIA = Data Into Action
- DiaDEM = Diagnosing Advanced Dementia Mandate
- DOAC's = Direct Oral Anticoagulants
- EDC = Elective Diagnostics Cancer
- EDI = Equality Diversity Inclusion
- ENT = Ear Nose and Throat
- EPR = Electronic Personal Record
- FDP = Federated Data Platform
- FDS = Faster Diagnosis Standard
- FeNO = fractional exhaled nitric oxide
- GIRFT = Getting it Right First Time
- HACT = Housing Associations' Charitable Trust
- HCAI's = Healthcare-associated infections
- HIV = Human immunodeficiency virus
- HPV = Human papillomavirus
- ICU = Intensive Care Unit
- IHA = Initial Health Assessment
- IHO = Integrated Health Organisation
- IMD = Index of Multiple Deprivation
- INT = Integrated Neighbourhood Team
- ITT = Invitation to Tender
- KPI = Key Performance Indicator
- LA = Local Authority
- LAASP = Liverpool Adult Acute and Specialist Providers

# Glossary

- LD&A = Learning Disability and Autism
- LeDeR = Learning from lives and deaths programme
- LGI = Lower Gastrointestinal
- LIFTco = Local Improvement Finance Trust Company
- LUHFT = Liverpool University Hospitals NHS Foundation Trust
- LOS = Length of Stay
- LRTI = Lower respiratory tract infection
- LTC = Long Term Conditions
- MDT = Multi-disciplinary Team
- MMR = Measles Mumps Rubella
- MOU = Memorandum of Understanding
- MSK = Musculoskeletal
- MWL= Mersey and West Lancashire Teaching Hospitals NHS Trust
- NDH = Non-Diabetic Hyperglycaemia
- NEET = Not in Employment Education or Training
- NEL = Non-Elective
- NROL = Neuro-Rehabilitation On-line
- NWAS = North West Ambulance Service
- OPIC = Office of the Public Independent Conciliator
- PCN = Primary Care Network
- PCRS = Primary Care Respiratory Society
- PHIP = Population Health Improvement Plan
- PTL = Patient Tracking List
- PREM's = Patient-Reported Experience Measures
- PROM's = Patient Reported Outcome Measures
- PTL = Patient Tracking List
- QaLYS = Quality-Adjusted Life Years
- RPA = Robotic Process Automation
- SABA = Short-Acting Beta-Agonists
- SEND = Special Educational Needs
- SHAPE = Strategic Health Asset Planning and Evaluation
- ShCR = Shared Care Record
- SMART = Specific, Measurable, Achievable (or Attainable), Relevant, and Time-bound
- SOP = Standard Operating Procedure
- SRO = Senior Responsible Officer
- STB = Supervised Teeth Brushing
- STT = Straight to Treatment
- TB = Tuberculosis
- UNICEF BFI = United Nations Children's Fund UK Baby Friendly Initiative
- VCFSE = Voluntary Community Faith Social Enterprise
- VPD = Vaccine Preventable Disease
- W&H = Warrington and Halton Teaching Hospitals NHS Foundation Trust

**NHS Cheshire and Merseyside  
Integrated Care Board  
Draft Outcomes Framework –  
5-Year Clinical and Strategic  
Commissioning Plan Priority Themes**

March 2026 Version 0.1



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Document Owner:	Approval date:	First published:
	Next review date:	Version:



## Introduction

This framework describes the key outcomes and measures which we are intending to deliver in 2026-27 in relation to the priorities identified in our 5-Year Clinical and Strategic Commissioning Plan and the associated Population Health Improvement Plan.

It should be highlighted that the measures focus on health related outcomes directly targeted through the programme areas highlighted in these plans and should be considered alongside our wider partnership plans which will reflect a broader set of outcomes and measures we are working collectively to achieve.

In line with the principles outlined in our Five-Year Clinical and Strategic Commissioning Plan (see page 15), we have identified a set of commissioning and contracting approaches that will enable our transition toward a strategic commissioning approach centred on improving population **health outcomes**. These approaches are designed to support collaborative, long-term planning; incentivise **outcome-focused delivery**; and ensure that all commissioning activity remains compliant with national regulations, statutory responsibilities, and recognised best-practice guidance.

As part of our new operating model, we will reflect revised and enhanced governance to oversee how we operate, and this will be reflected in our approach to delivery of the priorities in this plan.

- Each Programme will have an Executive Senior Responsible Officer and Programme Lead who will be responsible for ensuring that plans will deliver against a set of **defined outcomes and agreed objectives with clear measures of success and timescales**.
- As part of our revised operating model programmes will be assured through a consistent programme management approach, reporting delivery progress through either a new Strategic Commissioning Programme Board or, if appropriate, through another Board sub-committee and then as part of a single improvement plan to the ICB Board.
- Monitoring of progress against delivery will use **strategic trackers** of our key priority **milestones, metrics and measures** (based on outcomes wherever possible) through Board Sub Committees and through a monthly Integrated Performance Report (IPR) to Board.

This version is Draft and further engagement is taking place to finalise the outcomes and measures:

- Through engagement with partners

- To finalise the improvement trajectories/criteria across programmes
- Reporting arrangements including through a revised Integrated Performance Report

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# Starting Well – Maternity and Neonatal

Outcome		Measure of Progress
We will Improve the quality and safety of local maternity and neonatal services	We will improve the safety of maternity and neonatal services through reducing stillbirths, preterm births, maternal and neonatal deaths, maternal morbidity, and brain injuries.	HIE rate per 1,000
		Still Birth rate per 1,000
		Preterm Births %
		Neonatal Deaths per 1,000 Live Births*
	We will give babies the best start in life.	Smoking at Time of Delivery %
		Breast Milk at First Feed %
	We will reduce inequalities through increasing access to continuity-based midwifery care for women at highest risk, including women living in areas of deprivation and those from minority ethnic communities.	Placement on Continuity - Black/Asian women %
		Placement on Continuity - Women in most deprived areas %
	We will improve the experience of care across antenatal, intrapartum and postnatal care.	Improvement in CQC maternity survey results scores (annual)

*\*North West Neonatal Operational Delivery Network data only includes babies admitted to neonatal units. Therefore, delivery suite deaths re-admissions to paediatric wards and babies who die after being discharged from neonatal care are not included.*

# Growing Well – Children and Young People

A whole system Outcomes Framework is being developed for Children and Young People coordinated through our Beyond Children and Young People Programme. This will be finalised by the end of April 2026 and published in a revised version of this document.

# Living Well – Mental Health

Outcome		Sentinal Indicator in Bold	
		Measure of Progress	Metric
<p>We will improve the health outcomes and life expectancy of people with mental health needs.</p> <p>In doing this we will also reduce the inequality in outcomes for people with severe mental health (MH) conditions who have a significantly lower life expectancy, generally dying 15 to 20 years earlier than the general population.</p>	<p>We will proactively improve access to early intervention and support for Children and Young People and timely response when in crisis</p>	Expand coverage of Mental Health Support Teams in schools and colleges (inc. teams in training)	<b>Number accessing (1+ contact) Mental Health Support Teams for Children And Young People (age 0-17) - rolling 12-month</b>
		Reduce longest waits for CYP community mental health services by improving productivity, reducing local inequalities and unwarranted variation in access	<p>Number of Children And Young People (0-17) accessing (1+ contact) mental health services (12-month rolling metric)</p> <p>Number of Children and Young People with mental health waits over 104 weeks (help-based clock stop) at the end of the reporting period</p>
	<p>We will improve access to care in our neighbourhoods and communities</p>	Reduce the average length of stay in adult acute mental health beds	<p>Average Length of Stay for Patients in Adult Acute and PICU Mental Health Beds</p> <p>Average Length of Stay for Patients in Older Adult Acute Mental Health Beds</p>
		Implementing 24-7 neighbourhood mental health centres	<p>Winsford 26-27</p> <p>Sefton 26-27</p> <p>Liverpool and St Helens 27-28</p> <p>5 in 2028-29 (subject to capital plan approval)</p>
	<p>We will proactively improve access to early intervention and support for Adults and timely response when someone is in crisis.</p>	Mental Health Crisis Assessment Centres	<p>Chester and Arrows Park will be 2026-27</p> <p>27-28 (Macclesfield)</p> <p>28-29 at Leighton</p> <p><i>(subject to capital plan approval)</i></p>
		<p>Meet the existing commitments to expand NHS Talking Therapies and IPS</p>	<b>Reliable recovery rate for those completing a course of treatment and meeting caseness</b>
			<b>Reliable improvement rate for those completing a course of treatment.</b>
			<b>No. completed Talking Therapy courses of treatment</b>
			<b>Number of patients accessing Individual Placement Support services</b>
			Number of women accessing Specialist Community Perinatal Mental Health Services (12-month rolling metric)
	<b>Number of active inappropriate adult acute out of areas placements (OAPs)</b>		
	<p>We will reduce the disparity in health outcomes for people with Severe Mental Health Conditions</p>	Reduce the gap in Life Expectancy for People with SMI compared to general population*	We will sustain the proportion of people with SMI who have an annual Health Check to agree care plans <i>(subject to LES to incentivise consistent implementation)</i>
Eliminating Suicide*		<p><b>Mental Health attendances at emergency departments</b></p> <p>Number of people waiting admission from community (w/e last week of the mth)</p>	

Across all measures we would analyse referral, assessment, and treatment outcomes across different demographic groups to reduce disparities

# Living Well – Neurodiversity and Learning Disability and Autism

Outcome		Measure of Progress	Supporting Metric
We will improve the identification and support for neurodivergent individuals, focusing on understanding needs, improving access to earlier support and reducing waiting times for assessment	To provide consistent local, timely and early neurodevelopmental support*	75% of adult patients report a positive experience of ND services.	Increase number of patients accessing early support. Increase number of staff trained and number of profiling tools completed.
	To provide consistent local and timely access to diagnosis and treatment.	92% of adult patients referred for diagnostic assessment have their first appointment within 52 weeks of referral.	Reduce number of patients referred for diagnostic assessment
Eliminate CYP over 52-week waits for assessment/diagnosis.		Reduced independent sector spend (CYP and Adult).	
Reduce CYP numbers on assessment/diagnosis waiting list by 30%.			
Reduce the variation in healthy life expectancy for people with learning disability where currently on average people die almost 20 years earlier than someone without a learning disability	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people by at least 10%	Reliance on mental health inpatient care for adults with a learning disability	
		Reliance on mental health inpatient care for autistic adults	
	Provide proactive support for people with Learning Disability and Autism	Percentage of Annual Health Checks delivered to patients aged 14+ on the GP Learning Disability Register	

\* Whilst the measures here focus on the NHS aspects this forms part of a wider system working recognising the wider social impacts of better support, assessment and treatment stretch well beyond health including education, employment and social and criminal justice outcome measures.

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# Living Well – Proactive and Preventative Care

Outcome		Measure of Progress
Nationally defined Outcome	5 Year Strategic Commissioning Plan	
The NNHIP Place has an agreed set of neighbourhoods that align to a single health and wellbeing board (HWP) area the public can recognise, and GPs, trusts, local authority partners and VCSE services can see their teams working together in.	Not applicable	Each Health and Wellbeing Board agrees neighbourhood footprint
The population has good access to their GP practices. Where this isn't the case, there is an agreed improvement plan between the ICB and the practice.	Ensuring patients can access Primary Care support when they need it.	Increased % urgent care demand met same day in primary/community settings
Demonstrated improvement measured through local assessment on delivery or improvement in the areas highlighted in the Red Tape Challenge and 'Bridging the interface between primary and secondary care, mental health and community services' (Bridging the gap).	Not applicable	Local assessment
Establish more integrated, proactive and person-centred care for people with complex health and care needs that will reduce NEL, reduce outpatient and GP utilisation and improve the overall wider determinants to reduce inequalities.	Supporting people to proactively manage long term and complex conditions	Increased immunisation and vaccination rates across INT populations
		Improved secondary prevention of CVD (cholesterol and BP Management)
		Improved medicines optimisation and reduced harm from polypharmacy
		Reduction in unplanned admissions for chronic ambulatory care sensitive conditions including frailty
Improved care and a reduction in unnecessary non-elective admissions and bed days – and ensure that these and other measures reduce total non-elective admissions and bed days.	Caring for people in their own home or local community wherever possible	Increased discharges to usual place of residence
		Reduction in emergency admissions for people aged 65+
		Increased proportion of patients discharges on discharge-ready-date
		Increase end-of-life care delivered in preferred place of death
		Reduction in unplanned admissions for falls
(1) Reduction in unnecessary non-elective admissions and bed days as a result of INTs providing better and more joined up care (2) Shift of outpatient focus to be more preventative and aligned to a neighbourhood model		
Improve access to specialist opinion and diagnostics in an efficient and cost-effective way across specialities, focusing on co-morbidity but include all opportunities	Improving access to the care people need by integrating services around the needs of residents/patients	Increased use of virtual wards for admission avoidance and discharge

*Note that metrics need aligning across priority areas so we have single definitions e.g. frailty and falls and EOL care.*

# Ageing Well – Frailty

Outcome		Measure of Progress
We will deliver coordinated, person-centred frailty care	We will proactively care for people in neighbourhoods and communities to help prevent and reduce the impact of frailty	Reduction in people aged 65+ being discharged onto pathway 3 after an acute hospital stay to <5%
		90% of people with dementia have an annually reviewed care plan.
	We will reduce unnecessary hospital stays for people with frailty	We will reduce unnecessary non-elective admissions for patients with frailty (10% reduction against baseline)
		Reduction in average length of stay for frailty admissions (15% reduction against baseline)
		Bed days as a result of a fall for people aged 65+, 75+ and 85+ to national mean
	Supporting measures	% patients screened for frailty within 30 mins of arrival (data sources still being established)
		% polypharmacy reviews completed for high-risk cohort (data sources still being established)
		% of people who die who had an end-of-life care plan in place (EPACCS or ACP) - See EOL for trajectory
		Achieve ≥67% Dementia Diagnosis Rate
	There are also balancing metrics within the Frailty Improvement Plan	
		Community service caseload growth rate

# Dying Well – Palliative and End of Life Care

Outcome		Measure of Progress
We will enable equitable access to good quality end of life care	We will support people approaching the end of their life to plan ahead so we can help them receive the care they want, and also help to make things easier for their family and loved ones.	By 2031 60% of people who die to have been on a palliative care register.
		By 2031 60% of people who die to have had an have an Advance Care Plan or discussion.
	We will support people at the end of their life to receive care in the place they would prefer.	Reduce the proportion of our population dying in hospital
		10% reduction in A&E attendances and Non-Elective Admissions by people in the last 12 months of life by year 5 of the plan.

# Meeting of the Board of NHS Cheshire and Merseyside

## 26 March 2026

### Draft NHS Cheshire and Merseyside Single Improvement Plan

**Agenda Item No:** ICB/03/26/11

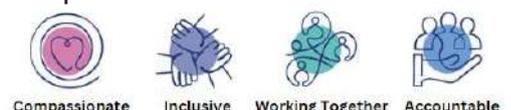
# Draft NHS Cheshire and Merseyside Single Improvement Plan

## 1. Purpose of the Report

- 1.1 This paper sets out the drivers, approach, details, oversight and next steps for the development of the Single Improvement Plan, incorporating all priorities and requirements for the next 6–12 months, including formal undertakings issued by NHS England.

## 2. Executive Summary

- 2.1 The draft Single Improvement Plan (SIP) responds to formal undertakings related to financial planning, quality and leadership and governance as agreed by the ICB with NHS England. The plan consolidates all required actions and system-wide improvement activity into one coherent programme, ensuring alignment, accountability, and strengthened leadership capability. It is subject to engagement with NHS England currently, feedback will be reflected when and as received.
- 2.2 In October 2025, the Integrated Care Board (ICB) received a formal letter from NHS England outlining a series of enforcement undertakings. These undertakings were issued in response to significant concerns regarding the ICB's financial planning, financial sustainability, and the robustness of its quality governance arrangements. The ICB accepted these undertakings in full, recognising the need for decisive action to restore confidence, strengthen organisational capability, and ensure compliance with statutory responsibilities.
- 2.3 Under Section 22 of the NHS Act 2006, the ICB is required to achieve joint financial objectives, operate within capital and revenue limits, and ensure that all functions are exercised effectively, efficiently, and economically. NHS England's concerns indicated that the ICB was not consistently meeting these expectations, and that improvements were required both in the way financial decisions were made and in how quality risks were identified, escalated, and managed across the system.
- 2.4 The Single Improvement Plan has been developed as the central mechanism for addressing these issues. It brings together all required actions, organisational priorities, and system-wide improvement activity into one coherent programme of work.
- 2.5 **Summary of NHS England Undertakings**  
 The undertakings are linked to finances, quality and leadership governance.  
 a. Financial Undertakings - The ICB is required to:
- Agree and submit a credible 2025/26 financial plan



- Demonstrate significant improvement in both reported and underlying financial performance
- Achieve an in-year statutory breakeven position
- Improve underlying performance through strengthened CIP delivery, improved income and expenditure management, and tighter control of WTE movements
- Deliver quarter-on-quarter run-rate improvements throughout 2025/26 and into 2026/27
- Appoint a System Financial Turnaround Director
- Comply with all actions overseen through Financial Performance Review Meetings and the NHS England System Development Group
- Confirm delivery of all elements of the plan, including the £235m system target, by October 2025
- Develop a medium-term financial plan demonstrating a trajectory to underlying financial balance

b. Quality Undertakings - The ICB must:

- Strengthen quality governance in line with National Quality Board guidance
- Improve the presentation and triangulation of quality risks across places
- Deliver a Mental Health Improvement Plan
- Implement national mental health initiatives
- Reduce long waits for mental health patients in emergency departments

c. Leadership and Governance Undertakings - The ICB must:

- Demonstrate sufficient leadership capacity and capability at board level
- Commission an independent governance review
- Engage NHS England in all board-level recruitment processes
- Strengthen governance systems and processes to address the issues identified

**2.6 Oversight and Reporting Requirements - The ICB must:**

- Report progress monthly through an oversight group
- Attend oversight meetings and provide evidence as requested
- Work collaboratively with NHS England Northwest on regulatory interventions and recovery planning

2.7 It is currently envisaged that Board oversight will be provided through a NED led task and finish group - the Single Improvement and Delivery Board - which it is proposed is established following consideration by the Board at its May meeting.

### 3. Ask of the Board and Recommendations

#### 3.1 The Board is asked to:

- **APPROVE** the Single Improvement Plan **NOTING** the plan will continue to iterate and as the ICB responds to anticipated and expected feedback from NHSE.
- Provide input into the timing and scope of Board oversight of the SIP.

### 4. Reasons for Recommendations

- 4.1 Approval of the plan will ensure a supported organisational response to statutory and regulatory requirements, embedding strengthened governance, leadership and Board oversight.

### 5. Background

#### 5.1 Key concerns driving formal undertakings

##### a. Financial Planning Concerns

A financial diagnostic review undertaken in May 2025 highlighted a number of significant weaknesses in the ICB's financial planning processes. At that time these included:

- A variance to plan of almost £40m
- An underlying deficit of £89.6m
- A system deficit of £201.3m for 2024/25, which was £51.3m adverse to plan
- An agreed deficit of £178.2m for 2025/26, with very high risks to delivery

These findings demonstrated that the ICB, at that time, did not have sufficient grip on its financial position, that planning assumptions were not robust, and that the system lacked the discipline required to deliver agreed trajectories. The review also highlighted weaknesses in forecasting, run-rate management, and the alignment of financial plans across system partners.

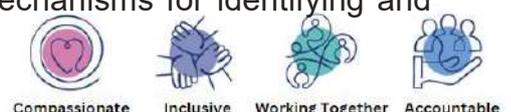
The scale of the financial challenge required a fundamental reset of financial governance, improved accountability, and a more rigorous approach to planning and performance management.

##### b. Quality Governance Concerns

NHS England also identified concerns relating to the ICB's quality governance arrangements. These included:

- Insufficiently embedded quality governance structures
- Inconsistent triangulation of quality data across places
- Weaknesses in escalation processes
- Limited assurance on quality risks across the system

These issues indicated that the ICB did not have a comprehensive or consistent view of quality across providers, and that the mechanisms for identifying and



responding to risks were not sufficiently mature. Strengthening quality governance is therefore a central component of the improvement plan.

## 5.2 The ICB's Approach

To meet the undertakings and ensure a coherent organisational response, the ICB has developed a Single Improvement Plan. This plan consolidates all improvement activity into one structured programme, ensuring alignment, clarity, and accountability. The plan also reflects the ICB's new leadership arrangements, operating model, Audits and grip and control reviews, external guidance and strategic priorities. It is designed not only to address the undertakings but to strengthen the organisation's long-term capability and resilience.

### 5.2 Development of the Plan

The plan has been developed through a structured process involving:

- Executive workshops
- PMO-supported planning sessions
- Review of external diagnostics and audits
- Alignment with national frameworks and statutory requirements

The PMO has ensured that each objective is supported by SMART actions, Clear ownership, Defined timelines, Dependencies, Success metrics and Risks and issues logs

### 5.3 There are a number of drivers behind the plan to ensure a comprehensive set of objectives for the next 6-12 months. These are:

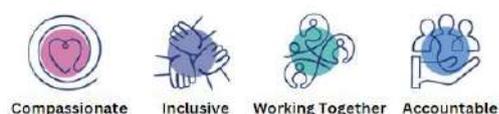
- NHS England enforcement undertakings
- PwC Grip and Control Review
- ICB Financial Governance Review
- MIAA Governance Review
- Well-Led Framework
- Insightful Board Framework

These drivers ensure that the plan is evidence-based, externally validated, and aligned with national expectations.

### 5.4 The plan is organised into six thematic sections, each with an Executive Senior Responsible Officer (SRO):

**Each section includes detailed actions, milestones, and metrics.**

The Single Improvement Plan sets out a comprehensive, organisation-wide programme of work across six major domains, each with clear objectives, actions, dependencies, and success measures. It is designed to deliver the NHS England undertakings, strengthen governance, improve quality, restore financial sustainability, and embed a new operating model.



## 6. Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities

6.1 The Single Improvement Plan impacts on every aspect of the ICB's delivery and therefore its objectives as follows:

**Objective One:** Tackling Health Inequalities in access, outcomes and experience

**Objective Two:** Improving Population Health and Healthcare

**Objective Three:** Enhancing Productivity and Value for Money

**Objective Four:** Helping to support broader social and economic development

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

7.1 The Single Improvement Plan impacts on every aspect of the ICB's delivery and therefore its objectives and annual plan. Key will be how the organisation works though the integration of delivery of our annual delivery plan with oversight and integration with the SIP. This is a live area of focus and consideration for the executive.

<https://www.cheshireandmerseyside.nhs.uk/media/2kvcnuzm/summary-version-of-the-ifp-delivery-plan-260623.pdf>

## 8. Link to meeting CQC ICS Themes and Quality Statements

8.1 The Single Improvement Plan impacts on every aspect of the ICB's delivery and therefore the CQC ICS themes and quality statements

**Theme One**      **Quality and Safety**

**Theme Two:**    **Integration**

**Theme Three:** **Leadership**

## 9. Risks

9.1 The ICB is currently seeking to manage recovery, whilst also developing and implementing a new operating model. Not focusing on and/or not delivering an improvement plan is not an option. Non delivery means the ICB will not achieve its objectives and ambitions nor succeed in delivering its undertakings. However the organisations' resources are currently distracted and are yet to be fully aligned to this endeavor.

## 10. Finance

- 10.1 The initiatives detailed are expected to be delivered within existing resource and, if realised will deliver significant CRES savings.

## 11. Communication and Engagement

- 11.1 The ICB will engage with partners following Board consideration of these proposals. We expected the SIP to form a significant part of the basis of our regular discussions with NHSE.

## 12. Equality, Diversity and Inclusion

- 12.1 EQIA will form a core part of any change proposals per established ICB processes.

## 13. Climate Change / Sustainability

- 13.1 n/a

## 14. Next Steps and Responsible Person to take forward

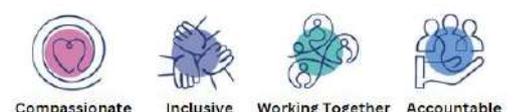
- 14.1 Designated executive lead is establishing internal governance to review, track and seek assurance on mobilisation and delivery of the plan
- 14.2 The organisation is currently going through a process of Management of Change. Establishment of new structures and alignment of resource to the delivery of this plan is key to successful delivery of the plan
- 14.3 When the internal delivery structure is established it is envisaged that the ICB will establish a route to support NED oversight of the management of our approach.

## 15. Officer contact details for more information

Ben Vinter, Executive Director of Corporate Services and Governance

## 16. Appendices

**Appendix One:** Draft C&M Single Improvement Plan Summary



## Appendix One

### Summary of Draft Single Improvement Plan

#### 1 1. Quality & Clinical Governance

##### **SRO: Executive Clinical Director**

This domain focuses on strengthening all aspects of quality governance, clinical assurance, and safety oversight.

##### Key themes

- Establishing a strengthened System Quality Group (SQG) with revised TOR, improved attendance, and clearer reporting.
- Delivering efficiency schemes in adult care, neurodiversity, and medicines management.
- Completing a full review of clinical leadership, safeguarding, digital/BI, medicines management, and quality team structures.
- Strengthening EQIA processes to ensure all decisions are underpinned by robust quality and equality impact assessments.
- Refreshing the Clinical Effectiveness Panel to ensure evidence-based decision-making.
- Developing a comprehensive Maternity & Neonatal Plan aligned to regional review findings.

#### 1.2. Strategy, Turnaround & System Recovery

##### **SRO: Executive Director of Strategy & Transformation (Turnaround)**

This domain drives financial recovery, turnaround governance, and system-wide transformation.

##### Key themes

- Establishing a robust Turnaround Programme Board with clear TOR, reporting templates, and independent assurance.
- Developing a credible turnaround plan aligned to commissioning intentions and large-scale change programmes.
- Embedding organisation-wide CRES planning, including staff engagement and prioritisation processes.
- Implementing a new Strategy & Transformation operating model.
- Translating commissioning intentions into clear transformation plans for frailty, CYP, out-of-hospital care, etc.
- Developing a comprehensive Urgent & Emergency Care (UEC) Plan, with system-wide engagement and performance dashboards.

### 1.3. Financial Planning & Sustainability

#### SRO: Executive Director of Finance

This domain focuses on stabilising the financial position, improving run-rate, and delivering required savings.

##### Key themes

- Finalising enforcement undertakings and agreeing year-end expectations with NHSE.
- Developing the 2026/27 financial plan, including contracting, left-shift assumptions, and activity planning.
- Building a Medium-Term Financial Plan with scenario modelling and multi-year CRES/CIP trajectories.
- Strengthening financial governance, including contract management, procurement oversight, and policy updates.
- Supporting NHSE's transition to regional oversight of provider financial performance.

### 1.4. Commissioning Strategy & Intentions

#### SRO: Executive Director of Health & Integrated Care Commissioning

This domain sets out the commissioning strategy, population health priorities, and delivery plans.

##### Key themes

- Developing and approving the 2026–31 Clinical & Strategic Commissioning Plan and Population Health Improvement Plan.
- Producing detailed implementation plans for all major programme areas (Neighbourhood Health, frailty, CYP, maternity and Neonatal care, mental health, neurodiversity, EoL, etc.).
- Enhancing Mental Health Improvement Plan oversight, including OPEL implementation, escalation pathways, and risk management.
- Establishing revised governance for quarterly monitoring of delivery of commissioning priorities.
- Aligning investment plans to left shift priorities.
- Developing a comprehensive Integrated Needs Assessment with multidisciplinary input.
- Implementing strengthened commissioning structures aligned to the new operating model.



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## 1.5 Governance

### SRO: Executive Director of Corporate Services & Governance

This domain strengthens governance, assurance, and constitutional compliance.

#### Key themes

- Commissioning an independent governance review covering committee structures, internal controls, BAF, SORD/OSORD, SFIs, and conflicts of interest.
- Strengthening financial governance through PwC deep dives, contract reviews, and performance oversight.
- Refreshing all Terms of Reference, decision frameworks, and the ICB Constitution.
- Updating templates for business cases, assurance reviews, and committee papers.
- Revising the Board Assurance Framework, risk management framework, and risk appetite.
- Ensuring a fully staffed and effective Board and Executive Team.
- Implementing strengthened structures for all governance and assurance functions.
- Developing governance for the Provider Blueprint and system-wide oversight.

## 1.6. Leadership Development, OD & Communications

### SRO: Chief Executive Officer

This domain focuses on leadership capability, organisational culture, and system relationships.

#### Key themes

- Designing and implementing a revised Target Operating Model aligned to the Model ICB Blueprint.
- Delivering a comprehensive Board Development Programme aligned to NHS leadership frameworks.
- Building commissioning capability through national training and accreditation.
- Implementing an Executive Leadership Development Programme and coaching offer.
- Delivering a system-wide communications and engagement strategy.
- Refreshing the Organisational Development Plan, including values, culture, and staff engagement.
- Responding to staff survey findings with targeted improvement actions.
- Strengthening stakeholder management, including mapping, engagement schedules, and partnership governance.



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# Meeting of the Board of NHS Cheshire and Merseyside

## 26 March 2026

### Board Assurance Framework Strategic Risks 2025-2028 and High Scoring Corporate Risks

**Agenda Item No:** ICB/03/26/12

# Board Assurance Framework Strategic Risks 2025-2028 and High Scoring Corporate Risks

## 1. Purpose of the Report

- 1.1 The purpose of the report is to present the current position of the 2025-28 Board Assurance Framework (BAF) and the high scoring (15+) risks to the Board for review.
- 1.2 The BAF provides a structure and process which enables the Board to focus on the key strategic risks which might compromise the achievement of our Strategic Objectives.

## 2. Executive Summary

- 2.1 A refreshed view of the strategic risks were explored, discussed and agreed by the Board at its November 2025 meeting where approval was received to run for a three-year period (as opposed to the more common 12-month time frame adopted). The rationale for this key change is to achieve a degree of consistency during a transitional period by aligning principal strategic risks against the four ICB 'core' purposes and the planning framework.
- 2.2 The BAF (Appendix One) reflects the strategic priorities contained within Ten Year Health Plan and the Cheshire and Merseyside Health and Care Partnership Plan 'All Together Fairer' whilst maintaining focus on wider NHS reform and the transition of ICBs to 'strategic commissioners' by 2027. The principal risks within the 'new' BAF are aligned against each of the four core purposes of an ICB, specifically:
  - Improve outcomes in population health
  - Tackle health inequalities in outcomes, experiences and access
  - Enhance productivity and value for money
  - Help the NHS support broader social and economic development.
- 2.3 The BAF risks are also aligned to the proposed Cheshire and Merseyside key strategic themes and goals 2026-2031.
- 2.4 All strategic risks have been reviewed by Risk Leads in quarter 4 and there are no proposed changes to risk scores.

## 3. Ask of the Board and Recommendations

- 3.1 **The Board is asked to:**
  - **Review** the current scores for the Board Assurance Framework 2025-2028 and scores relating to the High Scoring Corporate Risk
  - **Consider** if it feels suitably assured by the Controls and Assurances on each risk detailed in Appendix One.

- **Consider** whether this core appetite statement is still relevant and should continue to be adopted, or whether it should be reconsidered with reference to the current environment the ICB is operating in

## 4. Reasons for Recommendations

- 4.1 The Board has a duty to assure itself that the organisation has properly identified the risks it faces and that it has processes in place to mitigate those risks and the impact they have on the organisation and its stakeholders. The Board discharges this duty as follows:
- Identifying risks which may prevent the achievement of its strategic objectives
  - Determining the organisation's level of risk appetite in relation to the strategic objectives
  - Proactive monitoring of identified risks via the BAF and Corporate Risk Register
  - Ensuring that there is a structure in place for the effective management of risk throughout the organisation, and its committees (including through local areas)
  - Receiving regular updates and reports from its committees identifying significant risks, and providing assurance on controls and progress on mitigating actions
  - Demonstrating effective leadership, active involvement and support for risk management.
- 4.2 As a publicly accountable organisation, the ICB is required to evidence that its decision-making structure is aligned with a robust system of internal control and based on principles of good governance. This is underpinned by an effective risk management system which is designed to ensure the proactive identification, assessment and mitigation of risks against the ICB's strategic objectives, priorities and core purposes. This process is central to providing the Board with assurances that all required activities are focussed on the continued delivery of strategies and plans whilst maintaining compliance with legislation and regulatory requirements.
- 4.3 The ICB Risk Management Strategy incorporates the board assurance arrangements and sets out how the effective management of risk will be evidenced and scrutinised to provide assurance to the Board. The BAF is a key component of this strategy. The Board is supported through the work of the ICB Committees in reviewing risks, including these BAF risks, and providing assurance on key controls. The outcome of their review is reported through the reports of the committee chairs and minutes elsewhere on the agenda.
- 4.4 The establishment of effective risk management systems is vital to the successful management of the ICB and local NHS system and is recognised as being fundamental in ensuring good governance. As such, the BAF underpins all themes, but contributes particularly to leadership, good governance, effective management and financial sustainability.

4.5 The Board will be aware that there is more work to do, following this Board meeting, to ensure the actions and controls aligned to strategic objectives are fully captured and aligned with the ICBs 2026/7 plans, commitments and improvement focus over the next year. The executive has also received feedback through the Board’s committees that a review of controls and objectives is completed to ensure that the risk profile of the organisation is fully and accurately captured and that comprehensive mitigation trajectories are fully worked through in particular for any extreme risks scores.

## 5. Risk appetite

5.1 Risk appetite can be defined as “the amount and type of risk that an organisation is prepared to pursue, retain or take in the pursuit of its strategic objectives”. The ICB has adopted the GGI Risk Appetite matrix which outlines risk appetite levels:

Risk Appetite Level		
<b>0 – None:</b> avoidance of risk is a key organisational objective	<b>1 – Minimal:</b> preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential	<b>2- Cautious:</b> preference for safe delivery options that have a low degree of residual risk and only a limited reward potential
<b>3 – Open:</b> willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	<b>4 – Seek:</b> eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)	<b>5 – Significant:</b> confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.

5.2 The ICB must take risks to achieve its aims and deliver beneficial outcomes to patients, the public and other stakeholders. Risks will be taken in a considered and controlled manner, and the Board has determined the level of exposure to risks which is acceptable in general, and this is set out in the ICBs core risk appetite statement, which currently is:

*“The ICBs 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. The ICB has no tolerance for safety risks that could result in avoidable harm to patients. Our ambition to improve the health and wellbeing of our population and reduce inequalities can only be realised through an enduring collaborative effort cross 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 the local system / providers to take risk in pursuit of these objectives within an appropriate accountability framework.”*

5.3 Cheshire & Merseyside ICBs core appetite statement has not changed since 2023. **The C&M ICB Board is asked to consider whether this core appetite statement is still relevant and should continue to be adopted, or whether it should be reconsidered with reference to the current environment the ICB is operating in.** If the Board considers that it should be revisited, then a further opportunity to explore risk appetite will be developed for the Board to consider within the context of the new Operating Model and aim to transition to a 'strategic commissioner' in 2026.

## 6. Board Assurance Framework Risks 2025-2028 and high scoring (15+) risks

6.1 Table One outlines a summary of the eight proposed BAF risks, a proposed risk appetite against each risk and risk score (current and target). Appendix One provides a Summary Overview table and the greater detail against each BAF risk.

**Table One:**

BAF ID	Strategic risk title	Proposed risk appetite	Proposed Current score	Proposed Target Score
P4	Quality & Safety failures in commissioned services	Minimal	20	10
P11	Digital and Cyber Resilience Gaps	Open	16	8
P12	Failure to reduce health inequalities and improve population health	Cautious to open	15	10
P13	Inability to achieve financial sustainability and productivity	Minimal	20	10
P14	Failure to Recover Access and Performance Standards	Cautious	20	10
P15	System Fragmentation and Provider Sustainability	Cautious to open	12	8
P16	Failure to Deliver the Shift to Neighbourhood and Community-Based Care	Open	15	10
P17	Workforce Capacity, Capability, and Morale	Open	16	8

6.2 Of the eight proposed risks, three are identified as extreme risks (P4, P13, P14), four are identified as high risk (P11, P12, P16, P17) and one is identified as a moderate risk (P15). The proposed risk appetite against each BAF risk has been determined by engagement with Board Members and execs, the outputs of a risk appetite session with available Board members, as well as benchmarking against similar risks that feature on other ICB and provider BAFs.

6.3 In regard to principal risk **P15** (system fragmentation and provider sustainability), it is acknowledged that as one of the more complex strategic risk areas further discussion and iteration will be progressed as the new executive portfolios develop and where potential 'risk sharing arrangements' with strategic partners may be necessary.

6.4 Table Two provides a summary of the high scoring risks which meet the threshold for escalation to the Corporate Risk Register (as at 18 March 2026).

**Table Two**

Risk ID	Title	Inherent Risk Score	Current Risk Score
14DR	There is a risk of the ICB's critical information systems suffering a failure due to a cyber security attack leading to possible financial / Data loss, disruption to services and patient care and/or damage to the reputation of the organisation	16	16
QU05	Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm	20	20
WSC3	Failure to secure the required capital investment for the transformation of women's hospital services in Liverpool, combined with revenue implications, will negatively impact on the successful delivery of proposals.	16	16
WSC4	If the programme is unable to deliver an agreed a model of care, women's hospital services in Liverpool may not be able to meet clinical service specifications and could become clinically unsustainable leading to a loss of services; this could lead to further negative impacts on other providers across C&M and the north west region	15	15
WSC6	If patient safety, quality risks and clinical issues in the current model of care cannot be sufficiently mitigated, avoidable patient harm and poorer patient outcomes are likely	20	20
QU16	Inequity in availability of designated safeguarding professional capacity and administrative functions within place across Cheshire and Merseyside ICB	16	16
WSC7	The changes in NHS England and ICB structures in 2025/26 could impact on the ability to deliver the Women's Services Programme.	16	16
QU17	Widespread and/or systemic failings leading to significant concerns about the experiences and outcomes of children and young people SEND.	12	16
QU19	AACC Team - Workforce and Wellbeing	16	20
QU21	Risk of harm from delays in assessment and unmet need as a result of inadequate compliance with the CHC National Framework (28 day performance)	12	16
PG7b	ICB financial constraints / pressures may limit funding available to deliver strategic aims for GP primary care impacting on quality and trust and confidence in the ICB	20	16

Risk ID	Title	Inherent Risk Score	Current Risk Score
PP5b	ICB financial constraints may limit funding available to deliver strategic aims for community pharmacy, impacting on quality and trust and confidence in the ICB	20	16
QU08a	IF NHS Cheshire and Merseyside Integrated Care Board fails to deliver its duty to oversee the quality and safety of care within its commissioned health services, due to a lack of ICB quality staff capacity, THEN there is a risk of decreased oversight and assurance of services, which may result in ICB failing to identify when commissioned services are delivering reduced standards of care, with poor patient experience and avoidable harm.	15	15
QU09	East Cheshire Trust Summary Hospital Mortality Index (SHMI) is above the expected range which could be an indicator of sub-optimal care of patients resulting in avoidable harm.	15	15
QU10	Looked After Children (LAC) should receive an Initial Health Assessment (IHA) within statutory timescales. Failure to deliver within those timescales would result in the ICB breaching its statutory duty, with the potential for a negative impact on health support due to delays in identification of need.	16	16
QU18	AACC budget overspend	20	20
QU20	Delays in NHS Funded Nursing Care reviews	16	16

6.5 During the period December 2025 to February 2026 a ‘forensic review’ of the risk master list has been conducted with the aim of identifying those risks which have remained static for long periods or, in some cases are no longer relevant. Risks identified for closure following this exercise have been assessed against current organisational context and whether they align with the 2025-28 Board Assurance Framework. This work will continue into Q1 of the new financial year.

6.6 A significant proportion of high scoring risks fall within the domain of quality & performance. A review of all quality and performance corporate risks is also currently being undertaken with the aim of aligning with the BAF and related strategies, plans and objectives.

## 7. Schedule of reporting

7.1 In line with current practice, and as outlined within the ICBs Risk Management Strategy, if the BAF risks are approved by the Board then the following will continue:

- The BAF is updated and reported to Board on a minimum of a quarterly basis.
- Reporting of assigned risks to each appropriate Committee – with risk reports to each Committee meeting maintained as a standing agenda item.
- Scheduled strategic risk ‘deep dives’ factored into each Committees annual Workplan.
- Annual report to the Audit Committee who have oversight of the Risk Management Framework and Strategy.

## 8. Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities

1. Tackling Health Inequalities in access, outcomes and experience
2. Improving Population Health and Healthcare
3. Enhancing Productivity and Value for Money
4. Help the NHS support broader social and economic development

- 8.1 The BAF supports the objectives and priorities of the ICB through the identification and effective mitigation of those principal risks which, if realised, will have the most significant impact on delivery.

## 9. Link to achieving the objectives of the Annual Delivery Plan

- 9.1 The Annual Delivery Plan sets out linkages between each of the plan’s focus areas and one or more of the BAF principal risks. Successful delivery of the relevant actions will support mitigation of these risks.

## 10. Link to meeting CQC ICS Themes and Quality Statements

- Theme One: Quality and Safety**  
**Theme Two: Integration**  
**Theme Three: Leadership**

- 10.1 The establishment of effective risk management systems is vital to the successful management of the ICB (and the local NHS system) and is recognised as being fundamental in ensuring good governance. As such the BAF underpins all themes, but contributes particularly to leadership, good governance, effective management and financial sustainability.

## 11. Finance

- 11.1 There are no financial implications arising directly from the recommendations of the report. However, the proposed BAF does cover a number of financial risks as detailed in Appendix One.

## 12. Communication and Engagement

11.1 No patient and public engagement has been undertaken.

## 13. Equality, Diversity and Inclusion

13.1 Principal risks which have the potential to adversely impact on equality, diversity and inclusion in service delivery, outcomes or employment are detailed in Appendix One

## 14. Climate Change / Sustainability

14.1 There are no identified impacts in the BAF on the delivery of the Green Plan / Net Zero obligations.

## 15. Officer contact details for more information

### **Stephen Hendry**

Head of Business Support  
NHS Cheshire and Merseyside ICB

### **Gavin Wraige**

Risk and Compliance Officer  
NHS Cheshire and Merseyside ICB

**Appendix One - Cheshire and Merseyside Integrated Care Board - Board Assurance Framework 2025-2028– Summary (v1.4 March 2026)**

ICB Core Purpose	BAF ID	Strategic Risk	Risk Appetite (Draft)	Current Score	Target Score	Lead director(s) / board lead	Lead committee / board
Improve outcomes in population health	P4	<b>Quality &amp; Safety failures in commissioned services:</b> There is a risk that commissioned services will not consistently deliver high-quality, safe, and equitable care, undermining our statutory duty to improve population health and reduce inequalities. This risk is heightened as we shift resources from hospital to community and redesign care pathways to deliver the 10-Year Plan's ambitions for neighbourhood health, digital enablement, and prevention.	Minimal	20	10	Executive Clinical Director	Quality & Performance Committee
	P11	<b>Digital and Cyber Resilience Gaps:</b> Failure to ensure robust digital infrastructure, data sharing, and cyber security across the system could disrupt care, undermine public trust, and impede delivery of the "analogue to digital" shift. This would threaten our ability to deliver on the 10-Year Plan's requirements for a digitally enabled, data-driven, and patient empowered NHS	Open	16	8	Executive Clinical Director	Executive Committee
Tackle inequalities in outcomes, experience and access	P12	<b>Failure to reduce health inequalities and improve population health:</b> Risk that the ICB will not deliver measurable reductions in health inequalities or improvements in population health outcomes, particularly for the most deprived and vulnerable groups, if resources, commissioning, and partnership actions are not sufficiently targeted and aligned with All Together Fairer, Core20PLUS5, and the prevention and equity ambitions of the 10-Year Plan	Cautious to open	15	10	Executive Director of Health and Integrated Care Commissioning	Executive Committee
Enhance productivity and value for money	P13	<b>Inability to achieve financial sustainability and productivity:</b> risk that the ICB and system partners will not achieve required financial savings, productivity gains, and operational cost reductions, as mandated by the Model ICB Blueprint and the 10-Year Plan. This could limit our ability to invest in prevention, neighbourhood health, and digital transformation, and may result in failure to meet statutory financial duties	Minimal	20	10	Executive Director of Finance & Contracting	Finance, Investment and Contracts Committee
	P14	<b>Failure to Recover Access and Performance Standards:</b> There is a risk we will not deliver national standards for access and performance as set out in 2025/26 operational plans. This would undermine public confidence, exacerbate inequalities, and undermine delivery of the 10-Year Plan's commitment to timely, accessible care closer to home	Cautious	20	10	Executive Director of Strategy and Transformation	Quality & Performance Committee
	P15	<b>System Fragmentation and Provider Sustainability:</b> If we do not proactively shape and support a sustainable provider landscape, especially as we commission at-scale, integrated neighbourhood and digital-first services there is a risk of service loss, fragmentation, or failure. This would compromise our ability to deliver the Model ICB Blueprint's vision for joined-up, efficient, and resilient care	Cautious to open	12	8	Medical Director	Executive Committee
Help the NHS support broader social and economic development	P16	<b>Failure to Deliver the Shift to Neighbourhood and Community-Based Care:</b> There is a risk that the ICB will not achieve the required shift from hospital-centric to neighbourhood and community-based models of care, as set out in the 10-Year Plan and Model ICB Blueprint, due to insufficient investment, workforce capability, or provider collaboration. This would undermine prevention, integration, and local access ambitions	Open	15	10	Executive Clinical Director	Executive Committee
	P17	<b>Workforce Capacity, Capability, and Morale:</b> The scale and pace of organisational redesign, including significant headcount reductions and new ways of working, may disrupt strategic commissioning functions, destabilise workforce morale, and impede delivery of transformation priorities. This threatens our ability to build the skills and capabilities needed for the Model ICB and to deliver the 10-Year Plan's workforce and leadership ambitions	Open	16	8	Chief People Officer	Executive Committee

## Appendix Two: Board Assurance Framework Risks 2025-2028

NHS Cheshire & Merseyside ICB Board Assurance Framework 2025-2028

Risk Title																																																																																																																																																																																																			
<b>Quality and safety failures in commissioned services</b>																																																																																																																																																																																																			
<table border="1"> <tr> <th colspan="2">Strategic Risk Ref</th> <th colspan="1">Risk Description</th> <th colspan="7">Risk Scoring and Tolerance</th> </tr> <tr> <td rowspan="4"><b>P4</b></td> <td colspan="2" rowspan="4">There is a risk that commissioned services will not consistently deliver high-quality, safe, and equitable care, undermining our statutory duty to improve population health and reduce inequalities. 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Date of update: March 2025

Date next update due: June 2026

Digital & Cyber Resilience Gaps												
Risk Title	Risk Description			Risk Scoring and Tolerance								
Strategic Risk Ref	Failure to ensure robust digital infrastructure, data sharing, and cyber security across the system could disrupt care, undermine public trust, and impede delivery of the "analogue to digital" shift. This would threaten our ability to deliver on the 10-Year Plan's requirements for a digitally enabled, data-driven, and patient-empowered NHS.			Inherent risk score	Q1	Q2	Q3	Q4	In-year Target Score	Long Term Target Score	Long Term Target Date	
P11				Likelihood	5	4	4	4	4	4	2	March 2028
				Impact	4	4	4	4	4	4	4	
				Risk Level	20	16	16	16	16	16	8	
Number of Linked Risks on Corporate Risk Register												
			Low (1 - 4)	Mod (6 - 12)			High (15 - 25)					
ICB Core Purpose	Improve population health outcomes			Lines of Defence	Sources of Assurance					Assurance Level		
ICB Strategic Goal	Accelerate to digital innovation			1 <sup>st</sup> Line	Cyber security updates provided to ICB Audit Committee (quarterly)					Acceptable		
Directorate	Transformation			2 <sup>nd</sup> Line	Formal cyber risk reporting to ICB Board					Partial		
Lead Director	Medical Director											
Lead Committee	Audit Committee											
Risk Appetite	Open			3 <sup>rd</sup> Line	1. Regular Regional and National communication with NHSE and other NHS organisations. 2. Annual Data Security Protection Toolkit (DSPT) submission (reviewed by NHSE)					Acceptable		
Rationale for Risk Score and Progress made in the quarter												
The possibility of a cyber-attack cannot be completely removed, and a residual risk will remain, but the implementation of the 5-Year Cheshire and Merseyside Cyber Security Strategy aims to mitigate the level of risk that the ICB is exposed to over the lifetime of the strategy. Potential for patient harm, major effect on quality of clinical care, significant financial loss, significant loss of trust and confidence of stakeholders and adverse national media. Limited investments expected in 2025-26 will maintain the risk at the current level. In-year funding (secured through National Cyber Resilience Fund) will fund the delivery of priorities in the programme. A further round of funding is expected in 2026/27 with this year's programme aiming to build the business case to secure further funding. Issues in relation to cyber security manager vacancy mitigated via our IT providers.												
Action												
No	Action Required				Due Date	Update on Actions			BRAG RATING			
1.	Explore opportunity to standardize cyber tooling across C&M and procure at scale				Mar 26				On track			
2.	Analyse / map critical service/supply chain security assurances and gaps across C&M organisations. Identify significant exposure points and develop reporting				Mar 26				On track			
3.	Create standard security and assurance procurement & contracts requirements to be shared across all organisations across ICS				Mar 26				On track			
4.	Undertake a skills survey across Digital teams within the ICS, analysing data to identify gaps in organisations and across the footprint and build out a training needs assessment based upon the outcomes.				Mar 26				On track			
5.												
Key Controls												
1. C&M ICB Cyber Security Strategy 2. Cyber incident / Business Continuity Plan 3. ICB monitoring of system-wide cyber security standards 4. Digital Services Delivery Board (ICB infrastructure only) 5. Digital and Data Strategy Management group (system wide overview) – Cyber Management group reporting into this 6. Incident management and support in major incidents formally agreed with ICB providers 7. IT provider contracts and formal data sharing agreements												
Gaps in Control or Assurance												
ICS / ICB Capacity and investment to respond to continuously evolving threat – funding streams delayed by a year with consequent impact on control action timescales Gaps in ICB cyber leadership (Head of Cyber Security) and out of hours response capacity. Lack of organisational & system level monitoring and reporting of standards, compliance & risks. Further work required to raise awareness and understanding of cyber security at Board level & for all staff												

Date of update: **March 2026**

Date next update due: **June 2026**

Updates to actions

- The ICB is now in receipt of Cyber revenue funding from NHS England. Work is underway to develop a full programme to implement the Cheshire and Merseyside cyber strategy including these actions.
- The CIO Group and CMPC leadership group have agreed the creation of a single shared Cyber Team (centre of Excellence) Specification and Business case is in development.

Risk Title	Failure to reduce health inequalities and improve population health										
Strategic Risk Ref	Risk Description	Risk Scoring and Tolerance									
P12	There is a risk that C&M ICB will fail to deliver measurable reductions in health inequalities or improvements in population health outcomes, particularly for the most deprived and vulnerable groups, if resources, commissioning, and partnership actions are not sufficiently targeted and aligned with All Together Fairer, Core20PLUS5, and the prevention and equity ambitions of the 10-Year Plan. If the ICB does not embed prevention and fails to address the wider determinants (eg. housing, employment, environment) through commissioning and system leadership, it will limit our impact on long-term health outcomes and economic prosperity.	Inherent risk score	Q1	Q2	Q3	Q4	In-year Target Score	Long Term Target Score	Long Term Target Date		
		Likelihood	4	3	3	3	3	3	2	March 2028	
		Impact	5	5	5	5	5	5	5		
		Risk Level	20	15	15	15	15	15	10		
		Number of Linked Risks on Corporate Risk Register									
Low (1 - 4)			Mod (6 - 12)			High (15 - 25)					
ICB Core Purpose	Tackle health inequalities	Lines of Defence	Sources of Assurance						Assurance Level		
ICB Strategic Goal	Reduce health inequalities	1 <sup>st</sup> Line	Delivery of the Population Health Programme reporting into the Population Health Partnership.						Acceptable		
Directorate	Assistant Chief Executive		Population Health Partnership reporting to the C&M ICB Executive Committee and reporting to the ICB Board.						Acceptable		
Lead Director	Executive Director of Health and Integrated Care Commissioning								2 <sup>nd</sup> Line		
Lead Committee	Executive Committee	The ICB Core20+5 Health Inequalities Stocktake reported to the NHSE Population Health Directorate on a quarterly basis.						Acceptable			
Risk Appetite	Cautious-open							3 <sup>rd</sup> Line			
Rationale for Risk Score and Progress made in the quarter											
There is a significant risk the ICB will fail to deliver a range of strategic priorities such as the C&M Joint Forward Plan and the All Together Fairer: Our Health and Care Partnership Plan. The failure to deliver these strategic priorities will cause major reductions in health outcomes and life expectancy, alongside a widening of the health inequality gap for people living in deprived areas or who are socially excluded (Impact score: 5). While current controls are effective in reducing the likelihood of this risk materialising, it remains a possibility (Likelihood score: 3).											
Key Controls											
<ol style="list-style-type: none"> <li>1. Clear governance for ICB Population Health programme delivery reporting into the Population Health Partnership and ICB Exec Committee</li> <li>2. Collaborative working with the combined authorities to transition the governance for the delivery of the HCP plan All Together Fairer to the Combined Authorities</li> <li>3. The Strategic Commissioning Framework leading to the completion of an Integrated Needs Assessment to inform the priorities of the ICB Population Health Strategy with a particular focus on health inequalities</li> </ol>											
Gaps in Control or Assurance											
<ol style="list-style-type: none"> <li>1. The reduced investment in Health Inequalities funding in-year (2025/26) from the ICB has led to a delay in some programme commencement dates until April 2026.</li> <li>2. The lack of funding to invest in prevention and health inequalities</li> <li>3. The UK announcement of the intention to abolish the requirement for integrated care partnership risks a lack of focus and accountability for reducing health inequalities across the health and social care system</li> <li>4. NHSE changes and the implications for the future Population Health Programme</li> </ol>											
Action		No	Action Required	Due Date	Update on Actions		BRAG RATING				
		1.	Continue to take a Population Health approach to targeted action on the three leading causes of the gap in Healthy Life Expectancy (CVD, Respiratory and Cancer)	Mar 26			On track				
		2.	Integration of Population Health Management within Integrated Neighbourhood Teams	Apr 26			On track				
		3.	Population Health Partnership reporting lines to be confirmed (linked to approval of revised ICB governance arrangements / HCP)	Dec 25			Completed/BAL				
		4.	Work with NHSE NW and neighbouring ICBs in development of Office for Pan ICB Commissioning (OPIC) ahead of transfer of commissioning	April 27			On track				
		5.									

Date of update: Jan 2026

Date next update due: June 2026

Risk Title	Inability to achieve financial sustainability and productivity									
Strategic Risk Ref	Risk Description	Risk Scoring and Tolerance							Long Term Target Date	
P13	Risk that the ICB and system partners will not achieve required financial savings, productivity gains, and operational cost reductions, as mandated by the Model ICB Blueprint and the 10-Year Plan. This could limit our ability to invest in prevention, neighbourhood health, and digital transformation, and may result in failure to meet statutory financial duties.	Inherent risk score	Q1	Q2	Q3	Q4	In-year Target Score	Long Term Target Score	March 2028	
		Likelihood	5	4	4	4	4	3		2
		Impact	5	5	5	5	5	5		5
		Risk Level	25	20	20	20	20	15		10
Number of Linked Risks on Corporate Risk Register										
Low (1 - 4)			Mod (6 - 12)			High (15 - 25)				
ICB Core Purpose	Enhance productivity and value for money	Lines of Defence	Sources of Assurance						Assurance Level	
ICB Strategic Goal	Deliver financial stability	1 <sup>st</sup> Line	Regular financial performance reports provided to Finance, Investment & Contracting Committee (FICC)						Acceptable	
Directorate	Finance									
Lead Director	Executive Director of Finance & Contracting	2 <sup>nd</sup> Line	Formal update on ICB/ICS financial performance presented to ICB Board as standing agenda item (presented by Executive Director of Finance)						Acceptable	
Lead Committee	Finance, Investment and Contracts Committee									
Risk Appetite	Minimal	3 <sup>rd</sup> Line	Finance and Performance review meetings with ICB and high and medium risk providers, led by NHSE/PWC						Acceptable	
Rationale for Risk Score and Progress made in the quarter										
There is potential for a major financial loss, special measures and significant impact on trust and confidence of stakeholders (impact 5). The scale of the financial gap means that the likelihood is currently likely (4). Planned actions to secure ICS wide agreement and NHSE approval to a Medium-Term Financial Strategy are in progress. The ICB has agreed a forecast outturn for 2025/26 with NSHE regional team of break-even. A formal request for a change in the control team has been submitted to the national NHSE team. A medium term plan has been submitted which sets out a forecast break-even position for the ICB over the next 3 years. Contracts negotiations are underway with NHS providers which are due to conclude by the end of March. There is currently a gap between offers and providers of circa£50m. The system is currently unable to achieve the control total for 26/27.										
Action										
No	Action Required	Due Date	Update on Actions				BRAG RATING			
1.	Formalise contract offers and develop a balance plan with clear CRES delivery schemes for 26/27 (New Action)	Mar 26								
2.	Formal review of Financial governance including performance management arrangements.	July 26	Presented 3/3/26 to Audit Committee				On track			
3.	Continued meetings with PWC to provide assurance on remedial actions to address the financial gap (ICB and providers)	July 26	FPRM's commissioned to the end of the financial year 25/26				On track			
4.	Support PMO and AACC/S117 CRES work streams commissioned to commence in Jan 2026	Mar 26					On track			
5.							On track			
Key Controls										
<ol style="list-style-type: none"> <li>Revised SORD and OSORD and review of Finance Gov to ensure grip on authorised sign-off of expenditure</li> <li>Revised ICB Committee structure to prioritise financial recovery and strategic focus on financial risk</li> <li>Financial Control &amp; Oversight Group (FCOG) responsible for oversight / assurance of ICB and provider efficiency programmes (grip and control meetings) has been reconfigured to improve oversight and delivery of efficient scheme and now called Programme delivery group. FICC TOR revised and approved by Board</li> <li>Purchase Orders being reviewed</li> <li>PWC rapid reviews and support to the ICB PMO and key CRES work streams (AACC and S117)</li> <li>Finance and Performance review meetings with ICB and high and medium risk providers, led by NHSE/PWC</li> <li>Planning timetable in place for Financial Plans and contracts for 2026 to 2028</li> <li>Balance sheet reviews conducted (PWC finalising reviews by end of Mar 2026). Report anticipated end of March</li> </ol>										
Gaps in Control or Assurance										
<ol style="list-style-type: none"> <li>Conclude Financial Governance review</li> <li>Development of CRES plans 26/27</li> <li>Gap between 26/27 control total and provider plans.</li> <li>Differences between ICB and provider income and expenditure in 26/27 plan</li> </ol>										

Date of update: **March 2026**

Date next update due: **June 2026**

Risk Title	Failure to recover access and performance standards											
Strategic Risk Ref	Risk Description	Risk Scoring and Tolerance										
<b>P14</b>	There is a risk we will not deliver national standards for access and performance as set out in 2025/26 operational plans. This would undermine public confidence, exacerbate inequalities, and undermine delivery of the 10-Year Plan's commitment to timely, accessible care closer to home.	Likelihood	5	4	4	4	4	4	4	2	March 2028	
		Impact	5	5	5	5	5	5	5	5		
		Risk Level	25	20	20	20	20	20	10			
		Number of Linked Risks on Corporate Risk Register										
		Low (1 - 4)			Mod (6 - 12)			High (15 - 25)				
ICB Core Purpose	Enhance productivity and value for money	Lines of Defence	Sources of Assurance							Assurance Level		
ICB Strategic Goal	Improve planned and elective care	1 <sup>st</sup> Line	Weekly/monthly performance touch points via programme governance, e.g. provider collaborative on elective, diagnostics, Locality SROs for UEC, CMCA for cancer							Partial		
Directorate	Performance & Planning											
Lead Director	Executive Director of Strategy and Transformation	2 <sup>nd</sup> Line	Contract management processes, e.g. CQPM meetings Integrated Performance Report and scrutiny via Q&P Committee and Board Oversight via NHS Oversight Framework - identification of emerging concerns							Partial		
Lead Committee	Quality & Performance Committee											
Risk Appetite	Cautious	3 <sup>rd</sup> Line	NHSE Programme Boards and groups e.g. for UEC, Elective, MH, Primary Care NHSE Tiering regime for UEC, Cancer, Elective & Diagnostics NHSE oversight via NHS Oversight Framework Providers access to various external support offers e.g. GIRFT							Acceptable		
Rationale for Risk Score and Progress made in the quarter												
National standards cover a wide range of areas across acute hospitals, mental health and community settings and primary care. The likelihood of one or more not being achieved is high. Potential impact is inherently high, particularly for access to urgent and emergency care and cancer services. In terms of progress this quarter, performance against access standards for cancer and diagnostics remains strong, whilst the most significant challenges remain in UEC and elective as per the IPR.												
Action												
No	Action Required	Due Date	Update on Actions				BRAG RATING					
1.	UEC: Implementation of UEC Improvement Plan and NHSE Winter Assurance Framework	Mar 26	Focus on 4hr/12hr in A&E Focus on bed occupancy				On track					
2.	Elective: 65 week waits significantly reduced by original deadline of end December 2025. All Trusts required by NHSE to implement plans to reduce to Zero by Jan 26.	Jan 26	All Trusts have committed to delivery				Delayed					
3.	Cancer: Focus on improving faster diagnosis standard	Mar 26	CMCA anticipate delivery of this standard by year end				On track					
Key Controls												
<ol style="list-style-type: none"> <li>System Elective Recovery Dashboard / tracking of all performance, activity and operational planning objectives and constitutional standards. Mutual aid in place for elective, cancer and diagnostic care.</li> <li>Daily monitoring of A&amp;E activity (including breaches)</li> <li>C&amp;M ICB System Coordination Centre (SCC) oversees system operational activities, pressures and escalation.</li> <li>C&amp;M Provider Collaborative Elective Reform &amp; Transformation Plan - delivery via C&amp;M Provider Collaborative</li> <li>All providers have submitted RTT Delivery Plans aligned to the 'high impact' areas; 65wk Performance and Delivery Group in place to oversee 65wk recovery plan.</li> <li>NHSE Regional 'Tiering' arrangements for under-performing C&amp;M Providers</li> <li>Performance &amp; Delivery Meetings with individual providers (formally PTL's) focused on the 2025/26 metrics</li> </ol>												
Gaps in Control or Assurance												
NHSE Programme Boards and groups e.g. for UEC, Elective, MH, Primary Care NHSE Tiering regime for UEC, Cancer, Elective & Diagnostics Providers access to various external support offers e.g. GIRFT Potential impact of Industrial Action; Delays to transformation bid funding/approval and limited opportunity for additional investment to mitigate winter risk/demand or to fund additional elective activity; Inconsistent demand management in primary care for access to UEC and elective care.												
4.	Dental Access: Local Dental Improvement Plan 26/28	Mar 26	Focus on increasing activity for routine access and urgent care				On track					
5.												

Date of update: [March 2026](#)

Date next update due: [June 2026](#)

System fragmentation and Provider Sustainability											
Risk Title	System fragmentation and Provider Sustainability										
Strategic Risk Ref	Risk Description	Risk Scoring and Tolerance									
<b>P15</b>	If we do not proactively shape and support a sustainable provider landscape, especially as we commission at-scale, integrated neighbourhood and digital-first services there is a risk of service loss, fragmentation, or failure. This would compromise our ability to deliver the Model ICB Blueprint's vision for joined-up, efficient, and resilient care.	Inherent risk score	Q1	Q2	Q3	Q4	In-year Target Score	Long Term Target Score	Long Term Target Date		
		Likelihood	4	3	3	3	3	3	2	March 2028	
		Impact	4	4	4	4	4	4	4		
		Risk Level	16	12	12	12	12	12	8		
		Number of Linked Risks on Corporate Risk Register									
Low (1 - 4)			Mod (6 - 12)			High (15 - 25)					
ICB Core Purpose	Enhance productivity and value for money	Lines of Defence	Sources of Assurance						Assurance Level		
ICB Strategic Goal	Deliver financial stability	1 <sup>st</sup> Line	Provider Boards' internal governance arrangements; Programme Boards, Liverpool Provider Joint Committees, ICB Women's committee subsumed into Exec committee 2026; Reporting of patient safety and NHS Constitution performance to Quality & Performance Committee. Q&P Committee also maintains oversight of Maternity LMNS Assurance Report						Acceptable		
Directorate	Medical	2 <sup>nd</sup> Line	ICB Board oversight of Clinical Improvement Programmes via the digital transformation and establishment of the C&M Strategic commissioning programme/portfolio board						Acceptable		
Lead Director	Medical Director										
Lead Committee	Executive Committee										
Risk Appetite	Cautious-open	3 <sup>rd</sup> Line	NHS C&M is part of regional and national NHSE oversight / assurance of delivery of Clinical Improvement Programmes						Acceptable		
Rationale for Risk Score and Progress made in the quarter											
There is potential for major effect on quality of clinical care and non-compliance with national standards posing significant risk to patients, and significant impact on trust and confidence of stakeholders (impact 4). Current controls are maintaining the likelihood at possible (3). Strategic transformation programmes have been established to address service sustainability issues and work will continue to develop case for change and consultation proposals during 2025-26 but are not expected to be complete or impact on the risk level until 2026-27 and beyond. Progress has been made on key programs over the last quarter.											
Action											
No	Action Required	Due Date	Update on Actions				BRAG RATING				
1.	Review of Cheshire and Merseyside Maternity Services now incorporating outcome of Women's services in Liverpool Programme	May 26	Public engagement July '26. TOR for C&M review of maternity services under development				On track				
2.	Service chain model opportunities for CYP hospital services being developed by Alder Hey Foundation Trust	Mar 26	Provider presentation to board in January 26. Regular updates to board				On track				
3.	Oversight and support of the CMPC blueprint on future hospital and community delivery models	Mar ;26	ICB executive clinical director a member of Blueprint delivery group. Regular updates to board				On track				
4.	ICB providing clinical leadership to support the CMPC review of fragile services	June 26	Regular meetings of CMPC taking place and reporting to CEO group				On track				
5.	Collaboration between Merseycare and CWP on future delivery of mental health services	Mar 26	providers presenting to ICB board March 26 on track				On track				
Key Controls											
<ol style="list-style-type: none"> <li>C&amp;M Clinical Improvement Programmes include Womens Services In Liverpool Programme, Seton "Shaping Care Together", East Cheshire Trust /Stockport Foundation Trust</li> <li>C&amp;M Provider Collaborative alignment of in-hospital and out-of-hospital services supporting 'left shift' to neighbourhood and community healthcare</li> <li>C&amp;M Neighbourhood Framework / Neighbourhood Health Leadership</li> <li>Establishment of Liverpool Hospital Group model supports internal work on short-term patient safety improvement plans at Liverpool Womens Hospital site</li> <li>Mutual Aid arrangements in place across C&amp;M</li> <li>Cheshire and Merseyside Provider Collaborative Blueprint approved with delivery group established to oversee delivery</li> </ol>											
Gaps in Control or Assurance											
Issues in relation to affordability and timescales will need to be addressed in pre consultation business cases for key programmes. The impact of the current ICB financial situation and associated planning processes on the various transformation processes remains uncertain. Progression through programme plans includes (where appropriate) business case development, consultation and approval of key strategic transformation programmes are all required to improve controls/grip and reduce the risk.											

Date of update: Mar 2026

Date next update due: June 2026

Risk Title	Failure to Deliver the Shift to Neighbourhood and Community-Based Care											
Strategic Risk Ref	Risk Description	Risk Scoring and Tolerance										
P16	There is a risk that the ICB will not achieve the required shift from hospital-centric to neighbourhood and community-based models of care, as set out in the 10-Year Plan and Model ICB Blueprint, due to insufficient investment, workforce capability, or provider collaboration. This would undermine prevention, integration, and local access ambitions	Inherent risk score	Q1	Q2	Q3	Q4	In-year Target Score	Long Term Target Score	Long Term Target Date			
		Likelihood	4	3	3	3	3	2	March 2028			
		Impact	5	5	5	5	5	5				
		Risk Level	20	15	15	15	15	15			10	
Number of Linked Risks on Corporate Risk Register												
Low (1 - 4)			Mod (6 - 12)			High (15 - 25)						
ICB Core Purpose	Support broader social and economic development within the local area	Lines of Defence	Sources of Assurance							Assurance Level		
ICB Strategic Goal	Implement integrated neighbourhood teams	1 <sup>st</sup> Line	Neighbourhood health being identified as a key delivery priority within the Population Health Strategy and Implementation Plan.							Acceptable		
Directorate	Assistant Chief Executive		2 <sup>nd</sup> Line	Neighbourhood Health Programme Board' established and governance structure established include reporting into the ICB Exec committee and ICB Board							Acceptable	
Lead Director	Executive Clinical Director			3 <sup>rd</sup> Line	Core component leads at ICB and Place level agreed							Acceptable
Lead Committee	Executive Committee										Acceptable	
Risk Appetite	Open										Acceptable	
Rationale for Risk Score and Progress made in the quarter												
There is a significant risk that the ICB will fail to deliver the strategic priority of neighbourhood health across all nine places in Cheshire and Merseyside in a way that ensures a reduction in demand on secondary care services and ensures most health needs are met by the delivery of services within the community instead of hospitals.												
Action												
No	Action Required	Due Date	Update on Actions				BRAG RATING					
1.	Establishment of a Neighbourhood Health Programme Board	Nov 25					Completed/BAU					
2.	Establishment of Place based Neighbourhood Health Programme groups to oversee the establishment of Neighbourhood health at a Local Authority level	Mar 26					On track					
3.	Integration of Population Health Management within Integrated Neighbourhood Teams	Apr 27					On track					
4.	Individual Place assurance meetings between SROs to review Key Areas of discussion	Mar 26					On track					
5.	New Programme Management support to document Neighbourhood Health Programme Plan	Mar 26					On track					
Key Controls												
<ol style="list-style-type: none"> <li>Securing pioneer status for Sefton and St Helen's</li> <li>Establishing a clear governance process for the delivery of neighbourhood health across C&amp;M</li> <li>Establishing a profile of each neighbourhood to ensure the needs of each community are fully understood</li> </ol>												
Gaps in Control or Assurance												
<ol style="list-style-type: none"> <li>The current governance of the ICB is under review</li> <li>The changes to the ICB operating model</li> <li>Lack of additional funding to implement neighbourhood health</li> </ol>												

Date of update: [March 2026](#)

Date next update due: [June 2026](#)

Risk Title	<b>Workforce Capacity, Capability, and Morale</b>										
Strategic Risk Ref	Risk Description	Risk Scoring and Tolerance								Long Term Target Date	
<b>P17</b>	The scale and pace of organisational redesign, including significant headcount reductions and new ways of working, may disrupt strategic commissioning functions, destabilise workforce morale, and impede delivery of transformation priorities. This threatens our ability to address the enforcement undertakings at pace, implement the Model ICB and to deliver the 10-Year Plan's workforce and leadership ambitions. There is also an increased risk in staff stress and burnout which could result in staff absence	Inherent risk score	Q1	Q2	Q3	Q4	In-year Target Score	Long Term Target Score	March 2028		
		Likelihood	4	4	4	4	4	4			2
		Impact	4	4	4	4	4	4	4	March 2028	
		Risk Level	16	16	16	16	16	16	8		
		Number of Linked Risks on Corporate Risk Register									
Low (1 - 4)			Mod (6 - 12)			High (15 - 25)					
ICB Core Purpose	Enhance productivity & value for money	Lines of Defence	Sources of Assurance						Assurance Level		
Directorate	Nursing & Care	1 <sup>st</sup> Line	Organisation redesign process underway and inline with other north west ICB's. This includes co-design with NSHE NW						Partial		
Lead Director	Chief People Officer	2 <sup>nd</sup> Line	Head count reduction (through VR) underway with panels due to conclude end of Jan 26 an including three internal gateways and NSHE NW final sign off						Partial		
Lead Committee	Executive Committee								Partial		
Risk Appetite		3 <sup>rd</sup> Line	Internal Audit Plans; NHSE Assurance Mechanisms						Partial		
Rationale for Risk Score and Progress made in the quarter									Partial		
The current risk score reflects both existing and emerging factors relating to NHS Reform / Model ICB Blueprint and continued uncertainty of future workforce needs. In addition, responding to the enforcement undertakings has to be a priority. The challenges include: skill gaps, recruitment freeze and the impact of uncertainty on staff morale. The redesign of the new organisation (with its related head count reduction) is an extremely complex organisational change process.		Action									
Key Controls		No	Action Required	Due Date	Update on Actions	BRAG RATING					
1. Management of Organisational Change Policy 2. People's Operation Group (staff engagement forum) 3. Continued proactive engagement with staff and staff groups to address current and emerging workforce concerns, recruitment challenges and resilience. 4. Regular Trade Union engagement and the appointment of a permanent Trade Union representative for Cheshire and Merseyside ICB. 5. The implementation of the All Change Policy starting with the very senior managers and moving through to senior staff groups as soon as possible.		1	Undertake VR programme to the value of £14.9m.	Mar 26		On Track					
		2	Complete the process establishing senior team of 5 Exec directors	Jan 26		Completed					
		3	Complete the redesign process for other senior posts through to mid range posts	Mar 26		On Track					
		4	Complete whole organsastion redesign	July 26		On Track					
Gaps in Control or Assurance		Although the first round of VR is funded the process for additional head count reduction requires development There are a number of services that are unclear as to their destination and/or timescale Key elements of redesign are interdependent with legislative changes that are hard to be specific about									

Next Update Due: June 2026

# Meeting of the Board of NHS Cheshire and Merseyside

26 March 2026

## ICB Scheme of Reservation and Delegation (SORD) and Operational SORD Updates

Agenda Item No: ICB/26/03/13

## REPORT SUMMARY SNAPSHOT

Required Information	Details			
Responsible Executive Director	Andrea McGee			
Report approval	By	Andrea McGee		
	Date	19.03.26		
Presented by	Andrea McGee / Ben Vinter			
Ask of the Board	Approval	<input checked="" type="checkbox"/>	Decision	
	Endorsement	<input type="checkbox"/>	Ratification	
	Receive assurance	<input type="checkbox"/>	Note	
Route to Board – where has this report been discussed	n/a			
ICB Strategic Objective(s) the report relates to	Tackling Health Inequalities in access, outcomes and experience	<input type="checkbox"/>	Improving Population Health and Healthcare	
	Enhancing Productivity and Value for Money	<input type="checkbox"/>	Helping to support broader social and economic development	
Board Assurance Framework Risk(s) the report relates to*	n/a			
Financial Implications*	Yes	<input type="checkbox"/>	No	<input checked="" type="checkbox"/>
	If Yes:			
	Have the financial implications been reviewed by the Director of Finance			n/a
	Has a budget been identified			n/a
Legal Implications*	Board approval is required to ensure that the Scheme of Reservation and Delegation remains accurate, current and legally robust.. Approval of these changes provides clarity for the Board, committees and officers, supports effective and lawful decision-making, and ensures continued compliance with the ICB's Constitution and statutory responsibilities.			
Conflicts of Interest associated with this report	n/a			
Impact assessments undertaken*	Equality	<input type="checkbox"/>		n/a
	Quality	<input type="checkbox"/>		n/a
	Data	<input type="checkbox"/>		n/a
	Sustainability	<input type="checkbox"/>		n/a
Public or Clinical engagement undertaken	n/a			



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# ICB Scheme of Reservation and Delegation (SORD) and Operational SORD Updates

## 1. Purpose of the Report

- 1.1 This report provides an update to the Board on proposed changes to the ICB Scheme of Reservation and Delegation (SORD) and the ICB Operational SORD (OSORD).

## 2. Executive Summary

- 2.1 An updated ICB SORD and OSORD was last approved by Board in October 2025. Since then there are a small number of changes that have been required to be included in one or both documents to reflect, namely:

- establishment of a new Executive Team with differing Executive positions and portfolios
- disestablishment of the ICB Children's and Young Peoples Committee, ICB Women's Hospital Services in Liverpool Committee and the ICBs Research and Innovation Committee.

- 2.2 Board approval of the proposed changes is required, in line with the SORD, so as to ensure that the SORD and OSORD remain accurate, current and legally robust. The proposed updates reflect the changes outlined in 2.1 ensuring that decision-making responsibilities, accountability and delegated authorities are clearly and correctly aligned to the ICB's current governance and management arrangements. Approval of these changes provides clarity for the Board, committees and officers, supports effective and lawful decision-making, and ensures continued compliance with the ICB's Constitution and statutory responsibilities.

- 2.3 The proposed changes within the ICB SORD (Appendix One) and OSORD (Appendix Two) are highlighted within the document. New additions are highlighted in **BLUE** and text to remove is highlighted in **RED**.

## 3. Ask of the Board and Recommendations

- 3.1 The Board is asked to:

- **APPROVE** the proposed updates to the ICB OSORD and SORD

## 4. Next Steps

- 4.1 Following approval of the changes, the updated SORD and Operational SORD will be published on the ICB website.

## 5. Officer contact details for more information

**Matthew Cunningham**

Associate Director of Corporate Affairs and Governance

[matthew.cunningham@cheshireandmerseyside.nhs.uk](mailto:matthew.cunningham@cheshireandmerseyside.nhs.uk)

## 6. Appendices

**Appendix One:** Updated ICB Scheme of Reservation and Delegation

**Appendix Two:** Updated ICB Operational Scheme of Reservation and Delegation



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## NHS Cheshire and Merseyside Integrated Care Board Scheme of Reservation and Delegation (SoRD)

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
<b>1. Regulation, control, constitution &amp; governance</b>						
1.1	Determine the arrangements by which the ICB approves those decisions that are reserved for the Board where they have not been delegated	Board			Executive Committee	Assistant Chief Executive Executive Director of Corporate Services and Governance
1.2	Consider and approve applications to NHS England on changes to the Constitution	Board			Executive Committee	Assistant Chief Executive Executive Director of Corporate Services and Governance
1.3	Approval of the ICBs scheme of reservation and delegation (SORD), which sets out those decisions that are in statute the responsibility of the ICB and are reserved to the ICB Board, and those delegated to Committees, sub-committees, and employees	Board			Executive Committee  Audit Committee  Finance, Investment and Our Resources Committee	Executive Director of Finance and Contracting

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
1.4	Promote the governance arrangements of the ICB to employees and to people working on behalf of the ICB		Executive Committee			Assistant Chief Executive Executive Director of Corporate Services and Governance
1.5	Disclosure of non-compliance with the group's constitution (incorporating its standing orders, prime financial policies and scheme of reservation and delegation)	Board			Audit Committee Finance, Investment and Our Resources Committee	Assistant Chief Executive Executive Director of Corporate Services and Governance
1.6	Review of suspension of standing orders		Audit Committee			Assistant Chief Executive Executive Director of Corporate Services and Governance
1.7	Suspension of standing orders	Board				Assistant Chief Executive Executive Director of Corporate Services and Governance
1.8	Approval of the operational scheme of delegation (incl. financial limits) that underpins the ICB's overarching scheme of reservation and delegation	Board			Audit Committee Finance, Investment and Our Resources Committee	Executive Director of Finance and Contracting

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
1.9	Approval of the ICBs Standing Financial Instructions	Board			Executive Committee	Executive Director of Finance and Contracting
1.10	Approve the ICB's prime financial policies and financial governance	Board	Finance, Investment and Our Resources Committee			Executive Director of Finance and Contracting
1.11	Set out who can execute a document by signature / use of the seal	Board			Executive Committee	<del>Associate Director of Corporate Affairs and Governance</del> Executive Director of Corporate Services and Governance
1.12	Approve the arrangements for discharging the ICB's statutory duties and functions	Board			Executive Committee	<del>Assistant Chief Executive</del> Executive Director of Corporate Services and Governance
1.13	Establish governance arrangements to support collective accountability between partner organisations for whole system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations	Board			Quality and Performance Committee Executive Committee Finance, Investment and Our Resources Committee	Executive Director of Corporate Services and Governance Executive Director of Finance and Contracting Executive Clinical Director <del>Assistant Chief Executive</del>

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
						<del>Director of Planning and Performance</del> <del>Director of Nursing and Care</del> <del>Director of Finance and Contracting</del>
1.14	Approval of Patient Group Directions on behalf of the ICB for the Cheshire and Merseyside System			Medical Director	ICB Medicines Optimisation and Pharmacy Group	Chief Pharmacy Officer Deputy Chief Pharmacist
<b>2. Strategy &amp; Planning</b>						
2.1	Approve the values and planning in accordance with the strategic direction of the ICB	Board			Finance, Investment and Our Resources Committee Executive Committee	Executive Director of Finance and Contracting
2.2	Approve the ICB operating structure		Executive Committee	Chief Executive		Chief Executive
2.4	Approve the ICB arrangements for engaging the public and key stakeholders in the ICB's	Board			Executive Committee	<del>Assistant Chief Executive</del> Executive Director of Corporate Services and

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
	planning and commissioning arrangements					Governance
2.5	Approve the ICB budgets that meet the financial duties of the ICB	Board			Finance, Investment and Our Resources Committee	Executive Director of Finance and Contracting
2.6	Approve Cheshire and Merseyside Health and Care Partnership integrated care strategy		Cheshire and Merseyside Health and Care Partnership		Executive Committee	Assistant Chief Executive Executive Director of Health and Integrated Care Commissioning
2.7	Allocate resources to support the delivery of the Cheshire and Merseyside Health and Care Partnership integrated care strategy	Board			Executive Committee	Assistant Chief Executive Executive Director of Health and Integrated Care Commissioning
2.8	Agree a System Joint Forward Plan to meet the health and healthcare needs of the Cheshire & Merseyside population, within the context of the NHS national strategy, the C&M Health and Care Partnership integrated care strategy and place health and wellbeing strategies	Board			Executive Committee	Assistant Chief Executive Executive Director of Health and Integrated Care Commissioning

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
2.9	Allocate resources to deliver the Joint Forward Plan across the system, determining what resources should be available to meet population need across C&M and in each place, and setting principles for how they should be allocated across services and providers (both revenue and capital)	Board			Finance, Investment and Our Resources Committee	Executive Committee <del>Place Directors through Place-Based Partnership Boards</del>
2.10	Allocate resources to deliver the System Joint Forward Plan at place, determining what resources as delegated by the Board should be available to meet population need in place and setting principles for how they should be allocated across services and providers (both revenue and capital)	Board			Finance, Investment and Our Resources Committee	Executive Committee <del>Place Directors through Based Partnership Boards</del>
2.11	Agree and publish a Joint Capital Resource Use Plan with partner NHS trusts and foundation trusts within Cheshire and Merseyside	Board			Finance, Investment and Our Resources Committee	Executive Director of Finance and Contracting

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
2.12	Approve decisions on the review, planning and procurement of primary medical care services (to reflect the terms of the delegation agreement between NHS England and NHS Cheshire and Merseyside ICB)		System Primary Care Committee  Pharmacy Services Regulations Committee		Place Primary Care Committee / Forums  ICB Associate and Heads of Primary Care  <del>Place</del> ICB Primary Care Staff	<del>Assistant Chief Executive</del> Executive Director of Health and Integrated Care Commissioning <del>Place Directors</del>  Head of Primary Care
2.13	Approve decisions on the review, planning and procurement of Specialised Commissioning services for the Cheshire and Merseyside population (to reflect the terms of the delegation agreement between NHS England and NHS Cheshire and Merseyside ICB)		Executive Committee  Finance, Investment and Our Resources Committee		Financial Control and Oversight Group  Executive Committee	<del>Assistant Chief Executive</del> Executive Director of Health and Integrated Care Commissioning  Executive Director of Finance and Contracting
2.14	Approve decisions on the review, planning and procurement of Specialised Commissioning services for the North West of England population made at the North West Specialised Commissioning Services Joint Committee		North West Specialised Commissioning Services Joint Committee		Executive Committee  Finance, Investment and Our Resources Committee	<del>Assistant Chief Executive</del> Executive Director of Health and Integrated Care Commissioning  Executive Director of Finance and Contracting

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
2.15	Have oversight of and approve the strategy and priorities for NHS Cheshire and Merseyside with regards Children and Young People	Board	<del>Children and Young Peoples Committee</del> Executive Committee  Quality & Performance Committee			<del>Director of Nursing and Care</del> Executive Clinical Director  <del>Assistant Chief Executive</del> Executive Director of Health and Integrated Care Commissioning
2.16	Have oversight of, agree and approve the prioritisation of ICB funding and allocations for Childrens and Young Peoples functions and services that NHS Cheshire and Merseyside has responsibility for and which are delegated to the Committee	Board	<del>Children and Young Peoples Committee</del> Executive Committee  Quality & Performance Committee			<del>Director of Nursing and Care</del> Executive Clinical Director  <del>Assistant Chief Executive</del> Executive Director of Health and Integrated Care Commissioning
2.17	Approve the final draft strategic case for change for Women's Hospital Services in Liverpool to recommend to the ICB Board		<del>Women's Hospital Services in Liverpool Committee</del> Executive Committee			<del>Director of Nursing and Care</del> Executive Clinical Director  <del>Assistant Chief Executive</del> Executive Director of Health and Integrated Care Commissioning

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
2.18	Approve the Strategic Case for Change for Women's Hospital Services in Liverpool	Board			<p><del>Women's Hospital Services in Liverpool Committee</del> Executive Committee</p>	<p><del>Director of Nursing and Care</del> Executive Clinical Director</p> <p><del>Assistant Chief Executive</del> Executive Director of Health and Integrated Care Commissioning</p>
2.19	Approve joint decisions in relation to the planning and commissioning of services, and any associated commissioning or statutory functions, within the scope of the Shaping Care Together programme, for the population of Southport, Formby and West Lancashire		Shaping Care Together Joint Committee		Shaping Care Together Programme Board	<p><del>Assistant Chief Executive</del> Executive Director of Health and Integrated Care Commissioning</p> <p>Executive Director of Finance and Contracting</p>
2.20	Approve any case for Change for services within scope of the Shaping Care Together programme		Shaping Care Together Joint Committee		Shaping Care Together Programme Board	<p><del>Assistant Chief Executive</del> Executive Director of Health and Integrated Care Commissioning</p> <p>Executive Director of Finance and Contracting</p>

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
2.21	Approve any Pre-consultation business cases and any associated capital strategic outline case for services within scope of the Shaping Care Together programme		Shaping Care Together Joint Committee		Shaping Care Together Programme Board	<p><del>Assistant Chief Executive</del>            Executive Director of Health and Integrated Care Commissioning</p> <p>Executive Director of Finance and Contracting</p>
2.22	Approve any Outline Business Case or Full Business Case for services within scope of the Shaping Care Together programme		Shaping Care Together Joint Committee		Shaping Care Together Programme Board	<p><del>Assistant Chief Executive</del>            Executive Director of Health and Integrated Care Commissioning</p> <p>Executive Director of Finance and Contracting</p>
2.23	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		Shaping Care Together Joint Committee		Shaping Care Together Programme Board	<p><del>Assistant Chief Executive</del>            Executive Director of Health and Integrated Care Commissioning</p> <p>Executive Director of Finance and Contracting</p>
<del>2.24</del>	<del>Approve the ICB operating structure in each place</del>		<del>Executive Committee</del>		<del>Chief Executive Place Directors</del>	<del>Place Directors</del>

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
2.25	Agree system-wide <b>and locality</b> action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the center of their care		Executive Committee		Digital Transformation and Clinical Improvement Assurance Group	<p><del>Medical Director</del> Executive Clinical Director</p> <p>Chief Digital Officer</p>
2.26	<del>Agree <b>place action on data and digital</b>: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put the citizen at the center of their care</del>		<del>Executive Committee</del>		<del>Digital Transformation and Clinical Improvement Assurance Group</del>  Place Based Partnership Boards	<del>Place Directors</del>  Chief Digital Officer
2.27	Agree C&M <b>system wide or locality</b> joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability		Finance, Investment and Our Resources Committee		Executive Committee  <del>Place Based Partnerships Boards</del>  Financial Control and Oversight Group	<del>Executive Director of Finance and Contracting</del>

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
2.28	<del>Agree place action on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability</del>		<del>Finance, Investment and Our Resources Committee</del>		<del>Executive Committee Place-Based Partnerships Boards Financial Control and Oversight Group</del>	<del>Director of Finance and Contracting</del>
2.29	Agree arrangements for planning, responding to and leading recovery from incidents (EPRR), to ensure NHS and partner organisations are joined up at times of greatest need, including taking on incident coordination responsibilities as delegated by NHSE	Board	Executive Committee			<del>Director of Planning and Performance</del> Executive Director of Strategy and Transformation (Turnaround)
<b>3. Annual Reports and Accounts</b>						
3.1	Approval of the ICB Annual Report and Annual Accounts	Board			Audit Committee	Executive Director of Finance and Contracting
<b>4. Partnership, joint or collaborative working</b>						
4.1	Agree joint working arrangements with partners that embed collaboration as the basis for delivery within the ICB plan (including	Board			Executive Committee <del>Place-Based Partnership Boards</del>	<del>Assistant Chief Executive</del> Executive Director of Health and Integrated Care Commissioning

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
	arrangements under section 75 of the NHS Act 2006)					
4.2	Develop joint working arrangements with partners in place that embed collaboration as the basis for delivery within the ICB plan	Board			Executive Committee  <del>Place-Based Partnership Boards</del>	<del>Assistant Chief Executive</del> Executive Director of Health and Integrated Care Commissioning
4.3	Approve the delegated decision-making responsibilities of individual employees of the ICB who represent the ICB in joint or collaborative arrangements with another statutory body(ies)	Board			Finance, Investment and Our Resources Committee  Executive Committee	Chief Executive
4.4	Approve named positions within the ICB with the delegated authority to undertake any of the functions of the System Primary Care Committee were considered appropriate and / or necessary by the Committee		System Primary Care Committee			<del>Assistant Chief Executive</del> Executive Director of Health and Integrated Care Commissioning  Associate Director of Primary Care

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
4.5	Approve the arrangements governing joint or collaborative arrangements between the ICB and another statutory body(ies), where those arrangements incorporate decision making responsibilities (including arrangements under section 75 of the NHS Act 2006), Section 65Z5 or Section 65Z6 of the Health and Care Act 2022)	Board			Executive Committee	<p><b>Assistant Chief Executive</b> Executive Director of Health and Integrated Care Commissioning</p> <p>Executive Director of Corporate Services and Governance</p>
4.6	Approve arrangements for coordinating the commissioning of services with other ICBs, with local authorities, or with NHS Trusts where appropriate (including under section 12ZA of the 2006 Act ('Conferral of discretion')	Board			Executive Committee  Place Based Partnership Boards	<p><b>Assistant Chief Executive</b> Executive Director of Health and Integrated Care Commissioning</p> <p>Executive Director of Corporate Services and Governance</p>
4.7	Approve arrangements for risk sharing and /or risk pooling with other organisations (for example arrangements for pooled funds with other ICBs or pooled budget	Board	Finance, Investment and Our Resources Committee		Executive Committee	Executive Director of Finance and Contracting

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
	arrangements under section 75 of the NHS Act 2006, or Section 65Z6 of the Health and Care Act 2022)					
4.8	Receive the minutes of meetings of, or reports from, joint or collaborative arrangements between the ICB and another statutory body(ies)	Board	<p><del>Children and Young Peoples Committee</del></p> <p>North West Specialised Commissioning Services Joint Committee</p> <p>Shaping Care Together Joint Committee</p> <p>System Primary Care Committee</p>			<p>Assistant Chief Executive</p> <p>Executive Director of Health and Integrated Care Commissioning</p> <p>Executive Director of Finance and Contracting</p>
<b>5. Employment, Remuneration, Workforce &amp; OD</b>						

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
5.1	Agree system implementation of people priorities including delivery of the People Plan and People Promise by aligning partners across the ICS to develop and support 'one workforce', including through closer collaboration across the health and care sector, with local government, the voluntary and community sector and volunteers	Board			System Peoples Board	Chief People Officer
5.2	Agree implementation in Locality of People Priorities		<del>Place Partnership Boards</del>		System Peoples Board	Chief People Officer
5.3	Accountability for the ICB's responsibilities as an employer including adopting a Code of Conduct for staff	Board			Audit Committee Executive Committee	Chief People Officer
5.4	Approve the terms and conditions, remuneration and travelling or other allowances for Board members, including pensions and gratuities		Remuneration Committee		ICB People Committee	Chief People Officer

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
5.5	Approve the ICBs Pay Policy, including approving the terms and conditions of employment for non- AFC employees including pensions, remuneration, fees and travelling or other allowances for employees of the ICB and to other persons providing services to the ICB		Remuneration Committee		ICB People Committee Executive Committee	Chief People Officer
5.6	Approve any other terms and conditions of services for the ICB's AFC employees		Executive Committee			Chief People Officer
5.7	Approve disciplinary arrangements for all employees, including the Chief Executive (where he/she is an employee of the ICB) and for other persons working on behalf of the ICB		Remuneration Committee		Executive Committee	Chief People Officer
5.8	Approve disciplinary arrangements where the ICB has joint appointments with another group and the individuals are employees of that group			Shared Chief Executive discussion		Chief People Officer

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
5.9	Approval of the arrangements for discharging the ICB's statutory duties as an employer	Board	Executive Committee		ICB People Committee	Chief People Officer
5.10	Approve human resources policies for ICB employees and for other persons working on behalf of the ICB		Executive Committee		ICB People Committee	Chief People Officer
5.11	Approve arrangements for staff appointments (excluding matters detailed within the constitution)		Executive Committee		ICB People Committee	Chief People Officer
5.11a	Appointment of the ICB Chief Executive	Board			Remuneration Committee	Chief People Officer
5.11b	Appointment of all other roles		Remuneration Committee (non AfC levels only)		Executive Committee	Chief Executive or other responsible Executive
5.12	Approve the ICB organisational development plans		Executive Committee		ICB People Committee	Chief People Officer
<b>6. Quality and Safety</b>						
6.1	Establish clinical governance arrangements to support collective accountability between partner organisations	Board			Quality and Performance Committee	<del>Director of Nursing and Care</del> Executive Clinical Director through System Quality Surveillance Group

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
6.2	Approve arrangements to ensure duties are discharged effectively and foster the development of policies, processes and initiatives to minimise clinical risk, maximise patient safety, and promote equality to secure the continuous improvement in quality and patient outcomes	Board			Quality and Performance Committee	<del>Director of Nursing and Care</del> Executive Clinical Director
6.4	Approve the ICB arrangements for handling complaints and concerns		Quality and Performance Committee		Executive Committee	<del>Assistant Chief Executive</del> Executive Director of Corporate Services and Governance
6.5	Approve the ICB arrangements for safeguarding children and vulnerable adults		Quality and Performance Committee		Executive Committee	<del>Director of Nursing and Care</del> Executive Clinical Director
6.6	Approve the ICB arrangements for engaging patients and their carers in decisions concerning their healthcare		Quality and Performance Committee		Executive Committee	<del>Director of Nursing and Care</del> Executive Clinical Director <del>Assistant Chief Executive</del> Executive Director of Corporate Services and Governance

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
6.7	Approve arrangements for supporting the NHS in discharging its responsibilities in relation to securing continuous improvement in the quality of general medical services		Quality and Performance Committee		Executive Committee	<p>Director of Nursing and Care Executive Clinical Director</p> <p>Deputy Medical Director</p>
6.8	Approve the arrangements for the quality oversight, assurance and improvement systems within the ICS.		Quality and Performance Committee		Executive Committee	<p>Director of Nursing and Care Executive Clinical Director</p>
6.9	Approve the arrangements for delivering the NHS Patient Safety Strategy to achieve its vision to continuously improve patient safety and to develop and implement the patient safety initiatives that the strategy introduced.		Quality and Performance Committee		Executive Committee	<p>Director of Nursing and Care Executive Clinical Director</p>
6.10	Agree the Strategy for Quality and Patient Safety inclusive of the aligned quality priorities for the system		Quality and Performance Committee		Executive Committee	<p>Director of Nursing and Care Executive Clinical Director</p>
6.11	Agree the ICB arrangements for responding to and learning from patient safety events		Quality and Performance Committee		Executive Committee	<p>Director of Nursing and Care Executive Clinical Director</p>

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
6.12	Approve the operating structure for the monitoring, oversight and reporting on Quality and Safety in each place		Quality and Performance Committee	Executive Committee		<p style="color: red;">Director of Nursing and Care</p> <p style="color: blue;">Executive Clinical Director</p>
<b>7. Business Operation and Risk Management</b>						
7.1	Approve the ICB counter fraud and security management arrangements		Audit Committee			<p style="color: blue;">Executive Director of Finance and Contracting</p>
7.2	Approval of the ICB risk management arrangements	Board	Audit Committee		Executive Committee	<p style="color: blue;">Executive Director of Finance and Contracting</p>
7.3	Approve ICB operational policies (i.e., excluding those defined as clinical or finance)				Executive Committee	<p style="color: red;">Assistant Chief Executive</p> <p style="color: blue;">Executive Director of Corporate Services and Governance</p>
7.4	Approve ICB financial policies		Finance, Investment and Our Resources Committee		Financial Control and Oversight Group	<p style="color: blue;">Executive Director of Finance and Contracting</p>
7.5	Approve requests for the waiver of any procurement rules for goods and services on an exception basis		Finance, Investment and Our Resources Committee		Financial Control and Oversight Group	<p style="color: blue;">Executive Director of Finance and Contracting</p>
7.6	Approve the ICB procurement plans annually		Finance, Investment and Our Resources Committee		Financial Control and Oversight Group	<p style="color: blue;">Executive Director of Finance and Contracting</p>

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
7.5	Approve ICB Safeguarding, clinical and medical policies and clinical pathways		Quality and Performance Committee		Executive Committee	<del>Director of Nursing and Care</del> Executive Clinical Director
7.6	Approve system-level arrangements to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes		Quality and Performance Committee		Executive Committee	<del>Director of Nursing and Care</del> Executive Clinical Director
7.7	Approve arrangements for managing conflicts of interest, including gifts and hospitality and for standards of business conduct.		Audit Committee			<del>Assistant Chief Executive</del> Executive Director of Corporate Services and Governance
7.8	Approve arrangements for complying with the NHS Provider Selection Regime	Board			Finance, Investment and Our Resources Committee	Executive Director of Finance and Contracting
7.9	Report and provide assurance to the Board on the effectiveness of ICB governance arrangements		Audit Committee			<del>Assistant Chief Executive</del> Executive Director of Corporate Services and Governance
7.10	Receive the annual governance letter from the External Auditor and advise the Board of proposed action		Audit Committee			Executive Director of Finance and Contracting
7.11	Appointment or removal of either the Internal or External		Audit Committee			Executive Director of Finance and Contracting

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
	auditor for the ICB					
7.12	Approve the internal audit, external audit and counter-fraud plans and any changes to the provision or delivery of related services		Audit Committee			Executive Director of Finance and Contracting
<b>8. Information Governance</b>						
8.1	Approve the policies and arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data		Audit Committee			Advised and supported by IG & Data Security groups
8.2	Approve information sharing protocols with other organisations		Executive Committee			SIRO
8.3	Approve ICB Annual Data Security and Protection Toolkit submissions			SIRO		<del>Associate Director of Corporate Affairs and Governance</del> Executive Director of Corporate Services and Governance  IG Officers
8.4	Approve NHS Digital Data Access Requests (DARs) – Data Sharing Agreements,			SIRO		<del>Associate Director of Corporate Affairs and Governance</del>

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
	Data Sharing Framework Contracts					Executive Director of Corporate Services and Governance  IG Officers
8.5	Approve arrangements for handling Freedom of Information and Subject Access Requests		Executive Committee			<del>Assistant Chief Executive</del>  <del>Associate Director of Corporate Affairs and Governance</del> Executive Director of Corporate Services and Governance
<b>9. Communications</b>						
9.1	Approval of ICB communications and engagement plan	Board			Executive Committee	<del>Assistant Chief Executive</del>  <del>Associate Director of Communications and Empowerment</del> Executive Director of Corporate Services and Governance
<b>10. Arrangements for Patient &amp; Public Involvement</b>						
	Approve arrangements for the involvement of and	Board			Executive Committee	<del>Assistant Chief Executive</del>

Ref	Decision / responsibility	Reserved to Board	Delegated to committee or sub-committee	Delegated to Chair / specified ICB Officer	Responsible for recommending a course of action	Operational Responsibility
10.1	consultation with patients and the public in ICB decision making	Shaping Care Together Joint Committee			Shaping Care Together Programme Board	Executive Director of Corporate Services and Governance

**V1.5 Approved:** by the Board of NHS Cheshire and Merseyside on **XXX**



Section	Description	Reserved By:																					
		Integrated Care Board (ICB)	Audit Committee	Remuneration Committee	Finance, Investment & Resources Committee	Executive Committee	Quality & Performance Committee	System Primary Care Committee	Shaping Care Together Joint Committee	Place Committees	Children and Young People Committee	Women's Health Committee for Improvement Committee	Research and Innovation Committee	Pharmacy Services Regulations Committee	Northwest Specialist Commissioning Services Joint Committee	ICB Chief Executive	ICB Executive Director of Finance & Contracting	ICB Chief Systems Improvement & Delivery Officer	ICB Deputy Director of Finance & Contracting	ICB Executive Directors (Clinical)	Other ICB Directors (Named as Applicable)	Place Directors	Other named ICB Officer (or as per ICB published regulatory list)
F2	<p>Allocation of Consultancy (based on total expected cost as per below notes). Supporting Notes</p> <p>All prior approval from the ICB's vacancy Panel must be sought for all consultancy requests regardless of value.</p> <p>All prior approval from NHS must be sought for:</p> <ul style="list-style-type: none"> <li>Any expenditure above £50,000 or</li> <li>Any appointments over £50 per day or</li> <li>Any appointments for over a 6 month period, or</li> <li>Any appointment with significant influence (e.g. ICB roles)</li> </ul> <p>All prior to recruitment NHS must conduct and sign-off with relevant Director acknowledgement of RICS compliance and/or status confirmation and in line with agreed ICB RICS policy</p>	Over £500,000			Up to £500,000										Up to £150,000	Up to £150,000	Up to £150,000		Up to £10,000	Up to £10,000	Up to £10,000	Up to £10,000	
F3	Services including IT, maintenance, and support services (over lifetime of contract) where not included within agreed annual budgets	Over £2,000,000			Up to £2,000,000										Up to £1,000,000	Up to £900,000	Up to £900,000		Up to £100,000	Up to £100,000	Up to £100,000	Up to £100,000	
F4	Approval of non-healthcare payments within agreed budget *With appropriate consideration of procurement requirements														Over £2,000,000	Up to £2,000,000	Up to £2,000,000	Up to £100,000	Up to £100,000	Up to £100,000	Up to £100,000	Up to £100,000	As delegated by Chief Executive / DfP at the limits outlined within the Authorised Signatory List
G	RELOCATION EXPENSES In line with Policy approved by ICB Remuneration Committee														Over £8,500	Up to £8,500							
H	DECISION TO APPROVE 'NEW' INVESTMENT BUSINESS CASES																						
H1	Where funding is: a) available and identified within agreed financial plan or b) from additional notified resource allocations (e.g. new in-year) c) other identified income streams (e.g. other agencies / charges)	Over £10,000,000			Up to £10,000,000	Up to £1,000,000		Up to £1,000,000 *Primary Care Related	Up to £10,000,000						Up to £10,000,000	Up to £5,000,000	Up to £1,000,000	Up to £100,000	Up to £100,000	Up to £100,000	Up to £100,000	Up to £100,000	As delegated by Chief Executive / DfP at the limits outlined within the Authorised Signatory List
H2	Where not included in approved financial plan (but still subject to ICB Executive / Place Leadership Team Approval) NB any material underspend / variation from plan at individual budget holder level cannot be committed / reduced under Internal Policy - Section 12 without Executive team approval due to overall financial management requirements of the ICB.	Over £5,000,000			Up to £5,000,000	Up to £500,000 *Specialised services related		Up to £500,000 *Primary Care Related	Up to £5,000,000						Up to £5,000,000	Up to £500,000	Up to £500,000		Up to £20,000	Up to £20,000	Up to £20,000	Up to £20,000	
H3	Primary Care Capital Expenditure Approval (within ICB allocation) NB - Capital Plan to be approved by the ICB for each financial year	Over £1,000,000						Up to £1,000,000 *Primary Care Related							Up to £1,000,000 (in urgent cases)	Up to £500,000 (in urgent cases)							
I	CONTRACTING																						
I1	Signing of Healthcare Contracts including S75 agreements. S75 approval via place governance processes in line with S75 agreements operational policy. (Annual Contract Value)														Over £500,000,000	Up to £500,000,000		Up to £75,000,000					
I2	Approval of Healthcare Contract Payments All healthcare contract payments must be supported by signed contract (see 11).														As per agreed plan / budget value	As per agreed plan / budget value	As per agreed plan / budget value	As per agreed plan / budget value		As per agreed plan / budget value	As per agreed plan / budget value	As per agreed plan / budget value	As delegated by Chief Executive / DfP at the limits outlined within the Authorised Signatory List
I3	Signing of Non-Healthcare Contracts (Annual Contract Value)														Over £3,000,000	Up to £3,000,000		Up to £1,000,000		Up to £100,000	Up to £100,000	Up to £100,000	

Section	Description	Reserved By:																		Other named ICB Officer (or as per ICB authorised signatory list)				
		Integrated Care Board (ICB)	Audit Committee	Remuneration Committee	Finance, Investment & Resources Committee	Executive Committee	Quality & Performance Committee	System Primary Care Committee	Shaping Care Together Joint committee	Place Committees	Children and Young People Committee	Women's Health: Female to Female Committee	Research and Innovation Committee	Pharmacy Services Regulations Committee	Northwest Specialist Commissioning Services Joint Committee	ICB Chief Executive	ICB Executive Director of Finance & Contracting	ICB Chief System Improvement & Delivery Officer	ICB Deputy Director of Finance & Contracting		ICB Executive Directors (Clinical)	Other ICB Directors (Named as Applicable)	Place Directors	
J	APPROVAL OF OTHER HEALTHCARE PAYMENTS WITHIN BUDGET See authorised signatory list for approval limits for other officers.															Over £1,000,000	Up to £1,000,000	Up to £5,000,000	Up to £100,000	Up to £50,000	Up to £50,000	Up to £50,000	Up to £50,000	As delegated by Chief Executive / ICB or the limits outlined within the Authorised Signatory List
K	QUOTATIONS AND TENDERS HEALTHCARE / NON-HEALTHCARE																							
K1	Approval of ICB Procurement Plan				X																			
K2	Procurement route decision - in line with the options contained within the Healthcare Provider Selection Regime (2023) Regulations (Annual Contract Value)	X (For Novel or Continuous Issues escalated by FIR Committee)			X From £5,000,000 with Novel or Continuous Procurement route decisions to be escalated to the Board	Up to £3,000,000	Up to £3,000,000								Up to £5,000,000	Up to £5,000,000	Up to £1,000,000	Up to £5,000,000	Up to £1,000,000	Up to £663,000	Up to £663,000	Up to £663,000		
NW	Decision to put Non-Healthcare goods and services out to competitive procurement (Total contract value)	X (For Novel or Continuous Issues escalated by FIR Committee)			X From £5,000,000 with Novel or Continuous Procurement route decisions to be escalated to the Board										From threshold up to Up to £5,000,000	From threshold up to Up to £5,000,000	From threshold up to Up to £5,000,000	From threshold up to Up to £1,000,000						
K3	Approval of Quotations for Non-Healthcare expenditure (total value)	£20,000 to procurement thresholds specified in the Procurement Act 2023 (PA23) (currently E215k including VAT) in line with delegated limits for expenditure type. Minimum of three written quotes required																						
K4	Quotation Waiver Approval for Non-Healthcare goods and services (Total Contract Value) - see detailed financial policy on tendering when permissible	£20,000 to procurement thresholds (currently Non-Healthcare £24k) in line with delegated limits for expenditure type																						
K5	Procurement for Non-Healthcare goods and services through approved national / local framework agreement (in line with call off rules) (Total Contract Value)	From E20k to delegated budgeted limits for expenditure type (with approval from procurement team) Above delegated budgeted limits, subject to Finance, Investment & Resources Committee Approval																						
K6	Tender Waiver Approval for Non-Healthcare goods and services	In line with limits for procurement route decisions N.B. Reporting of all Tender Waiver Approval to Audit Committee																						
K7	Opening of Tender Documentation (where not received electronically) (at least 2 people from list)														X	X	X	X	X	X	X	X		
L	VIVEMENT	Relating to a transfer of funds from an unspent or uncommitted budget to another, within vivement rules to allow greater financial flexibility in using available resources. <ul style="list-style-type: none"> <li>All transfers must be:             <ul style="list-style-type: none"> <li>• justified within budget, and</li> <li>• agreed by both budget holders.</li> </ul> </li> </ul> Vivements may not be used to create new budgets.																						
L1	Within Existing Approved Pay or Non-Pay Budgets														Over £1,000,000	Up to £1,000,000		Up to £500,000			Up to £50,000	Up to £50,000		
L2	With regards to transfers from reserves (including distribution of new in-year resource / capital allocations)															Up to £70,000,000		Up to £21,000,000						
M	DISPOSALS AND CONDEMNATION All assets disposed at market value	Over £50,000													Up to £50,000	Up to £10,000		Up to £5,000						
N	CHARITABLE FUNDS (Not applicable to ICB)																							
O	HUMAN RESOURCES																							
O1	Approve HR Decisions Not Covered By ICB HR Policies or in Exceptional To Policies (e.g. additional compassionate leave or exceptional carry forward of leave days)					X										X	X		X	X	X	X	X	

Section	Description	Reserved By:																					
		Integrated Care Board (ICB)	Audit Committee	Remuneration Committee	Finance, Investment & Resources Committee	Executive Committee	Quality & Performance Committee	System Primary Care Committee	Shaping Care Together Joint committee	Place Committees	Children and Young People Committee	Women's Health Services Improvement Committee	Research and Innovation Committee	Pharmacy Services Regulations Committee	Northwest Specialist Commissioning Services Joint Committee	ICB Chief Executive	ICB Executive Director of Finance & Contracting	ICB Chief System Improvement & Delivery Officer	ICB Deputy Director of Finance & Contracting	ICB Executive Directors (Clinical)	Other ICB Directors (Named as Applicable)	Place Directors	Other named ICB Officer (or as per ICB published regulatory list)
O2	Decisions to Set Out Written HR Policies (where there is some management discretion e.g. study leave authorisation)														X	X				X	X	X	
O3	Approval of Operational Structure (ie staffing and departments), and in accordance with organisation change policy					X									X								
O4	Approval of Appointment to Posts Below Executive Directors (following approval at vacancy Panel)														X	X		X	X	X	X	X	X
O5	Approval of the below arrangements as required by the ICB: - Approval of the arrangements for discharging the CB statutory duties as an employer - Approval Human resources policies for ICB employees and for other persons working on behalf of the ICB - Approve any other terms and conditions of services for ICB A/C employees - Approve disciplinary arrangements for ICB employees - Approve arrangements for staff appointments (excluding matters detailed within the Constitution) - Approve the ICBs organisational development plans																						
P	EXTERNAL COMMUNICATIONS & REPORTING																						
P1	Approve Complaints Responses and Letters to Politicians and Media Responses														X					X	X		X (Associate Director of Corporate Affairs & Operations)
P2	Approve Public Consultation Material														X					X	X		X (Assistant Chief Executive)
P3	Approve Public & Staff Engagement Material inc Website														X					X	X		X (Assistant Chief Executive)
P4	Approve FOI Responses and Subject Access Requests																			X	X		X (Associate Director of Corporate Affairs & Governance)
P5	Approve Annual Engagement & Communication Plan	X																					
Q	FINANCE Approval of Operational Policies as required by the organisation				X	X																	
R	INDIVIDUAL PACKAGES OF CARE																						
R1	Approval of individual AACCC Packages of Care (Annual Value)																						As delegated by Chief Executive / DoP at the limits outlined within the Authorised Signatory List
R2	Approval of Mental Health and Learning Disability Packages of Care (complex and S117)																						As delegated by Chief Executive / DoP at the limits outlined within the Authorised Signatory List
S	INFORMATION GOVERNANCE																						
S1	Approve Digital and Data programmes Data Protection Impact Assessments (DPIA), Information / Data Sharing Agreements and Data Processing Agreements																			X (SRO and Caldicott Guardian)	X		X (ICB Data Protection Officer, SRO and Caldicott Guardian, or their Deputies)
S2	Approve Confidentiality Advisory Group (CAG) Applications																			X (SRO and Caldicott Guardian)	X		X (ICB Data Protection Officer, Deputy SRO and Deputy Caldicott Guardian)
S3	Approve NHS Digital Data Access Requests (DARs) – Data Sharing Agreements, Data Sharing Framework Contracts																			X (SRO)	X		X (SRO)
S4	Data Security and Protection Toolkit submissions approval																			X (SRO)	X		X (Deputy SRO)
S5	Privacy Notices																			X (SRO and Caldicott Guardian)	X		X (ICB Data Protection Officer, Deputy SRO or Deputy Caldicott Guardian)

V1.5 Approved: XXX by the Board of NHS Cheshire and Merseyside



# Meeting of the Board of NHS Cheshire and Merseyside 26 March 2026

## Report of the Chief Executives

Agenda Item No: ICB/03/26/14



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## REPORT SUMMARY SNAPSHOT

Required Information	Details			
Responsible Executive Director	Liz Bishop			
Report approval	By	Liz Bishop		
	Date	19.03.26		
Presented by	Liz Bishop			
Ask of the Board	Approval		Decision	
	Endorsement		Ratification	
	Receive assurance	✓	Note	✓
Route to Board – where has this report been discussed	n/a			
ICB Strategic Objective(s) the report relates to	Tackling Health Inequalities in access, outcomes and experience	✓	Improving Population Health and Healthcare	✓
	Enhancing Productivity and Value for Money	✓	Helping to support broader social and economic development	✓
Board Assurance Framework Risk(s) the report relates to*	P12: Failure to reduce health inequalities and improve population health P17: Workforce Capacity, Capability, and Morale:			
Financial Implications*	Yes		No	✓
	If Yes:			
	Have the financial implications been reviewed by the Director of Finance			n/a
	Has a budget been identified			n/a
Legal Implications*	n/a			
Conflicts of Interest associated with this report	n/a			
Impact assessments undertaken*	Equality			n/a
	Quality			n/a
	Data			n/a
	Sustainability			n/a
Public or Clinical engagement undertaken	n/a			



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# Report of the Chief Executive (March 2026)

## 1. Introduction

- 1.1 This report covers highlights of the work which takes place by the Integrated Care Board at a senior level and also key developments in health and care for Board information which is not reported elsewhere in detail on this meeting agenda.
- 1.2 Our role and responsibilities as a statutory organisation and system leader are considerable. Through this paper we have an opportunity to recognise the breadth of work that the organisation is accountable for or is a key partner in the delivery of.

## 2. Ask of the Board and Recommendations

- 2.1 **The Board is asked to:**
  - **consider** the updates to Board and seek any further clarification or details;
  - **disseminate** and cascade key messages and information as appropriate.

## 3. Key Updates

### Executive Team Reconfiguration

- 3.1 Since my last update to Board in January 2026 we have completed the consultation with staff who were direct reports to myself and I have completed the appointment of all posts to the Executive Team Structure of ICB. I can now confirm that the following people have been appointed to the Executive Team posts:
  - Executive Director of Finance and Contracting – Andrea McGee
  - Executive Director of Health and Integrated Care Commissioning – Clare Watson
  - Executive Clinical Director – Dr Fiona Lemmens
  - Executive Director of Corporate Services and Governance – Ben Vinter
  - Executive Director of Strategy and Transformation (Turnaround) – Jude Adams.

### Model ICB Running Cost Update

- 3.2 The ICB has progressed the first phase of its workforce change programme, including the conclusion of the initial Voluntary Redundancy (VR) scheme. The scheme is enabling planned reductions in workforce numbers while seeking to minimise the need for compulsory redundancies and to support continuity of critical functions.
- 3.3 Colleagues who applied to the scheme have now been informed of the outcome, and supported exits are being taken forward in line with nationally agreed arrangements. By 31 March 2026, approximately 150 colleagues will

have left the ICB after applying for and having been accepted for the VR Scheme. To those colleagues who are leaving, you leave with the thanks and gratitude of the ICB for your dedication to the NHS.

- 3.4 The ICB has also commenced the next phase of organisational change through the launch of formal consultation on proposed structures covering Very Senior Manager (VSM) to Band 8C roles. As part of this phase, a further targeted Voluntary Redundancy process has been opened for staff within scope, alongside the collective consultation process with recognised Trade Unions. This approach reflects the ICB's commitment to engagement, fairness and transparency during organisational change.
- 3.5 This programme of work is directly linked to the national Model ICB Blueprint, including the requirement for ICBs to operate within a revised running cost envelope and to implement a streamlined operating model. The changes underway are intended to ensure the ICB is structured to deliver its statutory responsibilities effectively, support system leadership and partnership working, and remain financially sustainable in line with national expectations.

### COVID-19 Day of Reflection

- 3.6 Sunday, 08 March 2026 marked the COVID-19 Day of Reflection<sup>1</sup> - a moment to come together to remember those who lost their lives during the pandemic and those who continue to be affected to this day. It was also an opportunity to pay tribute to the extraordinary dedication of health and care staff and frontline workers, who made enormous sacrifices at the height of the pandemic to keep members of the public safe. In a time of national - and international - crisis, we saw the very best of our NHS.

### Vaccinations

- 3.7 Vaccination proved crucial in the battle against COVID-19 - and a equally important with regard to measles. There has been an alarming rise in measles cases in some parts of the country, primarily in unvaccinated children. Vaccination remains the best form of protection and I would encourage anyone who is unsure whether they or their child is up to date with their vaccinations to check their records and contact their GP practice if they have missed a vaccine

### Cervical Screening – Living Well Service Milestones

- 3.8 Today's experience story features Dianna who attended a cervical screening clinic as part of our commissioned Living Well Mobile Health Service. I am pleased to highlight progress toward our 2,000 cervical screening milestone through the Living Well Mobile Health Service, delivered by Cheshire and Wirral Partnership NHS Foundation Trust, and which continues to expand its reach, providing accessible, drop-in cervical screening across Cheshire, Merseyside, Lancashire and South Cumbria.
- 3.9 This approach is successfully reducing inequalities and increasing uptake in underserved communities. For further information about the service and

<sup>1</sup> <https://dayofreflection.campaign.gov.uk/>

upcoming clinics across Cheshire and Merseyside please go to:

<https://www.cwp.nhs.uk/livingwellservice>

## New Specialist Palliative Care In-Patient Beds Open at Maple Suite in Liverpool

- 3.10 New specialist palliative care in-patient beds at the Maple Suite, located on the Liverpool Heart and Chest Hospital site have now opened. The service is delivered by NHS University Hospitals of Liverpool Group working in partnership with health and care organisations across the local system.
- 3.11 The new beds provide specialist assessment and treatment for people with the most complex palliative care needs, where this care cannot be safely delivered at home, in a care home, or in a hospital setting.
- 3.12 The specialist palliative care beds at Maple Suite are designed to offer intensive, short-term support from expert multidisciplinary teams, including specialist doctors, nurses and therapists - similar to the care and support offered at Woodlands Hospice in the north of the city. Their purpose is to assess and manage complex symptoms, stabilise a person's condition and support care planning at a critical time.
- 3.13 Once a person's needs have been stabilised, they will be supported to move on to the most appropriate setting for their ongoing care. This may be their own home, with community and specialist support, or a 24-hour care setting such as a nursing or residential care home.
- 3.14 Because specialist palliative care beds are a scarce resource nationally, specialist units such as Maple Suite are not able to provide respite care or longer-term care until the end of life. Specialist palliative care units focus on short-term, high-intensity input, enabling people to be cared for in the most appropriate place once their condition is stabilised.
- 3.15 The temporary nature of the Maple Suite beds has also been extended through to April 2027, allowing additional time to engage with partners and to co-produce a future model of specialist palliative care for Liverpool that is both sustainable and responsive to local need.
- 3.16 NHS Cheshire and Merseyside have commissioned this service as part of its responsibility to ensure access to high-quality palliative and end-of-life care, with the beds at Maple Suite forming part of a wider, integrated specialist palliative and end-of-life care model - linking inpatient care with community, outpatient and advice services. Referrals for in-patient care are triaged via the usual route through the Integrated Mersey Palliative Care Team (IMPACT) service.
- 3.17 NHS Cheshire and Merseyside and its partners recognise how important specialist palliative care services are to patients, families and carers at some of the most difficult times in their lives. The opening of these beds reflects a

continued commitment to compassionate, equitable care focused on what matters most to each individual.

### Adult ADHD Services – Needs-Led Model of Care

- 3.18 Demand for adult ADHD assessment and support continues to increase across Cheshire and Merseyside, reflecting both greater public awareness and historic variation in access and pathways. In response, the ICB is progressing a needs-led model of care that shifts the focus away from diagnosis alone and towards earlier, more equitable access to practical support for adults presenting with ADHD-related needs.
- 3.19 Building on initial pilot activity during 2025/26 across Cheshire West, Liverpool and Wirral, the ICB remains committed to the system-wide roll-out of the Adult ADHD Local Enhanced Service (LES) in 2026/27. The LES will be a core component of the new model, strengthening the role of primary care in supporting adults with ADHD-related difficulties, including improved access to advice, education, structured support and, where clinically appropriate, assessment and ongoing management.
- 3.20 The emerging model is designed to:
- Provide earlier support without requiring a formal diagnosis, reducing unnecessary escalation and long waits.
  - Ensure specialist services are targeted at individuals with more complex needs, improving clinical prioritisation.
  - Offer a consistent, fair and sustainable pathway for both adults who already have an ADHD diagnosis and those coming forward for the first time seeking help.
  - Address unwarranted variation across Cheshire and Merseyside and reduce reliance on fragmented or high-cost routes to care.
- 3.21 This work aligns with the ICB’s wider commitment to prevention, early intervention and health equity, and supports the development of a more sustainable, joined-up approach to adult neurodiversity across the system. Further updates on delivery milestones and evaluation of the pilot phase will be brought to the Board as the 2026/27 implementation programme is finalised
- 3.22 Further information about this can be found at:  
<https://www.cheshireandmerseyside.nhs.uk/your-health/adhd-services-for-adults/>

### Intensive and Assertive Outreach (IAO) – Community Mental Health Update

- 3.23 The Board is provided with an update in Appendix One on progress against the Intensive and Assertive Outreach (IAO) Adult Community Mental Health action plan, previously presented to Board in July 2025.<sup>2</sup> This update responds to NHS England’s requirement for ICB Boards to receive regular assurance on the system’s ability to identify, engage and support people requiring intensive and

<sup>2</sup> <https://www.cheshireandmerseyside.nhs.uk/get-involved/meeting-and-event-archive/nhs-cheshire-and-merseyside-integrated-care-board/2025/24-july-2025/>

assertive community mental health care, particularly following the Nottingham homicides (June 2023).

- 3.24 Since the last Board update, Cheshire and Wirral Partnership NHS Foundation Trust and Mersey Care NHS Foundation Trust have undertaken joint system learning and agreed a more standardised, multi-disciplinary approach to identifying and managing the IAO cohort. This includes clearer protocols for stepping care up and down, strengthened risk management arrangements, and prioritisation for inpatient admission where clinically required.
- 3.25 Progress has been made on a number of short-term actions, including improved cohort identification within electronic patient records, updated policies and procedures, and enhanced multidisciplinary oversight. However, the report highlights that significant risks remain, particularly where implementation of the IAO model is required without additional resource.
- 3.26 Key risks include:
- High community mental health caseloads limiting capacity to deliver intensive support without impacting wider access and waiting times.
  - Ongoing challenges with shared care and prescribing arrangements, contributing to pressure on secondary care caseloads.
  - Continued demand and complexity within crisis services, placing additional strain on community teams.
  - Poor digital interoperability and lack of alerting systems, increasing the risk that early warning signs of relapse are not shared or escalated across agencies.
  - Workforce instability and uncertainty around sustainable funding for VCFSE partners.
- 3.27 The Board is asked to note:
- Progress against the agreed action plan (detailed in the appended report and RAG-rated appendix).
  - The risks identified and proposed mitigations.
  - The intention to work with the ICB digital programme to explore opportunities to improve interoperability and develop cross-agency alerting systems.
- 3.28 While this position is consistent with national feedback to NHS England and Cheshire and Merseyside is not an outlier, the report confirms that the system is not yet able to provide full assurance that the needs of this high-risk cohort are being fully met without further workforce and system investment. The full report and action plan are appended to the Chief Executive's Report for Board members who wish to consider the detail.

## Healthier Futures / New Leighton Hospital

- 3.29 Following on from previous updates to the Board, I am pleased to advise the Board that the Strategic Outline Case (SOC) for the Healthier Futures New Leighton Hospital has now been formally approved by the Department of Health and Social Care. This represents a major national milestone for the programme and confirms the strength of the case for change, the alignment with the New Hospital Programme (Hospital 2.0), and the robustness of the clinical, financial

and strategic assumptions underpinning the new hospital. The approval enables the programme to progress confidently into the Outline Business Case stage, maintaining momentum towards delivery of a modern, digitally enabled hospital that is right-sized for future demand.

- 3.30 The Healthier Futures programme continues to place strong emphasis on meaningful engagement with staff, patients, communities and partners. Recent activity has included the inaugural Healthier Futures Forum, attended by around 150 staff and volunteers, targeted clinical and departmental engagement sessions, and the establishment of a Multi-Faith Advisory Group to shape inclusive design of faith and wellbeing spaces. Wider engagement has also taken place with care communities, local authorities, VCFSE partners and patient representative groups, with feedback directly informing design decisions and the emerging model of care. This engagement will continue throughout the OBC phase, supported by a refreshed communications and engagement strategy.
- 3.31 In parallel, I am delighted to confirm that the New Hospital Programme (NHS England) has approved a £2.5m system transformation business case to support delivery in 2026/27. This funding will enable Mid Cheshire Hospitals NHS Foundation Trust and system partners to accelerate community and service transformation required to realise the activity assumptions underpinning the new hospital, including shifting care from hospital to community settings, improving patient flow, and enhancing productivity. Mid Cheshire has been identified as a national pathfinder site, with learning from this work informing wider roll-out across the New Hospital Programme, and progress against agreed outcomes to be reviewed later in 2026.

### NHS Staff Survey Results

- 3.32 The [2025 National Staff Survey](https://www.nhsstaffsurveys.com/results/)<sup>3</sup> have now been released and shows for NHS Cheshire and Merseyside that while organisational values remain strong, staff experience has declined across all people-promise themes, with an overall decrease in response rate from 73% to 58%. Equality, diversity, compassionate leadership and flexible working continue to be areas of strength, helping teams stay connected and supported. However, confidence in learning, development, voice and wellbeing has weakened. Staff remain committed, but many do not feel fully part of the wider ICB, and pressures on workload and recognition are increasingly evident. Whilst equality and diversity remain a strong people promise theme, with the release of the WRES and DWES related data we need to work with our staff networks to fully understand our staff experience and develop an action plan to address any specific EDI concerns.
- 3.33 The most significant declines in our scores are in learning and performance (4.37 out of ten, down 0.76), including effectiveness and confidence in our appraisal process (decrease to 3.83), psychological safety (6.11, down 0.68 with raising concerns 5.95 down from 6.26), wellbeing and advocacy (burnout at 4.82 and work pressures at 4.63.).

<sup>3</sup> <https://www.nhsstaffsurveys.com/results/>

- 3.34 With reductions suggesting staff feel less able to raise concerns, less supported to grow, and more at risk of burnout. Engagement and advocacy have also dropped sharply, aligning with a rise in intention to leave. While commitment remains high, trust in the organisation’s ability to sustain current effort levels is beginning to slip.
- 3.35 Priorities for 2026 include tackling work-pressure drivers to protect wellbeing, rebuilding trust that staff voice leads to meaningful change, and fixing the learning and appraisal experience through a strengthened development offer and new online tools.
- 3.36 The results have been presented at the Executive Team and our next steps include working with our Staff Engagement Forum and People Operation Groups, present to Trade Union colleagues, targeted executive 1:1s with the aim of staff engagement sessions to both understand what actions staff need for having a voice that counts and to ensure explore our learning and development culture and opportunities. An organisation action plan will be developed with the oversight of the ICB People Committee.

**New Urgent Response Pathway Supporting Safer Use of 999 and Reducing Pressure on Emergency Services**

- 3.37 Partners across Cheshire and Merseyside continue to strengthen the way urgent care is delivered, with the Urgent Community Response (UCR) NWS Pathway now demonstrating clear benefits for patients and the wider system. Delivered jointly by Mersey Care NHS Foundation Trust and North West Ambulance Service (NWS), the pathway enables selected Category 3 and 4 (urgent and less urgent) 999 calls to be clinically triaged and, where appropriate, redirected away from emergency departments into rapid community-based care. Since its launch in November 2025, the pathway has helped ensure patients receive the right care, in the right place, at the right time, while protecting ambulance capacity for life-threatening emergencies.
- 3.38 Early evidence shows a positive system impact. More than 1,500 calls were triaged through Mersey Care’s Single Point of Contact in the initial months, with around 41% managed safely in the community through services such as two-hour Urgent Community Response teams, district nursing, matrons, urgent treatment centres and walk-in centres—helping to avoid unnecessary hospital attendances and admissions during peak winter pressures. The pathway supports faster ambulance response for higher-acuity calls and contributes to improved patient flow across urgent and emergency care.
- 3.39 The approach has recently received wider public attention, having been featured on ITV Granada Reports in March 2026,<sup>4</sup> highlighting how a new way of handling 999 calls is improving access to appropriate care and easing pressure on frontline emergency services. The coverage reinforces the value of strong partnership working across the system and the importance of community-based alternatives in delivering safe, sustainable urgent care. The

<sup>4</sup> <https://www.itv.com/news/granada/2026-03-10/new-way-of-dealing-with-999-calls-to-ensure-patients-get-the-right-help>

ICB will continue to support partners to embed and evaluate this pathway as part of the wider urgent and emergency care improvement programme.

## Workwell Rollout Progress

- 3.40 As previously reported to the Board at its September 2025 meeting,<sup>5</sup> from 2026 all ICBs will form WorkWell Partnerships with Local Authorities, Jobcentre Plus, VCFSE and community organisations to design and deliver their local offer. The funding allocation for Cheshire and Merseyside is £1.655m in year one with figures of £4.286m for year two and £4.607m in year three. This has been allocated using a weighted capitation model that reflects local working-age population size and levels of need.
- 3.41 Following work with our system partners and dialogue with the National Support Team (NST) and our Regional Partnership Advisor (RPA) the ICB submitted its initial WorkWell model as requested on 13 March 2026. Our delivery model for WorkWell is a Primary Care Network (PCN) embedded, ICB coordinated and neighbourhood / community driven model that embeds Work and Health coaches within Social Prescribing teams in PCN clusters to help people move into, return to, or stay in work.
- 3.42 Our primary-care model will co-ordinate delivery internally through the ICB (in collaboration with the VCFSE sector and our wider system partners), with clusters of our PCNs and other Member Practices. Our aim is to reduce economic inactivity and sickness absence by integrating work and health support in primary care-led neighbourhoods, using data-driven targeting and community-embedded delivery.
- 3.43 The model will adopt a person-centred community approach to supporting participants through: Social Prescribers, connections to the Voluntary, Community, Faith and Social enterprise (VCFSE) sector, and key local systems such as local authorities and employment services. The model is underpinned by dedicated focus on building strong BI, analytical and technical capabilities within healthcare services, developing the capacity and capabilities of VCFSE organisations, and supporting pilots already underway to help young people into employment.
- 3.44 This model will also take any relevant learning from other regions where similar models have been implemented such as Frimley, Cambridgeshire & Peterborough and Leicester, Leicestershire & Rutland.
- 3.45 We are in the process of establishing a system WorkWell steering group to add the detail to this outline submission it is anticipated that we will bring the first phase of services online in November 2026. Further updates on implementation and progress will continue to be reported to the Board at future meetings.

<sup>5</sup> <https://www.cheshireandmerseyside.nhs.uk/get-involved/meeting-and-event-archive/nhs-cheshire-and-merseyside-integrated-care-board/2025/25-september-2025/>

## NHS Decarbonisation Funding Secured Across Cheshire and Merseyside

- 3.46 NHS trusts across Cheshire and Merseyside have secured £8.3 million of national decarbonisation funding to support clean energy and energy-efficiency upgrades across hospital and community healthcare sites. The investment, awarded through the NHS Decarbonisation Fund by the Department for Energy Security and Net Zero, will support a range of measures including solar panels and battery storage, LED lighting upgrades, improvements to building management systems, and other clean heat and efficiency initiatives.
- 3.47 Eight trusts in the region were successful in their bids, including Mersey Care NHS Foundation Trust, Cheshire and Wirral Partnership NHS Foundation Trust, Liverpool University Hospitals NHS Foundation Trust and Mersey and West Lancashire Teaching Hospitals NHS Trust.
- 3.48 The funding will help reduce carbon emissions, lower energy costs and strengthen long-term financial sustainability, enabling savings to be reinvested into frontline patient care. This investment supports the NHS ambition to become the world's first net zero health service and aligns with the ICB's wider priorities on sustainability, financial resilience and anchor institution leadership across Cheshire and Merseyside.
- 3.49 Further details can be found at:  
<https://www.cheshireandmerseyside.nhs.uk/latest/news/nhs-trusts-in-cheshire-and-merseyside-secure-83-million-for-clean-energy-upgrades>

## All Together Fairer Neighbourhoods

- 3.50 A new framework has been developed by Cheshire and Merseyside's Champs Directors to support neighbourhood health approaches focused on prevention and reducing inequalities. The framework, endorsed by the ICB Neighbourhood Health Board, aligns with Fit for the Future: the 10 Year Health Plan for England and builds on the established All Together Fairer commitment to tackling health inequalities across the life course. It also aligned well with the recent publication nationally of the Neighbourhood Health Framework.<sup>6</sup> It sets out six shared guiding principles to help Health and Wellbeing Boards and system partners align neighbourhood planning and delivery. The intention is to provide coherence and shared direction across Cheshire and Merseyside, while allowing flexibility for local areas to respond to their own context and priorities.
- 3.51 Find out more here: <https://champspublichealth.com/champs-directors-launch-all-together-fairer-neighbourhoods-to-support-prevention-and-tackle-health-inequalities-across-cheshire-and-merseyside/>

<sup>6</sup> <https://www.gov.uk/government/publications/neighbourhood-health-framework/neighbourhood-health-framework>

## NHS Drink Free Days

- 3.52 The ICB is supporting the promotion of the NHS Better Health Drink Free Days app through a brand-new campaign targeting residents across Cheshire and Merseyside to encourage them to reduce their alcohol consumption and improve their wellbeing.
- 3.53 The free NHS Drink Free Days app helps people cut down on alcohol by choosing a few alcohol-free days each week. It provides simple, practical support to help people stay on track and see the benefits of making small changes. A paid digital campaign went live from 05 March 2026 and runs for 6 weeks across Google and Facebook targeting priority wards across Cheshire and Merseyside.
- 3.54 Find our more here: <https://champspublichealth.com/new-cheshire-and-merseyside-campaign-inspires-residents-to-take-charge-with-the-nhs-drink-free-days-app/>

## All Together Smoke Free

- 3.55 There has now been over 100k visits to the Smoking Ends Here website<sup>7</sup> since its launch 12 months ago. Cheshire and Merseyside PR activity around the Tobacco and Vapes Bill is ongoing, with recent coverage across BBC Radio Merseyside, North West Tonight and ITV Granada. Burst 1 of What Will You Miss, our first population level behaviour change campaign, ran for 6 weeks from late December 2025, delivering 17 million impressions and 50k clicks. Phase 2 (which includes radio and new digital assets) launched week commencing 09 March 2026. No Smoking Day last week garnered strong local coverage and social media engagement across the sub-region

## Fuel poverty scheme linked to reduction in GP appointments

- 3.56 A scheme to reduce the impact of fuel poverty on vulnerable people has been linked to a near 10 per cent reduction in GP appointments, according to a new report.
- 3.57 The project focused on adults with chronic obstructive pulmonary disease (COPD) in St Helens and Knowsley. It features an innovative package of interventions, including medicines optimisation, pulmonary rehabilitation referrals, referrals for tobacco dependency treatment and help with finances.
- 3.58 The report, compiled by NHS Cheshire and Merseyside who worked in partnership with Health Innovation North West Coast, shows a 9.8 per cent reduction in GP appointments in the 12 months after the project was launched.
- 3.59 The analysis compared a group of 254 patients who had benefited from an intervention and a matched group of patients who had not had the intervention. This evaluation showed around 400 GP appointments had been avoided. If the programme was then scaled up to over 1000 patients, we could potentially see a reduced demand for 1575 GP appointments.

<sup>7</sup> <https://smokingendshere.com/>

## 4. Decisions taken at the Executive Committee

4.1 At its meetings throughout February and March 2025, the Executive Committee has made decisions and also considered papers on the following areas (*Covering meetings: 22 Jan, 5 Feb, 19 Feb, 5 Mar 2026 (covering business approved since the ICB Board last met)*). The Strategic Themes emerging across all meetings are:

### 4.2 **Financial Sustainability and System Control Totals**

Financial recovery remained the dominant theme across all meetings. Key points covered across the reporting period:

- System position remains materially adverse to plan, with significant gaps in preliminary contract offers vs provider returns.
- A number of unresolved risks have been worked through including a tapered multi-year approach to block deconstruction.
- A system-wide CRES requirement of £118m is being worked with an expectation that this is fully identified by April.
- The CMPC is exploring provider clusters to support and enable planning response aligned with the system blueprint.

### 4.3 **Planning for 2026/27 – Clinical & Strategic Commissioning Plan**

Across Feb–Mar, substantial progress was reported on the draft five-year Clinical & Strategic Commissioning Plan and the Population Health Improvement Plan. Key themes

- Engagement with partners (providers, local authorities) underway.
- NHS England requires more detailed Left-Shift and transformation plans.
- Three-year Left-Shift allocations total: £29.6m (26/27), £36m (27/28), £40.7m (28/29).
- Need to identify high-impact, system-wide schemes that deliver measurable outcomes and reduced reliance on out of sector suppliers.

### 4.4 **Workforce, Transformation and Operating Model**

The Committee continued to manage significant transformation and workforce pressures.

#### **Themes:**

- HR and OD capacity remains stretched.
- Preliminary staff survey results showed declining engagement with emerging concerns about psychological safety and morale
- CSU transition poses risks around a number of key data services
- Voluntary redundancy (VR/MARS) support clarified with NHS for ICB and wider system including £7.5m system support from ICB to reduce 26/27 run rate.

#### **Decisions:**

- Ratification of TUPE transfers (CSU data roles and CHC-related staff).
- Agreement to proceed with a discovery phase on Digital/AI for AACC subject to PID.
- Agreement of dedicated actions on HR roadmap, appraisal, L&D, and a new diagnostic skills audit.

#### 4.5 **Quality, Safety and Statutory Functions**

Quality themes were explored through this series of meetings, with particular focus on CQC inspections and SEND reforms. Key issues:

- Challenges across multiple localities regarding safeguarding capacity and statutory nursing/ADQ responsibilities during transition.
- National reforms to SEND announced; Sefton inspection underway.
- Significant case review learning from East Cheshire escalated to NHS England.

##### **Decisions:**

- Agreement for a QIA review of organisational change proposals.
- Lessons-learned exercises to be completed and fed back.

#### 4.6 **Commissioning, Service Change & Improvement**

The Committee oversaw numerous service-specific decisions.

Key decisions across the period:

- Multiple Service Change Panel recommendations approved, including mental health reinvestment and MSK specification improvements.
- Agreement **not** to pause Adult ADHD activity for >25s (Oct 2025 review).
- Ophthalmology independent sector activity —strong contract management and public communication.
- Women’s Services Public Engagement Plan approved, including resource.
- Intermediate Care Beds (Sefton): block contract approach supported.
- Varicose Veins interim policy approved for performance reasons.
- Oral Nutritional Supplements programme accelerated (10.5 WTE dietitians; £6.4m CRES full-year).
- LIMS pathology programme approved in principle.

#### 4.7 **Urgent Decisions (2 March)**

- PTS / WMAS: A new arrangement approved to prevent service failure in Cheshire from 1 April. Additional £2m pa for two years, plus £5m capital exposure.
- Provider VR/MARS: £7.5m approved for organisational cost reduction.

#### 4.8 **Quality Update**

- Positive draft CQC feedback from Countess of Chester.
- National correspondence from RCN regarding statutory nursing functions.

#### 4.9 **Enforcement Undertakings & SIP**

- SIP progressing with defined owners and draft Terms of Reference.
- Monthly grip and control meetings proposed for year 1.

#### 4.10 **Decisions Taken at 05 March 2026 Meeting**

##### **GP Clinical System Mergers**

- **Decision:** ICB will fund merge costs **only** where the merger is initiated by the ICB (Option 4).

**SMS Fragment Reduction**

- Supported tapered reduction approach before moving to the pre-agreed cap - Clear communications required.

**Staff Survey**

- Priorities endorsed: psychological safety, L&D reform, new appraisal system, skills audit.

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

**5. APPENDICES**

**Appendix One:** Intensive and Assertive Outreach (IAO) – Community Mental Health Update

**6. Officer contact details for more information**

**Liz Bishop**

Chief Executive

Sally Thorpe, Executive Assistant,

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# **Meeting of the Board of NHS Cheshire and Merseyside 26 March 2026**

## **Appendix One to Chief Executives Report: Intensive and Assertive Outreach Community Mental Health Update**

**Agenda Item No:** ICB/03/26/14

# Intensive and Assertive Outreach Community Mental Health Update

## 1. Purpose of the Update

- 1.1 This report provides an update to the action plan presented to NHS Cheshire and Merseyside's Board on 24 July 2025 regarding Intensive and Assertive Outreach (IAO) Adult Community Mental Health Care. NHS England has asked that progress on IAO is reported directly to the Boards of Integrated Care Boards.
- 1.2 The update articulates the risks associated with implementing the IAO offer without additional resource, including those relating to community MH capacity, emerging issues with shared care, crisis resolution and home treatment team (CRHT) thresholds, and considers potential mitigations.

## 2. Executive Summary

- 2.1 NHS Cheshire and Merseyside's Board has previously received presentations and reports on IAO. These have provided an overview of the gaps in provision identified against the published guidance regarding the ability to comprehensively identify, maintain contact and meet the needs of people who require intensive and assertive community mental health care and follow-up.
- 2.2 Since the last update to the Board on 24<sup>th</sup> July 2025, Cheshire and Wirral Partnership NHS Foundation Trust and Mersey Care NHS Foundation Trust have held a joint learning workshop to agree a standardised approach to identifying the cohort of patients who require intensive and assertive support and to develop standard operating procedures.
- 2.3 The Trusts have agreed a multi-disciplinary approach to managing the IAO caseload and will be implementing protocols to appropriately step-up and step-down levels of support. This includes prioritisation for inpatient admission if required.
- 2.4 The workshop helped to identify specific actions required by system partners to ensure that timely, appropriate escalation is undertaken to mental health services to mitigate the risk of harm to the individual, or to others. Further work is needed to define partner responsibilities and to explore digital alert systems to support cross-agency risk management.

### 3. Ask of the Board and Recommendations

#### 3.1 The Board is asked to note:

- progress against previously identified actions, as outlined in Appendix 1
- the risks identified and an outline of proposed mitigations
- the intention to seek support from the NHS Cheshire and Merseyside's digital programme to explore interoperability and digital alert systems.

### 4. Reasons for Recommendations

4.1 NHS England has requested regular assurance updates, through the Boards of ICBs, regarding the ability to provide IAO community mental health support following the Nottingham homicides in June 2023. The Quality and Performance Committee is the agreed governance route for local assurance, with onward reporting to the Board as required by NHS England. The Quality and Performance Committee received a version of this paper on 12<sup>th</sup> March 2026.

4.2 Both NHS mental providers have continued to progress short-term goals which require either no resources or minimal resources, and they have helped to identify longer-term actions which have resource implications and require involvement from partner agencies.

4.3 Without digital interoperability and alerting systems, there is a risk that early warning signs of relapse may go undetected or not be shared with, or escalated to, another agency.

### 5. Background

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

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

5.3 Following an internal self-assessment process at the end of last year, Cheshire and Wirral Partnership NHS Foundation Trust (CWP) and Mersey Care NHS

Foundation Trust (MCFT) have progressed actions to define the patient cohort within electronic patient records and have updated policies and procedures. Appendix 1 details Red Amber Green (RAG) rating by provider for each action.

- 5.4 Both Trusts aim to ensure that all service users in this group have an assigned, and appropriately experienced and competent key worker and now adopt a multi-disciplinary team approach before agreeing to step-up or step-down support.
- 5.5 Personalised risk management procedures are in place and assessment, and care plans are coproduced with the service user and their family or carers.
- 5.6 Training needs analysis is underway to ensure that community mental health staff have the appropriate skills to support an enhanced care offer.
- 5.7 Whilst processes for escalation and rapid referral are being shared with wider health and social care teams, Voluntary Community Faith and Social Enterprise (VCFSE) partners, housing and support providers, there is a risk that early warning signs of relapse may go undetected or not be shared with, or escalated to, another agency. It is therefore proposed that consideration is given to establishing information sharing and alerting systems with partners.

## **6. Risks and mitigations**

- 6.1 Community mental health caseloads are currently high, and this limits the ability to provide intensive support for high-risk individuals without compromising waiting times for new referrals. Trusts are reviewing the practice for routine follow-up to try and balance capacity with demand.
- 6.2 There are emerging issues with shared care because of ongoing prescribing of amber medication affecting discharge from community mental health teams. Some GP practices will not accept the transfer of patients back to primary care if they are prescribed specific drugs. However, there does not appear to be a consistent approach across Cheshire and Merseyside, and this warrants further discussion to mitigate the risk of ever-increasing caseloads within secondary care services.
- 6.3 Mental health crisis services continue to experience increased demand and complexity and, as a result, thresholds to receive support from Crisis Resolution and Home Treatment Teams (CRHTs) are necessarily robust to ensure that those in greatest need can receive prompt intervention. This inevitably results in additional pressure in community mental health services. Mental Health Trusts are working with teams to clarify responsibilities for preventative and reactive interventions to ensure consistency in managing out-of-hours episodes.
- 6.4 Poor interoperability between systems hinders real-time monitoring, information sharing, and effective cohort tracking and this can lead to a lack of coordinated care across key partners. Work is required to strengthen alerting systems and

feedback loops to minimise delays in information sharing, particularly during crises or care transitions, which may compromise patient safety and care outcomes.

- 6.5 Ongoing workforce instability, including issues with Section 75 agreements, disrupts multi-agency continuity. In addition, sustainable funding for VCSFE partners remains uncertain despite their recognised contribution to system delivery.
- 6.6 NHS Cheshire and Merseyside is not yet able to provide full assurance that the needs of this patient group are being met and without additional resource to increase the workforce the gaps are unlikely to be fully addressed. This position has been reflected in returns to NHS England by 90% (43) of responding organisations meaning that Cheshire and Merseyside is not a national outlier.

## **7. Next Steps and Responsible Person to take forward**

- 7.1 CWP and Mersey Care have agreed to a monthly meeting to share wider staff learning, training and development planning to support practitioners with this high-risk patient cohort.
- 7.2 The MH Programme will support collaborative work to agree system stakeholder responsibilities and liaise with digital colleagues to explore the potential to develop alerting systems and improve interoperability via access to capital funding.

## **8. Officer contact details for more information**

Simon Banks, Place Director (Wirral) and Strategic Lead – Mental Health, Learning Disability and Autism [simon.banks@cheshireandmerseyside.nhs.uk](mailto:simon.banks@cheshireandmerseyside.nhs.uk)

Claire James, Mental Health Programme Director. [Claire.james12@nhs.net](mailto:Claire.james12@nhs.net)

Clair Haydon, Consultant Occupational Therapist, Clinical Director for Mental Health Complex Care for North West England. [Clair.haydon@nhs.net](mailto:Clair.haydon@nhs.net)

## 9. Appendices

### Appendix 1: NHS Cheshire and Merseyside Action Plan – Progress RAG rating

Overarching action	Milestones	CWP	Mersey Care
Policies have been reviewed to ensure that patient family and carers are involved, particularly at times of non-engagement	Trusts will review and align policies and procedures to include Intensive and Assertive Outreach standards.	Green	Green
	Trusts will develop and agree escalation pathways for local services and VCFSE to ensure that quick and easy access to the CMHT is available and communicated.	Yellow	Yellow
	Trusts will ratify policies and procedures to include I&OA standards	Green	Yellow
Eliminate 'blanket' policies and practices of using DNA as a reason for discharge	Trusts to review and amend their policies and practices to ensure DNA is never a reason for discharge for this group.	Green	Green
	Trusts will ensure that discharge as a result of DNA for this group is treated as a never event and reported through this route as per Trust Governance structures	Yellow	Yellow
	Trusts to escalate any areas of concern that require system support.	Green	Green
	Trusts to review and identify gaps in EPR systems to identify this group, link to incidents, compliments, comments and complaints quality metrics, and ensure robust governance processes in place.	Yellow	Yellow
	All CMH Team Managers will provide a list of service users who are known within their teams to meet the IO/AO criteria and/ or those who are known to be high risk if they disconnect with services, these will include all those on CTO's	Green	Green
	All service users identified through the process above will be reviewed by the MDT with the service user and their supports. They will agree a risk management plan and plan of care that takes into account an relapse indicators.	Green	Yellow
	This will be shared with all relevant parties including the GP and will detail escalation processes.	Green	Yellow
Go live for digital flag is first week of March 2026. Form and methodology shared with MCFT. Can now be rated Green	Green	Green	
All service users are assessed to see if they are eligible for intensive and assertive community treatment	Develop a Standard Operating Procedure (SOP) to support the identification and the eligibility	Green	Green
	Any new service users who meet the eligibility criteria will be supported as per the SOP and this will be evidenced within the EPR	Green	Green
Ensure all service users in this group have an assigned, and appropriately experienced and competent key worker (or care coordinator)	Trust to work across C&M to agree implementation of these standards and what is possible without resource.	Green	Green
Discharge plans should include early warning signs of relapse and subsequent actions. These plans are shared with the patient, the family, detailed on the patient record, and shared with other agencies.	Trust to review relapse/risk documentation to ensure this ask is met.	Green	Green
	Trust to review the skills and competency in the workforce to be able to complete this ask and escalate any training needs.	Blue	Green

Overarching action	Milestones	CWP	Mersey Care
Rapid re-referral/easy access is possible in the case a service user is discharged but requires additional support due to increasing needs.	Trusts to review/revise processes for re-referral for this group.	On track	On track
	Trusts to share processes for escalation and rapid referral with wider health and social care teams and VCFSE, housing and support providers.	Started and on track	Started and on track
Key workers (or care coordinators) stay in contact with the service user (and their inpatient care team) during inpatient admissions	Trusts to review current processes, identify any gaps and formulate plans to address, including system support.	Complete	On track
Assessments and care plans are coproduced with the service user and their family or carers	Trusts to review current processes, identify any gaps and formulate plans to address, including system support.	On track	On track
Daily planning meetings and weekly MDTs for all service users requiring intensive treatment	Trusts to review current processes, identify any gaps and formulate plans to address, including system support.	Complete	On track
Personalised risk management procedures are in place.	Trusts to review current processes, identify any gaps and formulate plans to address, including system support.	Complete	On track

Key:

Complete
On track
Started and on track
Started and not on track

# Meeting of the Board of NHS Cheshire and Merseyside 26 March 2026

## System Financial Position – Month 11

Agenda Item No: ICB/09/26/15



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# ICB and System Financial Position – Month 11

## 1. Purpose of the Report

- 1.1 This report provides an update to the Board on the financial performance of the Cheshire and Merseyside ICS (“the ICS”) at Month 11 2025/26, in terms of relative position against its financial plan, and alongside other measures of financial and operational performance (e.g. efficiency, productivity and workforce).

## 2. Executive Summary

- 1.2 On 27th March 2025 the System ‘ICS’ plan submitted was a combined £255m deficit, consisting of £23.6m surplus on the commissioning side (ICB) partially offsetting an aggregate NHS Provider deficit position of £278.7m. This plan was not approved by NHS England (NHSE), and subsequently a revised plan of £178.3m deficit (£50.4m surplus for the ICB and £228.6m for providers) was agreed and submitted on 30th April 2025.
- 1.3 As part of submitting a £178.3m deficit plan the ICS has been allocated £178.3m deficit support funding from NHSE to cover the deficit and allow the financial system plan to be adjusted to a balanced breakeven position. The funding has been allocated to providers via an agreed system methodology and in turn collective provider plans were improved. Within the original NHS business rules, the revenue deficit support is deemed repayable to NHSE, however an update from NHSE indicates that should the system deliver its 2025/26 plan it will not be repayable. The deficit support funding is released to the system quarterly subject to prospective assurance from NHSE covering areas such as progress with delivery of efficiency plans, and a review of expenditure and workforce run rates.
- 1.4 The system received £44.5m of deficit support funding (DSF) for Quarter 1 however, due to the level of financial risk in the Cheshire and Merseyside system, the Deficit Support Funding (DSF) for Quarters 2,3 and 4 was not awarded to the ICB. This month, DSF was awarded to Countess of Chester, Mersey and West Lancashire and Mid Cheshire Hospitals in recognition of meeting 25/26 plan and submission of a 26/27 plan compliant with expected Control Total. This equates to £72.9m (M11 impact £54.7m).
- 1.5 NHSE has placed several organisations, including the ICB, in formal undertakings, which highlights the level of concern in relation to the forecast position. A recovery plan is required to demonstrate the steps required to move the system into a balanced financial position.



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### 3. Financial Position as at Month 11

- 3.1 As of 28<sup>th</sup> February 2026 (Month 11), the ICS is reporting a year to date deficit of £177.8m (including Q1 DSF) against a planned year to date deficit of £79.4m resulting in an adverse variance of £98.4m which is all in relation to the withheld DSF.
- 3.2 Appendix 1 contains details of the ICB financial position and the overall system position.
- 3.3 Excluding DSF, the ICS is reporting £28.2m adverse to plan at month 11, which includes additional funding for Industrial Action costs of £18m, which were not planned for.
- 3.4 In line with the M10 NHSE forecast protocol, organisations have formally reported revised forecast outturns. At M11 the system forecast is a £289.6m deficit (exc. DSF) - £111.3m adverse to the full year plan. This forecast ICS position will result in a loss of £79m of DSF for certain providers (see Appendix 1 slide 4). The system will not therefore deliver the control total of £178m deficit, however there has been a significant improvement from previous forecasts. It is vital that the medium term plans submitted are compliant and move the individual organisations and the system to a sustainable position over the next three years.
- 3.5 In advance of Month 11 reporting NHSE updated the guidance regarding Deficit Support Funding (DSF). NHSE confirmed that in those systems forecasting an adverse position to plan it will allow providers that have lost DSF despite delivering their own plan to re-earn that DSF if they have a balanced plan for 26/27.
- 3.6 Therefore, for C&M ICS – this has meant that Mid Cheshire, Countess of Chester and MWL have all earned back their Q2-Q4 DSF – and reflected this in the M11 YTD and forecast outturn position. This is a £54.7m improvement in the DSF forecast compared to M10.
- 3.7 Based on 25/26 forecast outturns and 26/27 plans submitted there are 5 providers that have an aggregate of £79m of 2526 DSF withheld.
- 3.8 The impact on cash positions in NHS Providers is set out in Appendix 1 slide 7. Of the £349.4m requested - £179.5m has been approved by NHSE, with the cash request for March of £89.8m still under consideration, likely to be impacted by the late announcement in relation to DSF.

- 3.9 Price Waterhouse Coopers (PWC) is continuing to work alongside NHSE and the ICB until the end of the financial year, to undertake monthly reviews with High-risk organisations, including the ICB. In addition, they are conducting Rapid Baseline reviews for high-risk programmes within the ICB and Balance Sheet reviews across all ICS organisations.

## 4. Ask of the Board and Recommendations

- 4.1 The Board is asked to:
- note the financial position and metrics reported at Month 11..

## 5. Officer contact details for more information

**Andrea McGee**

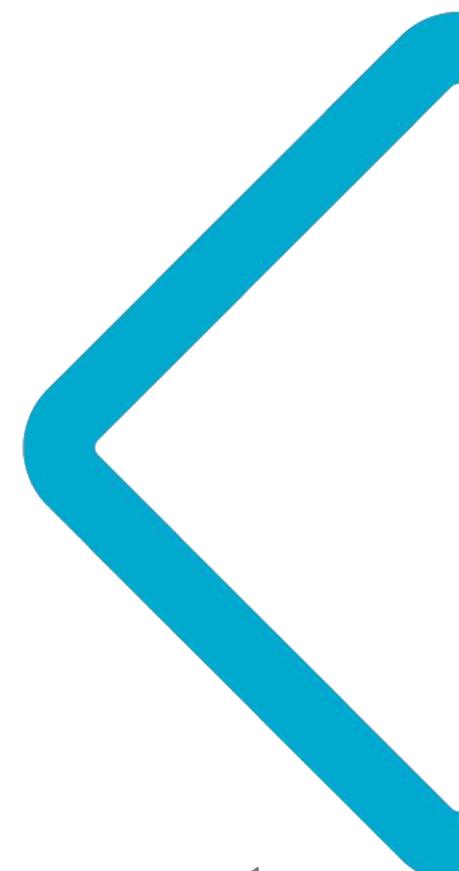
Executive Director of Finance (Interim) Cheshire and Merseyside ICB

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**Appendix One:** Cheshire and Merseyside ICB/ICS Financial Position Summary Month 11

# **Appendix 1: Cheshire & Merseyside ICB Financial position headlines**

## **Cheshire & Merseyside ICS M11 25/26 – key data 26<sup>th</sup> March 2026**



# Month 11 YTD – C&M ICB Position

ICB Total	C&M ICB TOTAL - Month 11 Position		
	Budget £'m	Actual £'m	Variance £'m
Acute	3,387	3,408	(22)
Community	673	667	6
Mental Health - Contracts	533	551	(17)
Mental Health - Packages of Care	197	198	(1)
CHC	431	438	(7)
Delegated GP	560	556	4
Delegated Other - DOP	299	280	19
Prescribing	498	512	(14)
Primary Care Other	117	115	2
Other Commissioned Services	14	13	1
Other Programmes	57	61	(4)
Reserves	(2)	0	(2)
Specialised Commissioning	705	699	6
<b>Sub Total - Programme Expenditure</b>	<b>7,470</b>	<b>7,500</b>	<b>(30)</b>
Running Costs	43	43	0
<b>TOTAL EXPENDITURE</b>	<b>7,513</b>	<b>7,542</b>	<b>(30)</b>
<b>Surplus / (Deficit) Plan</b>	<b>46</b>	<b>0</b>	<b>46</b>
<b>Sub Total - Net Surplus / (Deficit) Reported</b>	<b>7,559</b>	<b>7,542</b>	<b>16</b>

## ICB Headlines Month 11

£16m surplus YTD, against a plan of £46m surplus i.e. **-£30m** adverse to plan.

Key overspends continue to be:

- Primary care prescribing **-£14m**.
- ADHD **-£21m**.
- Acute Sector (incl. Independent Sector) **-£22m**.
- All Age Continuing Care **-£7m**.

Offset by the following underspends:

- Delegated POD £19m.
- Delegated GP £4m.
- Community £6m.
- Specialised commissioning £6m.

Risks/Issues:

- Securing remaining CRES delivery.
- Need to mitigate any emerging pressures to achieve breakeven position overall.

# Month 11 – C&M ICS YTD and FOT I&E – based on key data

Org	Month 11 YTD (including DSF)			DSF YTD			Month 11 YTD (excluding DSF)			FORECAST (excluding DSF)			
	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance	Full Year Plan	M11 FOT - submitted to NHSE	M11 Forecast Variance to FY Plan	M11 YTD as a % of M10 FOT
	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	%
Alder Hey Children's	2,115	2,115	0	0	0	0	2,115	2,115	0	7,160	7,160	0	30%
Bridgewater Community	(3,678)	(3,733)	(55)	0	0	0	(3,678)	(3,733)	(55)	(1,530)	(4,420)	(2,890)	84%
Cheshire & Wirral Partnership	(1,979)	1,917	3,896	0	0	0	(1,979)	1,917	3,896	3,985	3,985	0	48%
Countess of Chester Hospitals	(16,518)	(15,018)	1,500	(17,994)	(17,994)	(0)	(34,512)	(33,012)	1,500	(34,042)	(34,042)	(0)	97%
East Cheshire Trust	(9,654)	(16,589)	(6,935)	(9,473)	(2,583)	(6,890)	(19,127)	(19,172)	(45)	(17,934)	(24,184)	(6,250)	79%
Liverpool Heart & Chest	8,216	8,216	0	0	0	0	8,216	8,216	0	9,552	9,552	0	86%
Liverpool University Hospitals	(26,065)	(65,937)	(39,872)	(40,786)	(11,122)	(29,664)	(66,851)	(77,059)	(10,208)	(56,609)	(72,209)	(15,600)	107%
Liverpool Women's	(15,030)	(25,019)	(9,989)	(14,031)	(3,828)	(10,203)	(29,061)	(28,847)	214	(31,026)	(31,026)	0	93%
Mersey Care	6,646	10,459	3,813	0	0	0	6,646	10,459	3,813	14,305	13,280	(1,025)	79%
Mid Cheshire Hospitals	(16,648)	(16,465)	183	(21,121)	(21,121)	0	(37,769)	(37,586)	183	(39,380)	(39,380)	0	95%
Mersey & West Lancs	(33,459)	(20,306)	13,153	(27,708)	(27,704)	(4)	(61,167)	(48,010)	13,157	(40,950)	(40,950)	0	117%
The Clatterbridge Centre	538	550	12	0	0	0	538	550	12	890	890	(0)	62%
The Walton Centre	6,278	6,298	20	0	0	0	6,278	6,298	20	6,900	6,900	0	91%
Warrington & Halton Hospitals	(20,981)	(33,796)	(12,815)	(16,799)	(4,582)	(12,217)	(37,780)	(38,378)	(598)	(28,726)	(40,705)	(11,979)	94%
Wirral Community	(67)	4,800	4,867	0	0	0	(67)	4,800	4,867	900	5,100	4,200	94%
Wirral University Hospitals	(5,292)	(31,722)	(26,430)	(15,499)	(4,229)	(11,270)	(20,791)	(35,951)	(15,160)	(22,140)	(49,540)	(27,400)	73%
<b>TOTAL Providers</b>	<b>(125,578)</b>	<b>(194,230)</b>	<b>(68,652)</b>	<b>(163,412)</b>	<b>(93,163)</b>	<b>(70,249)</b>	<b>(288,990)</b>	<b>(287,393)</b>	<b>1,597</b>	<b>(228,645)</b>	<b>(289,589)</b>	<b>(60,944)</b>	<b>99%</b>
C&M ICB	46,170	16,415	(29,755)	0	0	0	46,170	16,415	(29,755)	50,367	0	(50,367)	
<b>TOTAL ICS System</b>	<b>(79,408)</b>	<b>(177,815)</b>	<b>(98,407)</b>	<b>(163,412)</b>	<b>(93,163)</b>	<b>(70,249)</b>	<b>(242,820)</b>	<b>(270,978)</b>	<b>(28,158)</b>	<b>(178,278)</b>	<b>(289,589)</b>	<b>(111,311)</b>	<b>94%</b>

- Aggregate ICS Position £177.8m deficit YTD (including notified deficit support) – £98.4m adverse from YTD plan, of which £70.2m relates to non receipt of DSF for certain providers
- Aggregate ICS position £271.0m deficit YTD (excluding all deficit support) – £28.2m adverse to YTD plan, the position includes receipt of £18m industrial action funding received in M9.
- **In line with the M10 NHSE forecast protocol, organisations have formally reported revised FOTs. At M11 the system continues to forecast a £289.6m deficit (exc. DSF) - £111.3m adverse to FY plan.** This forecast ICS position will also result in a loss £79m of DSF for certain providers (see next slide)

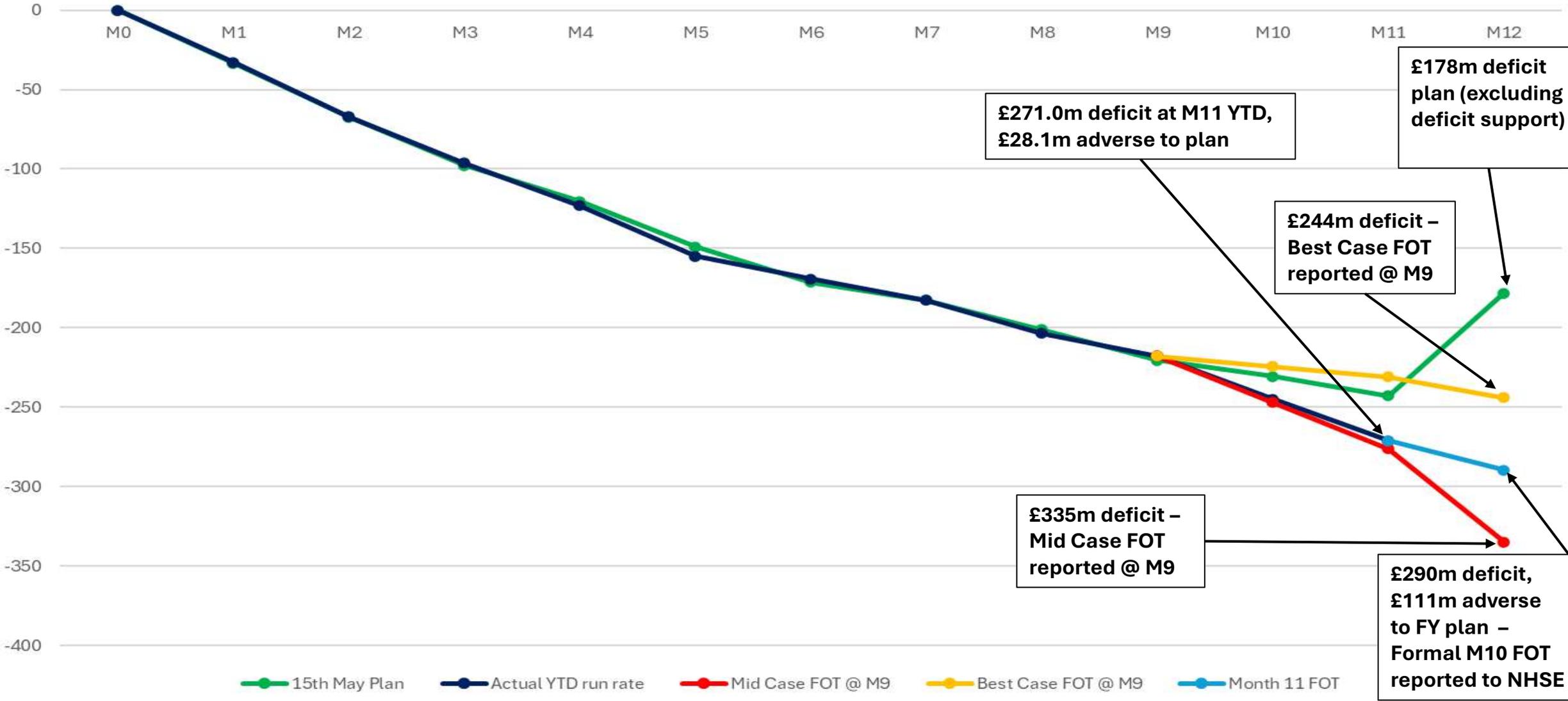
# Month 11 – Deficit Support Funding update

	DSF M11 YTD in PFR			DSF FOT in PFR at M11			DSF FOT M10	Change in DSF FOT M10 to M11
	YTD Plan	YTD Actual	YTD Variance	FY Plan	FOT	FOT Variance	Previous Month M10 FOT	
	£,000	£,000	£,000	£,000	£,000	£,000	£,000	
Alder Hey Children's	0	0	0	0	0	0	0	0
Bridgewater Community	0	0	0	0	0	0	0	0
Cheshire & Wirral Partnership	0	0	0	0	0	0	0	0
Countess of Chester Hospitals	17,994	17,994	(0)	19,631	19,631	0	4,907	14,724
East Cheshire Trust	9,473	2,583	(6,890)	10,334	2,583	(7,751)	2,583	0
Liverpool Heart & Chest	0	0	0	0	0	0	0	0
Liverpool University Hospitals	40,786	11,122	(29,664)	44,494	11,122	(33,372)	11,122	0
Liverpool Women's	14,031	3,828	(10,203)	15,307	3,828	(11,479)	3,828	0
Mersey Care	0	0	0	0	0	0	0	0
Mid Cheshire Hospitals	21,121	21,121	0	23,044	23,044	0	5,761	17,283
Mersey & West Lancs	27,708	27,704	(4)	30,223	30,223	0	7,556	22,667
The Clatterbridge Centre	0	0	0	0	0	0	0	0
The Walton Centre	0	0	0	0	0	0	0	0
Warrington & Halton Hospitals	16,799	4,582	(12,217)	18,327	4,582	(13,745)	4,582	0
Wirral Community	0	0	0	0	0	0	0	0
Wirral University Hospitals	15,499	4,229	(11,270)	16,916	4,229	(12,687)	4,229	0
<b>TOTAL Providers</b>	<b>163,412</b>	<b>93,163</b>	<b>(70,249)</b>	<b>178,276</b>	<b>99,242</b>	<b>(79,034)</b>	<b>44,568</b>	<b>54,674</b>

- In advance of Month 11 reporting NHSE updated the guidance with regard Deficit Support Funding (DSF).
- NHSE confirmed that those systems forecasting an adverse position to plan it will allow providers that have lost DSF despite delivering their own plan to re-earn that DSF if they have a balanced plan for 26/27.
- Therefore, for C&M ICS – this has meant that Mid Cheshire, Countess of Chester and MWL have all earned back their Q2-Q4 DSF – and reflected this in the M11 YTD and FOT position. This is a £55m improvement in the DSF forecast compared to M10.
- Based on 25/26 FOTs and 26/27 plans submitted there are x5 providers that have an aggregate of £79m of 25/26 DSF withheld.

# Month 11 – C&M ICS Financial Position – Run Rate

25/26 ICS Plan Profile and M11 Run Rate (Excluding Deficit Support)



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

	M1		M6		M7		M8		M9		M10		M11		M12		TOTAL 25/26	
	April		September		October		November		December		January		February		March		Request	Approved
	Request	Approved	Request	Approved	Request	Approved	Request	Approved	Request	Approved	Request	Approved	Request	Approved	Request	Approved		
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Countess of Chester			12.0	1.3	9.0	6.8	3.7	3.7					7.0	5.7	7.4		39.1	11.8
Liverpool Womens			3.8	3.8	2.5	2.5			3.0	3.0	2.5	2.5	7.0	6.8	4.0		22.8	11.8
MWL			11.0	10.7	11.0	11.0	8.0	0.0	17.9	0.0	0.0		0.0		0.0		47.9	21.7
Warrington & Halton			4.6	4.6	4.0	4.0	2.4	2.4	4.9	4.9	6.9	3.3	1.3	0.0	8.0		32.1	19.2
WUTH	14.0	8.0	16.5	10.0	5.5	5.5	6.0	6.0	6.5	6.5	4.0	4.0	2.0	2.0	16.3		70.8	40.0
East Cheshire													4.7	4.7	4.7		9.4	0.0
Mid Cheshire															10.0		10.0	0.0
LUHFT					21.0	13.8			15.0	8.4	28.1	23.8	13.6	9.7	39.5		117.2	46.0
<b>TOTAL</b>	<b>14.0</b>	<b>8.0</b>	<b>47.9</b>	<b>30.4</b>	<b>52.9</b>	<b>43.6</b>	<b>20.1</b>	<b>12.1</b>	<b>47.3</b>	<b>22.8</b>	<b>41.5</b>	<b>33.6</b>	<b>35.7</b>	<b>29.0</b>	<b>89.9</b>	<b>0.0</b>	<b>349.4</b>	<b>179.5</b>

- Table above sets out the YTD distressed cash requests that have been approved by NHSE YTD
- Of the £349.4m requested - £179.5m has been approved, with the cash request for March of £89.8m still under consideration
- The table to the right sets out the DSF funding currently on hold, which is material driver of the request for cash as part of providers underlying deficit positions.
- DSF Q2-4 has been awarded to providers who have met both their 25/26 plan and 26/27 Control Total. This will change the cash requirements in Month 12.

DSF Loss			
Q2	Q3	Q4	TOTAL
£m	£m	£m	£m
			0
3.8	3.8	3.8	11.4
			0
4.6	4.6	4.6	13.8
4.2	4.2	4.2	12.6
2.6	2.6	2.6	7.7
			0
11.1	11.1	11.1	33.4
<b>26.3</b>	<b>26.3</b>	<b>26.3</b>	<b>78.9</b>

# Meeting of the Board of NHS Cheshire and Merseyside

26 March 2026

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

Agenda Item No: ICB/03/26/16



Compassionate



Inclusive



Working Together



Accountable

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

<b>Committee Chair</b>	Sue Lorimer
<b>Terms of Reference</b>	<a href="https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/">https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/</a>
<b>Date of meeting(s)</b>	22 January 2026 and 17 February 2026

### Key escalation and discussion points from the Committee meeting

#### Alert

- Approved the Lung Cancer Screening Phase 5 Procurement for recommendation to the Board (£12.7m over 2 years funded by the NHS Cancer Programme to 2030; financial risk thereafter).
- The Committee noted the requirement to deconstruct block contracts and that any top ups in current contracts would be reduced over several years in line with planning guidance. This will increase provider financial pressure though some may benefit slightly from a clear activity-based contract.
- The committee endorsed a £3.1m contract modification for Mid Cheshire Hospitals NHS Foundation Trust to deliver fast-track end-of-life services; within PSR thresholds. Expected recurrent savings c£1.3m.
- The committee noted the month 10 financial position, as follows:
  - ICB reported £18m adverse to plan at month 10 (actual £24m surplus, against planned surplus of £42m). Key risks to delivery were highlighted as savings from the Independent Sector and Primary Care Prescribing.
  - ICS reported £14m adverse to plan at month 10 (actual £245m deficit, against planned deficit of £231m). This includes the loss of Deficit Support Funding (DSF) of £104m, which is significantly increasing the level of cash distress on providers.
- The committee noted the revised forecast outturn agreed with NHSE: ICB breakeven, ICS £111m deficit, reflecting a £100m improvement from the position reported at month 4.
- The committee received a presentation on the development of the CRES programme for 2026/27, which requires £118m of efficiency savings. Over 50% of schemes defined, strengthened controls to be implemented, aligned to both the ICB's undertakings and PwC's 'grip and control' recommendations.
- The committee endorsed revised Terms of Reference subject to clarification on risk and the reporting relationship with the Systems Primary Care Committee. The revisions reflected both the emerging ICB blueprint, and the findings of the early finance governance review undertaken as part of the enforcement undertakings. This included the removal of provider members due to the

changing role of the ICB and legal challenge risk. The 2 areas queried to be finalised and the revised ToRs presented to the ICB Board for approval. The committee noted the continued need for transparency with provider partners and were assured that regular meetings will continue to be held between the senior finance teams of the ICB and providers and information will continue to be shared as much as possible.

**The Board is asked to approve the updated Committee Terms of Reference (Appendix One)**

**Advise**

- The committee received a verbal update confirming the 2026-29 ICB planning submission was endorsed by Board on 11th February, and all organisations had submitted their plans by the national deadline. Misalignment remains between the ICB's assumptions and those of providers e.g. RTT activity, block deconstruction, and growth. NHSE expects a unified system approach.
- A presentation was received from the Digital Diagnostics Capability Programme (DDCP), including details of the digital diagnostics roadmap for Cheshire and Merseyside, approved by ICB Executives, the Chief Information Officer Group, the Digital Diagnostics Board, and the Diagnostics Board. The roadmap is now awaiting national review.
- An update was received from the Financial Control and Oversight Group (FCOG), including the current CRES status. The key risks were highlighted as follows:
  - AACC and Section 117 – continuing volatility in forecast and CRES delivery.
  - Independent Sector - noted to be a core driver of financial pressure due to delayed savings delivery, new market activity and volatility in demand.

The terms of reference for the Financial Control and Oversight Group meeting had been revised and confirm continued monthly reporting to FIRC.

- The committee noted a report on Capital planning. There have been no changes made to the ICB's capital allocation since the previous report. The Committee was advised that around 40% of total capital spend was still required in the final two months, which, although challenging, is consistent with the pattern seen in previous years.
- The committee received an update on the national capital programme, with the paper setting out progress on the deployment of Primary Care and Secondary Care capital, including Public Dividend Capital (PDC) allocations over a four-year period totalling £281m, designated for investment across primary and secondary care. It was noted that schemes exceeding £1m would require more extensive documentation and scrutiny at both ICB and national levels, potentially

impacting delivery timescales. These schemes will be approved in line with the ICB scheme of reservation and delegation.

**Assure**

- The committee noted a report on the implementation of, and risk associated with, a new accounting system (Integrated System Financial Environment (ISFE2)). The level of risk has reduced, and further assurance will be sought through a post implementation review by Mersey Internal Audit Agency (MIAA).
- The committee at its January meeting considered 2 reports from PWC as follows:
  - Priority Programme Baseline Review – this set out an assessment of key ICB CRES schemes and made recommendations to improve robustness and identify mitigation opportunities. The committee was assured that the recommendations had been taken into account by FCOG in its oversight of CRES planning and delivery.
  - Grip and Control Review for the ICB and the ICS - the committee was assured that recommendations from the ICB review had been incorporated into the internal Financial Governance Review and they would be presented to the Audit Committee at its next meeting.

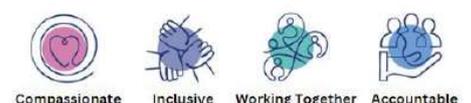
**Committee risk management**

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

Corporate Risk Register risks	
Risk Title	Key actions/discussion undertaken
BAF risk P13	No specific risk papers were presented to this meeting. However, a comprehensive discussion took place regarding the risks relating to the 25/26 financial outlook, and the 26/29 planning submission. Key actions are included within the Alert, Advise, Assure update above, at this stage.

Board Assurance Framework Risks	
Risk Title	Key actions/discussion undertaken
BAF risk P13	No specific risk papers were presented to this meeting. However, a comprehensive discussion took place regarding the risks relating to the 25/26 financial outlook, and the 26/29 planning submission. Key actions are included within the Alert, Advise, Assure update above, at this stage.

**Achievement of the ICB Annual Delivery Plan**



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

Service Programme / Focus Area	Key actions/discussion undertaken
Financial plan delivery	The committee received updates on the revised month 10 financial forecasts for the ICS approved by NHS England.

## Appendices

### Appendix One: Updated Committee Terms of Reference

# **NHS Cheshire and Merseyside Integrated Care Board**

## **Finance, Investment and Contracting Committee**

Terms of Reference

DRAFT



**Document revision history**

Date Approved by Board	Version	Revision	Comment	Author / Editor
October 2022	1.0	Initial		Mark Bakewell
Feb 2023	1.1			Matthew Cunningham
Sept 2025	1.2		Amendments to responsibilities around workforce, updates around	Matthew Cunningham
Feb 2026	1.3		Establish FICC principles and wider ICB alignment	Erica Saunders (on behalf of the Chair) & Ben Vinter

**Review due: December 2026**

**V1:XX approved by the ICB Board on add date**



# Finance, Investment and Contracting Committee

## TERMS OF REFERENCE

<b>Constitution</b>	Cheshire and Merseyside Integrated Care Board hereby resolves to establish a Committee of the Board to be known as the Finance, Investment and Contracting Committee (the Committee).
<b>Membership</b>	<p>Non-Executive Directors x 3 [one of whom shall be the Chair and must have a professional finance background]</p> <p>Executive Director of Finance and Contracting</p> <p>Executive Director of Strategy and Transformation</p> <p>Executive Director of Health and Integrated Care Commissioning</p> <p>Executive Clinical Director</p> <p>Executive Director of Corporate Services and Governance</p> <p>[List others]</p>
<b>Attendance</b>	<p>The following would be expected to attend each meeting:</p> <p>Deputy Director of Finance</p> <p>Chief Digital and Information Officer</p> <p>Specialised commissioning representative</p> <p>[List others]</p> <p>The following would attend as required by the agenda:</p> <p>All other Executive Directors</p> <p>Other persons by invitation</p> <p>Secretarial support shall be provided to the Committee to take formal minutes of the meeting, maintain an action log and give appropriate support to the Chair and Committee members.</p>
<b>Quorum</b>	Chair or nominated deputy, one other NED, two Executive Directors one of whom must be the Executive Director of Finance and Contracting or their designated Deputy.
<b>Frequency/ Duration</b>	Meetings of the Committee shall normally take place on a monthly basis and the Committee will meet not less than 10 times per year.
<b>Authority</b>	<p>The Committee will operate under broad powers to scrutinise the development and delivery of annual budgets, operational and joint financial plans, to oversee financial management, investment / disinvestment and contracting arrangements, in order to provide assurance to the Board that delivery in these areas supports the ICB's strategic aims and commissioning intentions. In doing so the Committee may investigate and approve any activity as outlined within its terms of reference</p> <p>The Committee is authorised to:</p>

	<ul style="list-style-type: none"> <li>• approve decisions within the financial limits as set out in the ICB’s Scheme of Reservation and Delegation (SoRD), operational SoRD (OSoRD) and Standing Financial Instructions (SFIs). Decisions exceeding those limits will be recommended to the Board.</li> <li>• agree C&amp;M joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability</li> <li>• agree actions on estates, procurement, supply chain and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability</li> <li>• seek any information within its remit from any ICB employee or member; all are directed to comply with such requests.</li> <li>• obtain independent professional advice as required and commission reviews/investigations or task-and-finish sub-groups.</li> <li>• commission any reports it deems necessary to help fulfil its obligations</li> <li>• obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice</li> <li>• commission, review and approve policies where they are explicitly related to areas within the remit of the Committee as outlined within the TOR, or where specifically delegated to the Committee by the ICB Board.</li> </ul> <p>For the avoidance of doubt, the Committee will comply with the ICB Standing Orders, Standing Financial Instructions and the SoRD.</p>
<p><b>Duties</b></p>	<p><u>Under its strategic oversight remit, the duties of the Committee are to:</u></p> <p><b><u>Financial Governance: Decision Making, Assurance and Oversight</u></b></p> <ul style="list-style-type: none"> <li>• oversee a system-based approach to preparing the annual operational plan, ensuring alignment with national priorities and recommending this for approval by the Board;</li> <li>• oversee the development of robust joint financial plans with the ICB’s partner NHS organisations and recommend these for approval by the Board; ensuring that plans clearly demonstrate the use of resources to improve outcomes and tackle health inequalities. This will include a plan to meet statutory financial duties (the system financial strategy) and a joint capital resource use plan;</li> <li>• assure oversight of the delivery of multi-year efficiency and productivity plans, aligned to the NHS Payment Scheme (NHSPS) assumptions (e.g., general efficiency factor), and the medium-term planning framework;</li> <li>• seek assurance that the ICB’s annual budgets are prepared within limits of available funds and recommend these for approval to the Board, including review of draft ICB annual operating plan prior to submission to Board for approval;</li> <li>• ensure agreed ICB strategies and operational plans are underpinned by an approved sustainable financial plan, monitoring and scrutinising delivery of and performance against the approved plan;</li> <li>• scrutinise investments/disinvestments arising from approved strategic and operational plans, assuring a robust prioritisation framework is applied to recovery plans and commissioning intentions;</li> <li>• monitor and scrutinise the ICB’s in-year budgetary performance, monthly forecast against plan and scrutiny of any recovery plans to address and mitigate negative variance, ensuring that required efficiencies are identified and delivered, including opportunities at system level;</li> <li>• ensure that robust action plans are developed in response to any material</li> </ul>

breaches or variation against plan;

- seek assurance that the ICB's expenditure in each financial year does not exceed the aggregate of any sums received within that financial year and that the local capital and revenue resource use for each financial year does not exceed the limits specified by NHS England;
- monitor and scrutinise overarching and longer-term recovery plans including time-scales, forecast savings or return on investment;
- approve recovery/QIPP plans above the SoRD thresholds of other Committees or Officers and receive monthly delivery assurance;
- consider and recommend the ICB's financial risk appetite and tolerances at least annually and regularly review contingency plans for managing risks to breakeven and resource limits (including ICS collective duties) following scrutiny of monthly updates on risk positions and mitigations consistent with NHS England ICB/system finance business rules;
- approve arrangements for risk sharing and /or risk pooling with other organisations (for example arrangements for pooled funds with other ICBs or pooled budget arrangements under section 75 of the NHS Act 2006, or Section 65Z6 of the Health and Care Act 2022);
- receive and approve key ICB financial policies and financial governance arrangements;
- approve new investment business cases in line with the Committee's delegated authority as outlined within the OSoRD (H1 – up to £10million, H2 – Up to £5million);
- escalate to/make recommendation to the Board on new investment business cases in line with delegated authority amounts as outlined within the OSoRD (H1 – over to £10million, H2 – over to £5million);
- receive regular assurance reports on and scrutinise new investment business case decisions made by other ICB Committees and Officers that have been made within their delegated authority as outlined within the OSoRD;
- approve any losses and special payments up to £500k as per delegated authority within the OSoRD;
- receive regular assurance reports on and scrutinise any approvals on losses and special payments made by ICB Officers under their delegated authority as outlined within the OsoRD;
- make recommendations to and seek approval from the Board for any losses and special payments over £500k;
- approve the requisitioning of goods and services (Non-healthcare) in line with the delegated authority limits as set out within the OSoRD (F1 and F2 – up to £500k, F3 – up to £2million).

**Procurement and Contract Decisions and Monitoring**

- oversee activity and cost against plan (both under and over agreed thresholds), and steps to address the same, including:
  - oversight of any proposals that will impact upon the volume or quality of services provided (where there is an impact on quality this will be referred to the Quality and Performance Committee);
  - actions that will have a material impact upon a Provider's ability to achieve its own targets (including financial balance);
  - assurance of how contracts are being used to monitor and improve VFM/productivity, address inequalities and contribute to social/economic development.
  - assurance from any System Integrated Commissioning and Contracting meetings and any plans being developed to address under-performance.
  - assuring the adherence of the ICB's procurement and contracting policy and framework.

- receive and approve the ICB Procurement Policy/plan(s);
- make procurement route decisions (from £5million), in line with the options contained within the Healthcare Provider Selection Regime (2023) Regulations (Annual Contract Value), with any novel or contentious procurement route decisions to be escalated to the Board;
- make decisions to put non-Healthcare goods and services (from £5million) out to competitive procurement (total contract value) with any novel or contentious procurement route decisions to be escalated to the Board;
- receive regular assurance reports on and scrutinise procurement decisions made by other ICB Committees and ICB individuals that have been made within the delegated authority as outlined within the OSoRD;
- approve requests for the waiver of any procurement rules for goods and services on an exception basis.

**Estates and Capital**

- monitor plans for prioritisation of future capital resource use and development of capital funding bids;
- monitor and scrutinise the progress and delivery of a system wide estates and infrastructure strategy (including Primary Care);
- gain assurance that the estates and infrastructure strategy is built into ICS financial framework;
- ensure there is effective oversight of future prioritisation and capital funding bids, seeking assurance from and scrutinising any decisions made by other ICB committees and Officers in line with their delegated authority as outlined within the OSoRD;
- review the annual Joint Capital Resource Use Plan prior to recommending approval by the ICB Board.

**Digital**

- seek assurance that digital investments decisions are aligned to the ICB's financial strategy, comply with the SORD/OSoRD, and deliver value for money;
- scrutinise regular reports on the financial performance and outcomes of digital programmes, seek assurance on risk management and remedial actions, and escalate any concerns or investments exceeding delegated limits to the Board.

**Primary Care (PC)**

- seek assurance that PC investments decisions and spend are aligned to the ICB's financial strategy, comply with the SORD/OSoRD, and deliver value for money recognising the delegated responsibilities of the SPCC Committee and the discrete contracting approaches within primary care;
- scrutinise regular reports on the financial decisions and outcomes of primary care programmes, seeking assurance through reporting to and triangulation at the Board that risk management and remedial actions, and escalations on any concerns or investments are taking place

**Specialised commissioning**

- seek assurance that specialised commissioning decisions are financially sustainable, aligned with ICB strategy and commissioning intentions, and within delegated limits;
- scrutinise value for money, financial risks, and delivery outcomes through receipt of regular reporting and oversight
- escalate concerns or decisions exceeding financial limits to the Board.

	<p><b><u>Risk Management</u></b></p> <ul style="list-style-type: none"> <li>• through oversight of the information provided to the Committee, identify related areas of strategic and financial risk and report these to the Board via the Board Assurance Framework or other appropriate mechanisms;</li> <li>• request substantive reports to be submitted to the Committee to provide assurance on risk mitigation and action plans;</li> <li>• assess risk appetite and tolerances on at least an annual basis to contribute to the Board risk appetite statement.</li> </ul>
<p><b>Reporting</b></p>	<p>The Committee will ensure that the minutes of its meetings are formally recorded and submitted to the Board along with a Chair’s report identifying key issues, risks and assurances. Any items of specific concern or which require Board approval will be the subject of a separate report.</p> <p>The Finance, Investment and Contracting Committee will prepare and submit an annual report on its activities to the Board setting out its performance against these Terms of Reference.</p> <p>The committee will receive reports from the following groups/committees:</p> <ol style="list-style-type: none"> <li>1) System Primary Care Committee</li> <li>2) Financial Recovery Programme Group</li> <li>3) Procurement Decisions Review Group</li> <li>4) Specialised Commissioning Joint Committee</li> </ol>
<p><b>Conduct</b></p>	<p>The Committee will develop a work plan at the start of each financial year with specific objectives which will be reviewed regularly by the Chair and formally on an annual basis. The Committee will also review its performance against the effective committee checklist after six months and thereafter on an annual basis.</p> <p>Agendas, papers and minutes to be distributed not less than <u>4 working days</u> prior to meetings. Papers may be tabled in exceptional circumstances at the discretion of the Chair. Any other business to be notified to the Chair in advance.</p> <p>Declarations of interest will be dealt with in accordance with the ICB’s Conflicts of Interest Policy.</p>
<p><b>Other Matters</b></p>	<p>Committee Terms of Reference to be reviewed following 6 months of operation and thereafter on an annual basis.</p>

**Review date:** September 2026

# Meeting of the Board of NHS Cheshire and Merseyside

## 26 March 2026

### Integrated Performance Report

Agenda Item No: ICB/03/26/17

# Integrated Performance Report

## 1. Purpose of the Report

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

## 2. Executive Summary

- 2.1 The integrated performance report for March 2026, see appendix one, provides an overview of key metrics drawn from the 2025/26 Operational plans, specifically covering Urgent Care, Planned Care, Diagnostics, Cancer, Mental Health, Learning Disabilities, Primary and Community Care, Health Inequalities and Improvement, Quality & Safety, Workforce and Finance.
- 2.2 For metrics that are not performing to plan, the integrated performance report provides further analysis of the issues, actions and risks to delivery in section 5 of the integrated performance report.

## 3. Ask of the Board and Recommendations

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

## 4. Reasons for Recommendations

- 4.1 The report is sent for assurance.

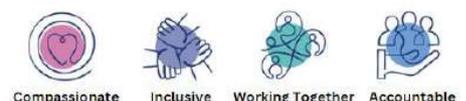
## 5. Background

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

## 6. Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities

### **Objective One: Tackling Health Inequalities in access, outcomes and experience**

Reviewing the quality and performance of services, providers and place enables the ICB to set system plans that support improvement against health inequalities.



**Objective Two: Improving Population Health and Healthcare**

Monitoring and management of quality and performance allows the ICB to identify where improvements have been made and address areas where further improvement is required.

**Objective Three: Enhancing Productivity and Value for Money**

The report supports the ICB to triangulate key aspects of service delivery, finance and workforce to improve productivity and ensure value for money.

**Objective Four: Helping to support broader social and economic development**

The report does not directly address this objective.

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

7.1 The integrated performance report monitors the organisational position of the ICB, against the annual delivery plan agreed with NHSE and national targets.

**8. Link to meeting CQC ICS Themes and Quality Statements**

**Theme One: Quality and Safety**

The integrated performance report provides organisational visibility against three key quality and safety domains: safe and effective staffing, equity in access and equity of experience and outcomes.

**Theme Two: Integration**

The report addresses elements of partnership working across health and social care, particularly in relation to care pathways and transitions, and care provision, integration and continuity.

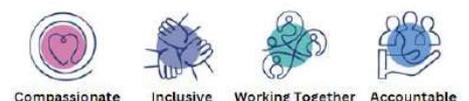
**Theme Three: Leadership**

The report supports the ICB leadership in decision making in relation to quality and performance issues.

**9. Risks**

9.1 The report provides a broad selection of key metrics and identifies areas where delivery is at risk. Exception reporting identifies the issues, mitigating actions and delivery against those metrics.

9.2 There is a risk that the system will not meet elective care recovery targets set out in the 2025/26 Operational Planning Guidance, including referral to treatment times, time to first appointment and 52-week RTT waiting time standards, due to constrained elective capacity, rising demand, workforce



shortages and financial constraints. This may result in prolonged patient waits, increased clinical risk, poor patient experience, financial impact, and reputational harm. This corresponds to Board Assurance Framework Risk P14.

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

## 10. Finance

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

## 11. Communication and Engagement

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

## 12. Equality, Diversity and Inclusion

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

## 13. Climate Change / Sustainability

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

## 14. Next Steps and Responsible Person to take forward

- 14.1 Actions and feedback will be taken by Jude Adams, Interim Executive Director of Strategy and Transformation. Actions will be shared with, and followed up, by relevant teams. Feedback will support future reporting to the Q&P committee.

## 15. Officer contact details for more information

- 15.1 Andy Thomas: Associate Director of Planning:  
[andy.thomas@cheshireandmerseyside.nhs.uk](mailto:andy.thomas@cheshireandmerseyside.nhs.uk)

## 16. Appendices

**Appendix One:** Integrated Quality and Performance report

# Integrated Performance Report

26<sup>th</sup> March 2026



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## Provider Acronyms:

### ACUTE TRUSTS

COCH COUNTESS OF CHESTER HOSPITAL NHS FT

ECT EAST CHESHIRE NHS TRUST

MCHT MID CHESHIRE HOSPITALS NHS FT

LUFT LIVERPOOL UNIVERSITY HOSPITALS NHS FT

MWL MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST

WHH WARRINGTON AND HALTON TEACHING HOSPITALS NHS FT

WUTH WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT

### SPECIALIST TRUSTS

AHCH ALDER HEY CHILDREN'S HOSPITAL NHS FT

LHCH LIVERPOOL HEART AND CHEST HOSPITAL NHS FT

LWH LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

TCCC THE CLATTERBRIDGE CANCER CENTRE NHS FT

TWC THE WALTON CENTRE NHS FT

### COMMUNITY AND MENTAL HEALTH TRUSTS

BCHC BRIDGEWATER COMMUNITY HEALTHCARE NHS FT

WCHC WIRRAL COMMUNITY HEALTH AND CARE NHS FT

MCFT MERSEY CARE NHS FT

CWP CHESHIRE AND WIRRAL PARTNERSHIP NHS FT

### KEY SYSTEM PARTNERS

NWAS NORTH WEST AMBULANCE SERVICE NHS TRUST

CMCA CHESHIRE AND MERSEYSIDE CANCER ALLIANCE

### OTHER

OOA OUT OF AREA AND OTHER PROVIDERS

## Key:

### Data formatting

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

### C&M National Ranking against the 42 ICBs

$\leq 11^{\text{th}}$	C&M in top quartile nationally
$12^{\text{th}}$ to $31^{\text{st}}$	C&M in interquartile range nationally
$\geq 32^{\text{nd}}$	C&M in bottom quartile nationally
-	Ranking not appropriate/applied nationally

### C&M National Ranking against the 22 Cancer Alliances

$\leq 5^{\text{th}}$	C&M in top quartile nationally
$6^{\text{th}}$ to $17^{\text{th}}$	C&M in interquartile range nationally
$\geq 18^{\text{th}}$	C&M in bottom quartile nationally
-	Ranking not appropriate/applied nationally

## Notes on interpreting the data

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

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

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

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

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

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

## Integrated Quality & Performance Report – Interpreting SPC Charts:

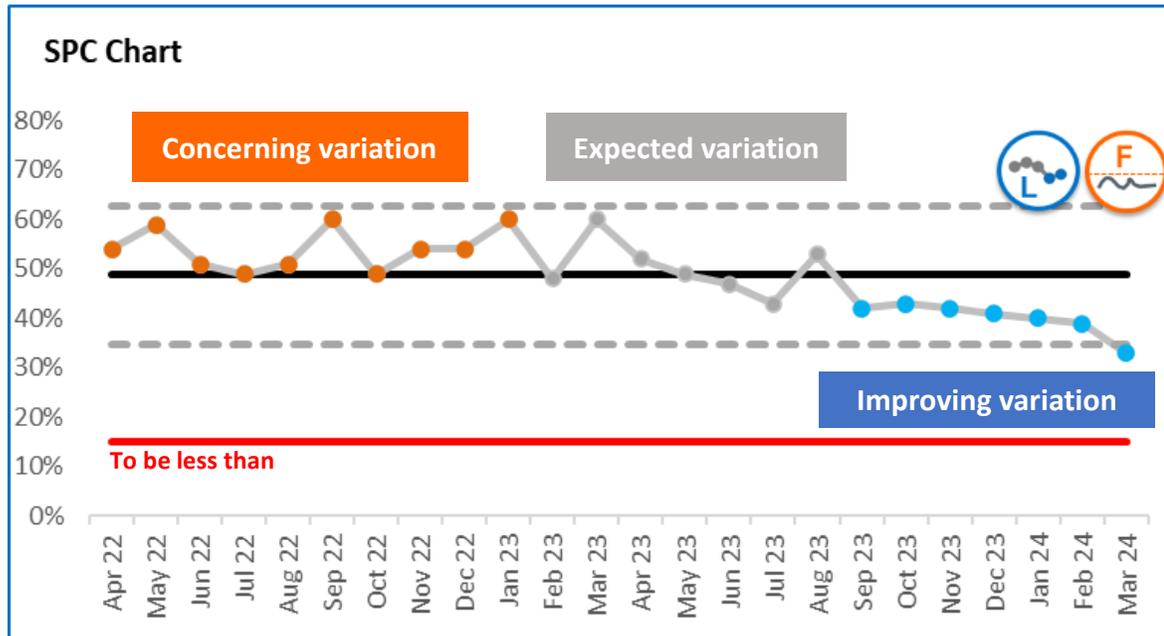
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

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

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

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

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



- UPL
- Average
- LPL
- Target

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

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

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

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

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

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

# 1. ICB Aggregate Position

Category	Metric	Latest period	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Local Trajectory	National Target	Region value	National value	Latest Rank
Urgent care	4-hour A&E waiting time (% waiting less than 4 hours)	Feb-26	73.1%	72.6%	72.7%	73.7%	73.0%	71.9%	72.8%	72.5%	71.9%	72.4%	71.5%	71.5%	71.6%	78.1%	78% by Year end	71.2%	74.1%	29/42
	Ambulance category 2 mean response time	Feb-26	00:38:28	00:32:43	00:27:58	00:26:44	00:30:22	00:32:05	00:27:24	00:28:44	00:32:51	00:37:31	00:45:25	00:40:49	00:31:46	-	00:30:00	00:27:00	00:29:27	28/42
	Mean Ambulance Handover time (ED and Non ED)	Feb-26	00:39:09	00:34:32	00:34:23	00:31:57	00:32:58	00:31:04	00:25:02	00:27:41	00:31:48	00:34:37	00:38:39	00:49:33	00:37:08	00:29:25	00:15:00	00:31:35	00:30:43	29/42
	A&E 12 hour waits from arrival (Type 1 & 2)	Feb-26	17.4%	16.2%	15.9%	16.6%	16.8%	17.0%	16.3%	17.6%	17.2%	17.1%	17.4%	18.7%	18.3%	15.8%	-	15.4%	11.3%	40/42
	Adult G&A bed occupancy (all acutes)	Feb-26	97.2%	95.9%	96.4%	96.5%	95.8%	95.6%	94.9%	96.1%	95.7%	96.2%	94.3%	96.0%	96.2%	94.9%*	92.0%	95.2%	95.4%	27/42
	Percentage of beds occupied by patients no longer meeting the criteria to reside (Rolling 7-day average last week of month)	Feb-26	21.6%	22.9%	21.2%	20.0%	20.3%	20.0%	20.7%	19.7%	19.1%	19.7%	18.7%	20.4%	21.4%	17.5%	-	n/a	n/a	-
	Discharges - Average delay (exclude zero delay)	Jan-26	9.0	10.1	9.8	8.8	8.6	8.4	7.9	8.6	8.8	8.2	8.4	8.2		8.9		6.7	5.9	36/42
	Percentage of patients discharged on discharge ready date	Jan-26	89.0%	89.0%	88.3%	88.3%	88.4%	88.5%	88.5%	89.1%	87.2%	85.9%	85.2%	84.8%		84.0%		85.3%	84.1%	18/42
Planned care	Total incomplete Referral to Treatment (RTT) pathways	Jan-26	356,570	360,184	354,386	350,979	355,722	362,412	366,066	367,700	367,494	355,626	349,685	346,862		339,165	-	1,002,098	7,155,958	-
	The % of people waiting less than 18 weeks on the waiting list (RTT)	Jan-26	57.3%	58.0%	58.0%	59.1%	59.0%	58.7%	58.4%	59.2%	59.4%	59.1%	58.7%	58.8%		61.6%	92.0%	59.4%	61.4%	32/42
	The % of people waiting more than 52 weeks on the waiting list (RTT)	Jan-26	3.3%	3.0%	3.5%	3.7%	3.9%	3.9%	3.9%	3.6%	3.3%	2.9%	2.4%	2.2%		1.4%		2.0%	1.9%	34/42
	Number of 52+ week RTT waits, of which children under 18 years.	Jan-26	919	750	972	983	1,031	1,098	1,114	899	992	947	847	731		623	-	n/a	n/a	-
	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Jan-26	1,091	659	990	1,443	1,325	1,242	941	677	444	319	74	58		-	0 by Sept 2024	122	7,417	
	Patients waiting more than 6 weeks for a diagnostic test	Jan-26	5.9%	6.7%	10.1%	12.0%	11.4%	11.2%	14.2%	12.4%	9.5%	9.2%	10.2%	10.7%		5.0%	5.0%	15.1%	24.7%	3/42
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Dec-25	74.7%	76.4%	76.1%	75.0%	73.8%	75.4%	76.2%	72.7%	72.3%	74.2%	74.6%			74.7%	85.0%	74.4%	71.8%	14/42
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Dec-25	95.8%	95.3%	94.7%	95.5%	95.5%	95.2%	95.1%	93.7%	94.4%	94.4%	95.3%			96.0%	96.0%	95.0%	92.5%	12/42
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitely Excluded	Dec-25	76.6%	76.3%	75.4%	71.8%	73.6%	71.7%	70.5%	70.6%	73.6%	74.8%	75.3%			79.2%	77% by Year end	77.3%	77.4%	30/42
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028. (Rolling 12 months)	Oct-25	59.0%	59.2%	59.3%	59.4%	59.2%	58.6%	59.0%	59.3%	59.4%					70.0%	75% by 2028	58.7%	59.6%	24/42
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Dec-25	83%	85%	86%	86%	86%	87%	87%	88%	85%	84%	85%			70.0%	70.0%	88.0%	84.0%	29/42
	Virtual Wards Utilisation	Jan-26	73.5%	83.1%	75.3%	74.7%	63.7%	78.9%	72.0%	72.9%	72.0%	99.8%	85.1%	87.3%		80.0%	80.0%	76.8%	90.2%	20/42
	Community Services Waiting List (Adults)	Dec-25	41,919	43,198	42,897	41,462	54,290	66,869	72,441	68,623	62,270	55,301	53,675					102,497	824,131	-
	Community services Waiting List (CYP)	Dec-25	20,184	20,110	20,519	21,794	24,606	25,457	19,198	19,103	20,279	18,547	18,632					39,026	323,826	-
	Community Services – Adults waiting over 52 weeks	Dec-25	94	118	95	71	237	424	613	449	410	231	219			0		629	8,954	-
Note/s	* from BIP sentinel metric run report																			

# 1. ICB Aggregate Position



## Cheshire and Merseyside

Category	Metric	Latest period	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Local Trajectory	National Target	Region value	National value	Latest Rank	
Mental Health	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Dec-25	79.0%	83.0%	77.0%	76.0%	69.0%	79.0%	80.0%	84%	76%	75%	72%			60.0%	60.0%	61.0%	74.7%	24/42	
	People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months	To Dec 25	62.0%		56.0%			53.0%			54.0%					-	60.0%	57.0%	59.0%	33/42	
	Dementia Diagnosis Rate	Dec-25	67.4%	67.6%	67.6%	67.6%	67.8%	68.0%	68.2%	68.1%	68.4%	68.4%	68.2%			66.7%	66.7%	70.6%	66.3%	16/42	
	CYP Eating Disorders Routine	Dec-25	87.0%	86.0%	92.0%	93.0%	93.0%	93.0%	94.0%	93.0%	92.0%	92.0%	91.0%			95.0%	95.0%	82.0%	83.3%	3/42	
	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact	Dec-25	34,550	34,625	35,450	35,185	35,485	35,090	35,105	35,220	35,940	36,195	36,410			37246	-	125700	863472	-	
	Number of people accessing specialist Community PMH and MMHS services	Dec-25	3,555	3,625	3,620	3,600	3,645	3,635	3,655	3,675	3,465	3,645	3,665			3420	-	8825	66845	-	
	Talking Therapies 1st to 2nd Treatment >90 days	Dec-25	32%	31%	36%	31%	30%	19%	15%	17%	15%	12%	13%			-	10%	26%	21.6%	6/42	
	Talking Therapies completing a course of treatment - % of plan achieved	Dec-25	92.0%	91.0%	102.0%	97.0%	104.0%	98.0%	95.0%	97.0%	99.0%	100.0%	100.0%			100.0%	100.0%	99.0%	97.0%	18/42	
	Talking Therapies Reliable Recovery	Dec-25	47.0%	49.0%	48.0%	48.0%	48.0%	47.0%	47.0%	44.0%	47.0%	47.0%	47.0%			48.0%	48.0%	45.0%	45.8%	25/42	
	Talking Therapies Reliable Improvement	Dec-25	68.0%	68.0%	67.0%	68.0%	68.0%	67.0%	66.0%	64.0%	67.0%	66.0%	66.0%			67.0%	67.0%	65.0%	66.5%	26/42	
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Dec-25	80	80	80	75	75	75	75	75	75	75	75	70		46	-	220	1,825	16/42	
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Dec 25 YTD	73.3%	85.5%	3.1%	7.5%	12.7%	18.5%	23.4%	31.1%	38.3%	46.4%	52.8%			49.1%	75% by Year end	54.3%	52.0%	16/42	
Primary Care	Units of dental activity delivered as a proportion of all units of dental activity contracted	Jan-26	94.0%	95.0%	82.0%	81.0%	80.0%	79.0%	77.0%	82.0%	84.0%	87.0%	76.0%	80.0%		80.0%	100.0%	87.0%	85.0%	33/44	
	Number of unique patients seen by an NHS Dentist – Adults (24 month)	Jan-26	936,873	937,773	940,716	941,167	941,865	944,188	944,511	946,089	947,758	947,371	944,217	950,227			950,302		2,674,357	18,281,377	-
	Number of unique patients seen by an NHS Dentist – Children (12 month)	Jan-26	332,480	333,475	333,796	333,871	334,907	335,719	336,440	337,729	338,502	338,564	336,188	339,791			346,638		1,047,021	7,305,352	-
	Appointments in General Practice & Primary Care networks	Dec-25	1,258,627	1,342,136	1,237,198	1,220,981	1,272,114	1,377,472	1,167,168	1,364,319	1,688,291	1,337,024	1,326,865				1,203,796		-	-	-
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care. (rolling 12 months)	Nov-25	7.02%	7.09%	7.14%	7.18%	7.22%	7.28%	7.29%	7.29%	7.32%	7.34%					10.0%	10.0%	-	7.62% (Dec 24)	-
	Total volume of antibiotic prescribing in primary care	Nov-25	0.98	0.97	0.95	0.94	0.94	0.93	0.92	0.92	0.92	0.91					0.871	0.871	-	1.00	-
Integrated care BCF metrics	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (average of place rates) (New data source)	Sep-25	220	239	229	232	237	228	208	191	181						-	-	-	190.4	-
	Percentage of people who are discharged from acute hospital to their usual place of residence (New data source)	Sep-25	80.4%	80.5%	82.3%	82.3%	83.1%	82.3%	83.0%	82.0%	82.5%						-	-	-	80.7%	-
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 (average of place rates) (New data source)	Aug-25	116	127	145	147	132	138	138	125							-	-	-	132.0	-
Note/s																					

# 1. ICB Aggregate Position

Category	Metric	Latest period	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Local Trajectory	National Target	Region value	National value	Latest Rank		
Specialised Commissioning	Cardiac Treatment waiting list (LH&CH) ^	Feb-26	386	376	363	383	403	402	402	398	395	408	369	461	378	386					-	
	Neurosurgery waiting list (TWC) ^	Feb-26	921	967	974	950	993	1,006	1,021	989	1,023	958	860	1,082	939	921						-
	Specialised Paediatric surgery waiting list (AHCH) ^	Feb-26	269	248	238	221	203	180	180	207	225	216	193	244	222	269						-
	Vascular waiting list (LUFT) ^	Feb-26	167	180	160	183	182	213	214	197	176	167	173	161	172	167						-
Health Inequalities & Improvement	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q2 25/26	69.07%			67.34%			67.42%								77.0%	80.0%	68.60%	68.7%	29/42	
	CVD treated to cholesterol threshold LDL-cholesterol less than or equal to 2.0 mmol/l or non-HDL cholesterol less than or equal to 2.6 mmol/l)	Q2 25/26	46.0%			45.6%			46.7%									50.0%	48.2%	48.93%	30/42	
	Smoking at Time of Delivery V2	Q2 25/26	5.9%			5.4%			4.8%								-	6.0%	4.9%	4.30%	28/42	
	Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems.(Aged 15+) ~	Feb-26	13.4%				14.0%	14.0%	14.0%	13.9%	13.8%	16.4%	16.3%	16.3%	16.2%	12.0%	12.0%	-	12.7%^		-	
Continuing Healthcare	Standard Referrals completed within 28 days	Q3 25/26	76%			71.70%			70.40%			63.90%					80.0%	>80%	78.0%	77.0%	34/42	
	Number eligible for Fast Track CHC per 50,000 population (snapshot at end of quarter)	Q3 25/26	27.04			23.78			23.85			27.19					18.00		21.33	16.22	40/42	
	Number eligible for standard CHC per 50,000 population (snapshot at end of quarter)	Q3 25/26	54.67			54.27			53.8			52.71					34.00		44.74	33.25	40/42	
Maternity	HIE (Hypoxic ischemic encephalopathy) grade 2 or 3 per 1,000 live births (>=37 weeks)	Q3 25/26	0.5			0.7			0.7			0.5					2.5	2.5	0.8			
	Still birth per 1,000 (rolling 12 months) (GP Reg MSDS)	Nov-25	2.54	2.49	2.41	2.43	2.49	2.44	2.54	2.56	2.60	2.65					-	2.6*	-	3.8	-	
Quality & Safety	Healthcare Acquired Infections: Clostridium Difficile - Place aggregation (All cases)	12 months to Dec 25	1210	1191	1155	1143	1133	1134	1129	1108	1090	1079	1049			843		2950	17277			
	Healthcare Acquired Infections: E.Coli Place aggregation (All cases)	12 months to Dec 25	2333	2330	2330	2326	2330	2297	2325	2334	2320	2346	2353			2001		5928	44814			
	Summary Hospital-level Mortality Rate (SHML) - Deaths associated with hospitalisation #	Sep-25	0.988	0.986	0.989	0.996	0.989	0.989	1.000	1.005						0.887 to 1.127 *		-	1.000		-	
	Never Events	Feb-26	1	2	0	5	3	2	0	3	1	2	3	5	1	0	0	-	-	-	-	
Workforce / HR (ICS total)	Staff in post	Jan-26	74,450	74,600	74,524	74,471	74,458	74,346	74,372	74,426	74,646	74,572	74,337	74,281		73,161	-					
	Bank	Jan-26	5,289	5,459	5,216	4,852	4,566	4,782	4,830	4,762	4,616	4,600	4,278	4,545		4,162	-					
	Agency	Jan-26	775	749	638	620	602	555	513	490	474	420	408	416		609.4	-					
	Turnover	Dec-25		10.4%	10.1%	10.0%	9.9%	9.8%	9.7%	9.7%	9.5%	9.5%	9.7%			11.3%	-					
	Sickness##	Dec-25	5.7%	6.1%	6.1%	6.1%	6.1%	6.1%	6.2%	6.2%	6.2%	6.3%	6.3%			5.8%	-					
Note/s	^ RAG rating based on 12 month comparison (Red = Higher, Green = Lower) # Banding changed Aug 23 to reflect SOF bandings for providers. Green = no providers higher than expected, Amber = 1-2 providers higher than expected, Red = more than 2 providers higher than expected ~ New methodology from June, data now reported in line with CIPHA ## latest rank, region and national values are one month behind latest data * Original NHS target was to halve the 2010 stillbirth rate of 5.1 per 1,000 by 2025. replaced with a reduction to 2.3 per 1,000 by 2030																					

## 2. ICB Aggregate Financial Position

### ICB Overall Financial Position:

Category	Metric	Latest period	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Plan (£m)	Dir. Of Travel	FOT (£m) Plan	FOT (£m) Current	FOT (£m) Variance
Finance	Financial position £m (ICS) <b>ACTUAL</b>	Jan-26	-109.7	-89.7	-45.9	-	-37.4	-51.7	-78.4	-110.4	-124.8	-138.0	-159.0	-173.2	-200.4	-82	↘	0.0	-245.0	-245.0
	Financial position £ms (ICS) <b>VARIANCE</b>	Jan-26	-47.3	-33.2	-45.9	-	0.2	1.4	-17.3	-35.6	-42.6	-59.4	-76.7	-86.3	-118.4		↘			
	Efficiencies £ms (ICS) <b>ACTUAL</b>	Jan-26	321.3	362.7	417.1	-	61.0	98.1	147.8	180.7	226.1	264.3	312.4	364.5	420.4	434.7	↗	572.5	575.8	3.3
	Efficiencies £ms (ICS) <b>VARIANCE</b>	Jan-26	-23.4	-29.4	-22.8	-	-1.9	1.0	9.3	0.0	2.2	-9.6	-11.7	-11.0	-14.3		↘			
	Capital £ms (ICS) <b>ACTUAL</b>	Jan-26	204.1	241.0	327.0	-	-	-								-	-	239.0	239.0	0.0
	Capital £ms (ICS) <b>VARIANCE</b>		24.6	10.9	-16.7	-	-	-								-	-	N/A	N/A	

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

Category	Metric	Latest period	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Vs Target expenditure (Current)	Vs Target expenditure (Previous)	Dir. Of Travel
Finance	Mental Health Investment Standard met/not met (MHIS)	Jan-26	Yes	Yes	Yes	-	Yes	Yes	↔									
	BCF achievement (Places achieving expenditure target)	Jan-26	9/9	9/9	9/9	-	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	↔

### 3. Provider / Trust Aggregate Position

Category	Metric	Latest period	Providers																	Net OOA/ Other/ ICB	ICB*	
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts							
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP				
NHS SOF	Segment <sup>@</sup>	25/26 Q2	④	④	④	④	④	④	③	①	①	④	①	①	③	①	②	③				
	Segment movement from previous quarter	25/26 Q2	→	↘	↘	→	→	→	→	→	→	↘	→	→	→	→	→	↗				
Urgent care	4-hour A&E waiting time % waiting less than 4 hours	Feb-26	59.8%	47.3%	59.9%	71.8%	67.9%	72.2%	77.2%	87.6%		89.1%	-	-	-	-	-	-	-	71.6%		
	Mean Ambulance Handover time (ED and Non ED)	Feb-26	00:40:56	00:29:33	00:24:21	00:33:39	00:36:59	00:38:39	00:44:55	00:21:22											00:37:08	
	A&E 12 hour waits from arrival	Feb-26	25.5%	21.6%	17.9%	21.8%	25.1%	16.7%	20.7%	0.3%	-	0.0%	-	-	-	-	-	-	-	-	18.3%	
	Adult G&A bed occupancy	Feb-26	98.8%	99.5%	96.0%	95.1%	96.5%	96.7%	97.8%	-	86.6%	61.8%	90.1%	89.5%							96.2%	
	Percentage of beds occupied by patients no longer meeting the criteria to reside (NEW - rolling 7-day average last week of month)	Feb-26	21.4%	23.1%	19.8%	16.2%	26.4%	22.1%	21.8%												21.4%	
	Discharges - Average delay (exclude zero delay)	Jan-26	13.9	7.3	**	5.8	8.9	5.7	10.2	0.0	5.2	1.8	3.5	0.0							8.2	
	Percentage of patients discharged on discharge ready date	Jan-26	81.5%	80.7%	**	88.3%	83.2%	81.5%	84.9%	100.0%	98.0%	91.5%	97.4%	100.0%							84.8%	
Planned care	Total incomplete Referral to Treatment (RTT) pathways	Jan-26	29,823	19,788	37,395	46,478	33,246	63,111	72,747	16,535	5,052	13,458	965	13,091			52			-	346,862	
	The % of people waiting less than 18 weeks on the waiting list (RTT)	Jan-26	55.1%	50.1%	54.6%	59.2%	61.5%	55.5%	61.7%	62.0%	79.8%	48.9%	95.9%	64.1%			96.2%				58.8%	
	The % of people waiting more than 52 weeks on the waiting list (RTT)	Jan-26	3.6%	2.8%	2.1%	2.1%	2.6%	1.5%	2.0%	1.4%	0.6%	6.7%	0.0%	0.9%			0.0%				2.2%	
	Number of 52+ week RTT waits, of which children under 18 years.	Jan-26	81	39	50	132	64	35	89	238	0	3	0	0							731	
	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Jan-26	4	20	6	0	0	0	6	3	0	9	0	0			0				58	
	Patients waiting more than 6 weeks for a diagnostic test	Jan-26	20.7%	19.9%	8.6%	8.3%	3.0%	8.9%	12.4%	8.8%	4.0%	9.7%	3.1%	0.6%	1.5%	0.0%	-	-			10.7%	
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	Dec-25	76.4%	73.8%	71.2%	70.0%	67.8%	72.3%	80.3%	100.0%	77.1%	51.9%	85.7%	100.0%	71.4%						74.6%	
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Dec-25	96.5%	98.5%	85.4%	89.5%	82.5%	90.2%	94.5%	100.0%	98.0%	93.2%	99.8%	100.0%	62.1%		m	mmmm			-	95.3%
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitely Excluded	Dec-25	80.3%	78.3%	77.5%	69.9%	76.4%	75.2%	77.0%	100.0%	55.6%	63.1%	92.3%	100.0%	65.2%						-	75.3%
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028 (calendar YTD)	Oct-25	58.8%	65.4%	61.8%	59.6%	50.2%	59.1%	57.1%	40.0%	55.7%	74.8%	75.7%	-	100.0%	-						59.4%
Note/s	<p>* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6, 7 and 8 for the ICB's latest position on the above metrics</p> <p>** Indicates that provider did not meet to DQ criteria and is excluded from the analysis □</p> <p>@ NHS SOF Segments - Highest = 1 (Consistently high performing), 2 (Requires some improvement or support), 3 (Experiencing significant challenges and requires more intensive support), 4 (Mandated intensive support due to serious problems or risks to care quality)</p> <p># - Numbers suppressed due to small numbers</p>																					

### 3. Provider / Trust Aggregate Position

Category	Metric	Latest period	Providers																	
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts				Net OOA/ Other/ ICB	ICB*
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP		
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Nov-25	82.0%	88.0%	86%	Community Service Providers only									96.0%	84.0%	80.0%	70%	79%	85.0%
	Virtual Wards Utilisation ~	Jan-25	100.0%	100.0%	0.0%	82.0%	75.0%	69.8%	100.0%	100.0%									87.3%	
	Community Services Waiting List (Adults)	Dec-25	0	3,881	6,033		-	-	253	0	107	-	-	-	3,699	5,473	18,199	5,473	10557	53,675
	Community services Waiting List (CYP)	Dec-25	1,442	577	3,044		-	-	616	4,667	0	-	-	-	5,144	332	890	332	1588	18,632
	Community Services – Adults waiting over 52 weeks	Dec-25	0	5	0		-	-	0	0	0	-	-	-	106	0	0	0	108	219
Mental Health	Referrals on the Early Intervention in Psychosis (EIP) pathway seen in 2 weeks	Dec-25				Mental Health service providers only									71.0%	75.0%	-	72%		
	CYP Eating Disorders Routine	Dec-25							90%								86.0%	95.0%		91.0%
	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact	Dec-25				1695			5125					1695		9040	8595	10260	36,410	
	Number of people accessing specialist Community PMH and MMHS services	Dec-25														2410	1300		3665	
	Talking Therapies completing a course of treatment - % of LTP trajectory	Dec-25	Just number available / no target																100.0%	
	Talking Therapies Reliable Recovery	Dec-25																47.0%		47.0%
	Talking Therapies Reliable Improvement	Dec-25																66.0%		66.0%
Learning Disabilities	Inpatients with a learning disability and/or autism (rounded to nearest 5)	Jan-26							#							50	25		70	
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6, 7 and 8 for the ICB's latest position on the above metrics # Value suppressed due to small numbers □ ~ NHSE published and MWL local BIP data are different, NHSE published MWL data includes 20 paediatric hospital at home beds which is not included in local BIP published data □																			

### 3. Provider / Trust Aggregate Position

Category	Metric	Latest period	Providers																	
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts				Net OOA/ Other/ ICB	ICB/ICS *
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP		
Maternity	HIE (Hypoxic ischemic encephalopathy) grade 2 or 3 per 1,000 live births (>=37 weeks)	25/26 Q3	0.0	0.0	0.0	1.5	1.6		0.0			0.0								0.5
	Still birth per 1,000 (rolling 12 months)	Nov-25	3.88	0.84	3.33	4.66	3.31	-	2.56	-	-	3.71	-	-						2.65
Quality & Safety	Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation (Healthcare Associated)	12 months to Dec 25	68	22	39	126	77	170	115	18	5	2	19	14						675
	Healthcare Acquired Infections: E.Coli (Healthcare associated)	12 months to Dec 25	55	27	52	95	77	271	155	12	7	7	32	12						802
	Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation** #	Sep-25	0.8889	1.2440	1.0824	1.0352	1.0190	0.9643	0.9966											1.005
	Never Events (rolling 12 month total)	12 Months to Feb 26	3	1	3	4	4	1	6	3	1	0	0	0	0	0	0	0	1	0
Workforce / HR (Trust Figures)	Staff in post	Jan-26	4,481	2,436	5,158	5,880	4,268	14,090	9,617	4,181	1,912	1,738	1,877	1,523	1,299	1,444	10,481	3,896	-	74,281
	Bank	Jan-26	325	198	414	347	388	930	766	88	63	74	13	70	27	43	632	169	-	4,545
	Agency	Jan-26	15	28	81	33	41	98	43	3	3	6	5	6	1	0	35	18	-	416
	Turnover	Dec-25	10.5%	10.8%	9.1%	9.8%	9.2%	8.5%	8.4%	9.8%	8.3%	10.6%	9.8%	11.7%	11.5%	11.9%	10.2%	9.2%	-	9.7%
	Sickness	Dec-25	5.5%	5.2%	5.5%	5.9%	6.1%	6.1%	6.5%	6.1%	4.9%	6.2%	5.1%	5.8%	7.3%	6.8%	7.7%	6.6%	-	6.3%
Finance	Overall Financial position - YTD Surplus / (Deficit) (£m) (including deficit support funding)	Jan-26	-26.57	-15.77	-28.36	-27.96	-30.25	-59.65	-38.28	1.20	7.37	-22.66	0.23	5.69	-3.48	4.25	9.01	1.05	23.70	-200.47
	Overall Financial position - YTD Surplus / (Deficit) (£m) (excluding deficit support funding)	Jan-26	-31.48	-18.35	-34.12	-32.19	-34.83	-70.77	-45.84	1.20	7.37	-26.49	0.23	5.69	-3.48	4.25	9.01	1.05	23.70	-245.04
	Overall Financial position - YTD Variance from plan (£m) (including deficit support funding)	Jan-26	0.60	0.00	0.47	-13.39	-0.50	-4.85	10.34	-0.18	0.00	0.03	0.01	0.04	-0.06	4.38	3.61	3.37	-18.24	-14.37
	Efficiencies - YTD Variance from plan (£m)	Jan-26	-9.06	0.00	0.16	-0.00	0.02	-3.35	2.00	0.01	-0.59	1.34	0.19	-0.00	0.02	-0.19	-0.96	0.45	-4.24	-14.21
	Capital - YTD Variance from plan £m	Jan-26	-0.67	1.65	4.53	0.98	2.02	3.83	3.67	-1.04	3.35	-0.51	-2.13	2.27	-0.88	-0.20	4.28	1.13	0.00	22.28
Note/s	<p>* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6, 7 and 8 for the ICB's latest position on the above metrics</p> <p>** The SHMI banding gives an indication for each non-specialist trust on whether the observed number of deaths in hospital, or within 30 days of discharge from hospital, was as expected when compared to the national baseline, as the UCL and LCL vary from trusts to trust. This "banding" is different to the "rate" used for the ICB on slide 5, therefore a comparison cannot be drawn between the two.</p> <p># Banding changed Aug 23 to reflect SOF rating by NHSE. 'As expected' rating is RAG rated Green, 'Higher than expected' is RAG rated Red.</p>																			

## 4. Place Aggregate Position

Category	Metric	Latest period	Sub ICB Place									ICB *	Local Trajectory	National Target	
			Cheshire & Wirral				Merseyside								
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton				
			East **	West **							South Sefton				S/port & Formby
Urgent Care	4-hour A&E waiting time % waiting less than 4 hours	Feb-26	55.2%	59.8%	29.5%#	57.1%	73.9%	72.0%	77.9%	72.1%	66.4%	71.6%	78.1%	78% by Year end	
	Ambulance category 2 mean response time	Dec-25	00:38:38		00:45:33	00:46:14	00:45:07	00:48:49	00:43:16	00:48:32	00:46:42	00:45:25		00:30:00	
	A&E 12 hour waits from arrival	Jan-26	19.6%		23.5%	25.4%	13.3%	24.2%	16.3%	26.5%	18.8%	18.7%	15.8%	-	
	Discharges - Average delay (exclude zero delay)	Jan-26	7.9	11.8	5.4	8.6	6.4	12.7	8.4	10.2	6.0	8.2	8.9		
	Percentage of patients discharged on discharge ready date	Jan-26	85.4%	84.8%	88.5%	84.7%	82.8%	87.6%	85.4%	85.7%	80.3%	84.8%	84%		
Planned Care	Total incomplete Referral to Treatment (RTT) pathways	Jan-26	108,006		50,843	27,794	54,185	27,543	22,380	20,120	35,991	346,862	339,165	-	
	The % of people waiting less than 18 weeks on the waiting list (RTT)	Jan-26	56.3%		60.0%	63.4%	56.6%	63.4%	59.5%	60.4%	56.9%	62.8%	58.8%	61.6%	
	The % of people waiting more than 52 weeks on the waiting list (RTT)	Jan-26	2.5%		2.0%	2.3%	2.2%	1.8%	2.2%	2.5%	1.8%	2.2%	1.4%		
	Patients waiting more than 6 weeks for a diagnostic test	Jan-26	15.3%		6.6%	3.6%	8.1%	7.0%	7.1%	6.6%	14.2%	10.2%	5.0%	5%	
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Dec-25	72.1%	74.6%	73.1%	77.7%	71.0%	84.8%	84.3%	66.7%	71.2%	74.6%	74.7%	85.0%	
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Dec-25	90.7%	91.7%	95.5%	92.4%	95.4%	97.5%	98.9%	93.9%	94.2%	95.3%	96.0%	96.0%	
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Dec-25	77.8%	79.3%	69.9%	71.8%	74.1%	79.4%	79.9%	79.7%	73.7%	75.3%	79.2%	77% by Year end	
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028 (calendar YTD)	Oct 25 YTD	60.9%		60.7%	57.3%	58.8%	57.7%	58.8%	54.5%	57.5%	60.7%	59.4%	75% by 2028	
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Dec-25	87.0%	77.0%	84.0%	98.0%	78.0%	81.0%	91.0%	94.0%	80.0%	85.0%	70.0%	70.0%	
	Virtual Wards Utilisation Number only	Jan-25	73	88	46	24	79	57	11	17	17	411			
	Community Services Waiting List (Adults) - data only available at ICB/Provider level											53,675			
	Community services Waiting List (CYP) - data only available at ICB/Provider level											18,632			
	Community Services – Adults waiting over 52 weeks - data only available at ICB/Provider level											219			
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6, 7 and 8 for the ICB's latest position on the above metrics ** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT. # Wirral A&E figure affected by missing data submissions														

## 4. Place Aggregate Position

Category	Metric	Latest period	Sub ICB Place									ICB *	Local Trajectory	National Target	
			Cheshire & Wirral				Merseyside								
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton				
			East **	West **							South Sefton				S/port & Formby
Mental Health	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Nov-25	76.0%		69.0%	100.0%	64.0%	82.0%	71.0%	86.0%	86.0%	*	72.0%	60.0%	60.0%
	People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months	To Dec 2025	51.0%		55.0%	59.0%	51.0%	52.0%	55.0%	68.0%	49.0%	66.0%	54.0%	-	60.0%
	Dementia Diagnosis Rate	Jan-26	68.3%		68.0%	72.1%	69.3%	66.9%	66.9%	66.8%	67.40%		68.3%	66.7%	66.7%
	CYP Eating Disorders Routine	Nov-25	98.0%		95.0%	100.0%	87.0%	92.0%	93.0%	100.0%	70.0%	93.0%	91.0%	95.0%	95.0%
	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact	Nov-25	6335		4740	3865	8980	3985	2905	1690	2480	1640	36410	37246	-
	Number of people accessing specialist Community PMH and MMHS services	Nov-25	1015		400	310	720	305	295	195	270	150	3665	3420	-
	Talking Therapies 1st to 2nd Treatment >90 days	Nov-25	13%		3%	32%	3%	*	18%	28%	41%	28%	13%		<=10%
	Talking Therapies completing a course of treatment	Nov-25	7265		2860	1805	4960	2145	1420	840	1345	975	100.0%	100.0%	100.0%
	Talking Therapies Reliable Recovery	Nov-25	50.0%		42%	51.0%	47.0%	49.0%	45.0%	49.0%	34.0%	49.0%	47.0%	48.0%	48.0%
	Talking Therapies Reliable Improvement	Nov-25	70.0%		56.0%	71.0%	64.0%	68.0%	62.0%	71.0%	60.0%	71.0%	66.0%	67.0%	67.0%
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Dec-25	20		5	5	15	5	5	5	10		70	46	-
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Dec 25 YTD	51.5%		51.0%	44.5%	54.7%	49.4%	63.7%	51.6%	56.3%		52.8%	49.1%	75% by Year end
Primary Care	Appointments in General Practice & Primary Care networks @	Dec-25	381,138		213,983	114,911	257,135	83,797	82,875	59,413	133,613		1,326,865	1,203,796	
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care. (rolling 12 months)	Nov-25	6.23%	7.43%	9.35%	6.28%	7.52%	6.33%	6.75%	6.59%	7.95%		7.34%	10.0%	10.0%
	Total volume of antibiotic prescribing in primary care	Nov-25	0.77	0.85	1.01	0.81	0.91	1.08	1.10	0.95	0.94		0.91	0.871	0.871
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6,7 and 8 for the ICB's latest position on the above metrics ** Supressed due to small numbers @ RAG based on last year postion, Green for greater than last year														

## 4. Place Aggregate Position

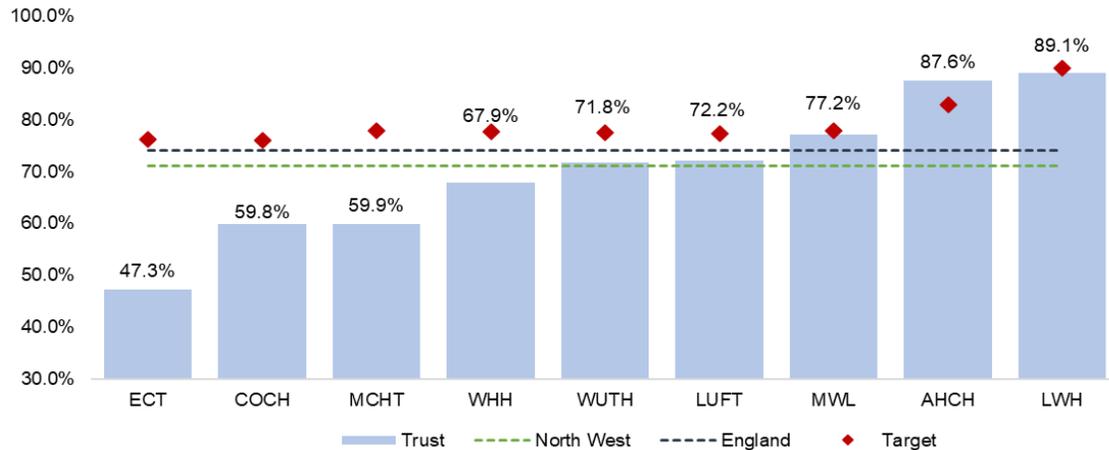
Category	Metric	Latest period	Sub ICB Place									ICB *	Local Trajectory	National Target	
			Cheshire & Wirral				Merseyside								
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton				
			East **	West **							South Sefton				S/port & Formby
Integrated care BCF metrics ***	Unplanned hospitalisation for chronic ambulatory care sensitive conditions Per 100,000 (New data source)	Oct-25	173.8	218.0	175.4	269.4	275.5	64.4	124.3	157.6	169.5	180.9	-	-	
	Percentage of people who are discharged from acute hospital to their usual place of residence (New data source)	Oct-25	77.5%	78.0%	85.7%	84.6%	84.4%	81.2%	87.1%	83.3%	80.6%	82.5%	-	-	
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 (New data source)	Sep-25	137.0	118.3	134.9	140.6	147.4	90.2	142.1	98.5	117.9	125.2	-	-	
Health Inequalities & Improvement	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q2 25/26	68.4%		66.0%	67.9%	67.7%	66.9%	67.2%	70.3%	64.8%	67.4%	77.0%	80.0%	
	CVD treated to cholesterol threshold: LDL-cholesterol less than or equal to 2.0 mmol/l or non-HDL cholesterol less than or equal to 2.6 mmol/l)	Q2 25/26	47.9%		49.5%	45.8%	46.2%	44.2%	47.4%	47.1%	43.1%	46.7%		50%	
	Smoking at Time of Delivery	Q2 25/26	3.5%		6.9%	2.2%	4.5%	6.5%	7.8%	10.0%	4.5%	4.8%		<6%	
	Smoking prevalence (aged 15+) - As reported on CIPHA from GP Systems	Feb-26	13.60%		16.20%	16.20%	18.70%	15.90%	18.60%	19.10%	16.70%	15.70%	16.2%	12%	12%
Continuing Healthcare	Standard Referrals completed within 28 days	Q3 25/26	57.0%		62.0%	83.0%	57.0%	98.0%	94.0%	80.0%	51.0%	66.0%	63.90%	>80%	>80%
	Number eligible for Fast Track CHC per 50,000 population (snapshot at end of quarter)	Q3 25/26	16.98		27.89	22.38	32.78	27.02	10.23	20.57	51.19	71.46	27.19	18	
	Number eligible for standard CHC per 50,000 population (snapshot at end of quarter)	Q3 25/26	62.1		64.0	41.5	46.9	36.7	32.5	43.4	58.1	64.0	52.71	34	
Quality & Safety	Still birth per 1,000 - (rolling 12 mths) (GP Reg MSDS)	Nov-25	1.86	2.17	5.16	2.28	3.74	2.61	0.00	0.00	2.43	2.65			
	Healthcare Acquired Infections: Clostridium Difficile - (All cases)	12 months to Dec 25	220		183	107	204	71	75	64	125	1049	843	-	
	Healthcare Acquired Infections: E.Coli - (All cases)	12 months to Dec 25	657		281	178	489	203	173	102	270	2353	2001		
Finance	Overall Financial position Variance (£m)	Jan-26	-9.3	-2.4	-5.0	-1.6	-11.4	-1.4	-5.5	-4.0	1.3	-11.0	0.0	0.0	
	Efficiencies (Variance)	Jan-26	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0.0	0.0	
	Mental Health Investment Standard met/not met (MHIS)	Jan-26	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Yes	Yes	
	BCF achievement (Places achieving expenditure target)	Jan-26	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	9/9	9/9	
Note/s	<p>* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6,7 and 8 for the ICB's latest position on the above metrics</p> <p>** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT.</p> <p>*** Local trajectories set by Place as part of their BCF submissions to NHSE, therefore RAG rating will vary for Places with lower/higher trajectories</p>														

## 5. Exception Report – Urgent Care

### A&E 4 hour waits from arrival

Latest ICB Performance (Feb-26) **71.6%** National Ranking **29/42**

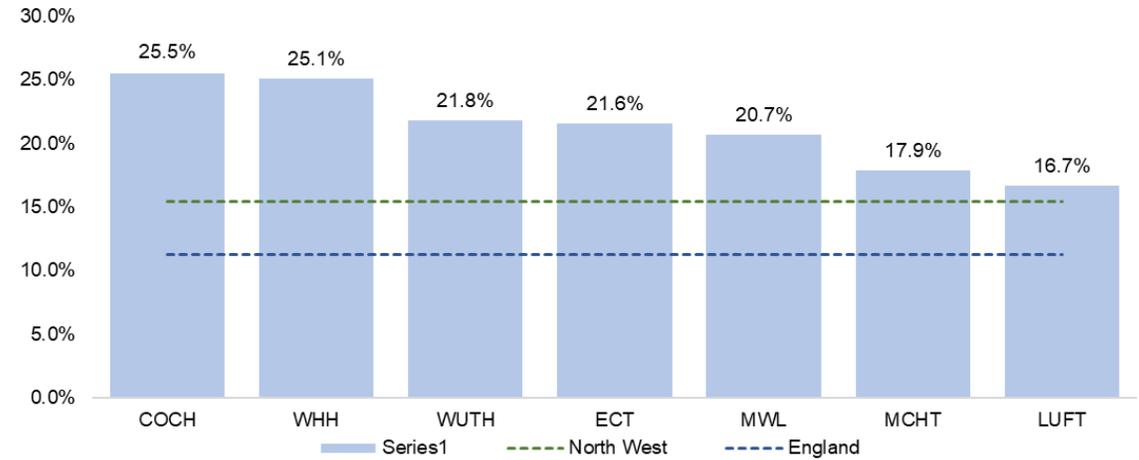
Provider Breakdown (Feb-26) **Improved**



### A&E 12 hour waits from arrival (Type 1 & 2)

Latest ICB Performance (Feb-26) **18.3%** National Ranking **40/42**

Provider Breakdown (Feb-26) **Improved**



#### Issue

- A&E 4-hour performance is 71.6%, with a national ranking of 29/42. Performance has improved for some providers, but is variable across sites, and remains below the 78% national ambition. A&E 12-hour waits are 18.3%, with a national ranking of 40/42. The system continues to experience high demand and occupancy levels, long length of stay, and inconsistent discharge performance, limiting the pace of recovery and constraining front-door flow

#### March Sprint Actions:

- Grip, Control and Leadership:** Senior clinical and operational leadership embedded on the floor (manager of the day, executive oversight, ward and ED presence) with cancellation of non-urgent activity and redeployment of focus to flow; Real-time performance tracking and validation, including breach chasing and hourly review
- Front Door Streaming & Early Decision Making:** Expansion of “See and Treat” and ENP models, including 7-day coverage with GP and primary care streaming at the front door, with extended hours where possible; Strengthened triage, RAT and streaming models, supported by senior decision makers and increased utilisation of UTC, SDEC and ambulatory pathways to reduce admission.
- Flow, LLOS and 12-hour Reduction:** Daily LLOS reviews and cohort management embedded, targeting >7 and >14 day patients. NCTR, Fit-to-Sit and criteria-led discharge scaled across sites; Twice-daily 12-hour reviews and targeted cohort clearance plans and dedicated flow roles (trackers, flow leads) to drive progression through the system
- Discharge and Back-Door Flow:** 7-day discharge model strengthened, including weekend decision-making and therapy input with discharge lounges, brokerage and community pathways maximised; Focused improvement on EDD quality, ward processes and discharge huddles
- Workforce and Capacity Optimisation:** Targeted workforce deployment to match demand peaks (e.g. twilight/overnight cover, additional registrars, ENPs, CSWs) and use of diagnostic support (ECG techs, phlebotomy) to reduce delays in decision-making
- Paediatric and Specialty Pathways:** Paediatric streaming and ambulatory models (PEACH, assessment units) to reduce ED pressure and Specialty in-reach and alternative pathways to avoid ED attendance and support faster decision-making

#### Delivery :

- The March Sprint represents a step-change in operational intensity, with clear alignment to Perfect Month principles and the UEC Improvement Plan. Sustained delivery of these actions through March is expected to: Improve 4-hour performance trajectory and reduce 12-hour waits

## 5. Exception Report – Urgent Care

### Ambulance category 2 mean response time

Latest ICB Performance (Feb-26)

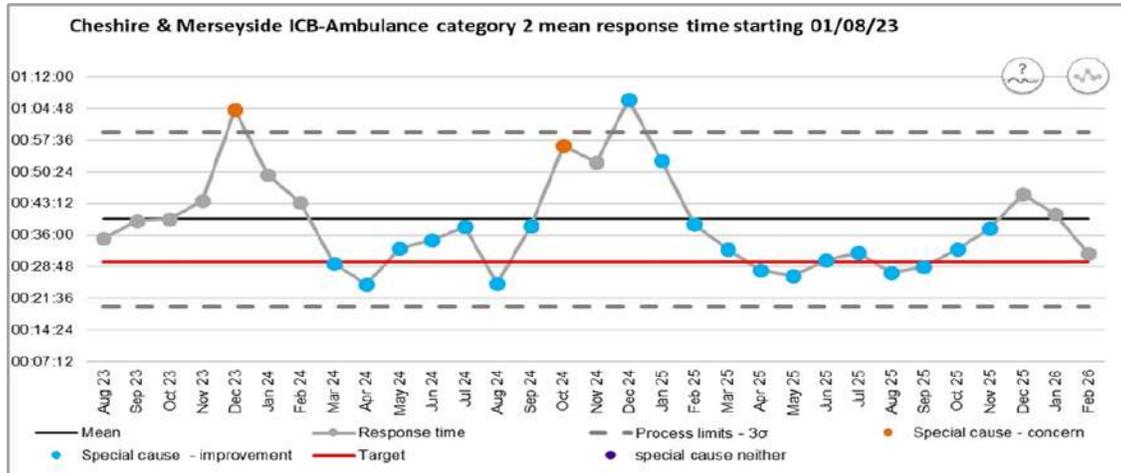
**00:31:46**

National Ranking

**28/42**

ICB Trend (Feb-26)

**Improved**



#### Issue

- Mean Cat 2 response time is 00:31:46, with a national ranking of 28/42.
- Performance has improved compared to previous months, with sustained recovery following winter pressures. However, performance remains above the 30-minute national standard.
- Key drivers of ongoing system pressures continue to be handover delays, hospital flow constraints, and sustained demand, impacting ambulance availability and turnaround.

#### Actions

- Sustained system-wide focus on handovers within 45 minutes, with tightened escalation for >30 and >45 minute breaches.
- Rapid offload protocols and site accountability strengthened across all acute providers.
- Real-time performance monitoring via SHREWD, aligned to OPEL escalation.
- Improved coordination between ambulance service, ED, and flow teams.
- Accelerated discharge and reduction in length of stay cohorts through March Sprint action.
- Focus on bed occupancy reduction and improved patient flow, enabling ambulance turnaround.

#### Delivery

- The improvement in Cat 2 response times reflects increased operational grip and impact of system actions, particularly around flow and escalation processes.
- Sustained improvement will depend on maintaining flow gains and reducing variation across sites, with handover performance remaining a critical enabler of Cat 2 recovery.

### Mean Ambulance Handover time (ED and Non ED)

Latest ICB Performance (Feb-26)

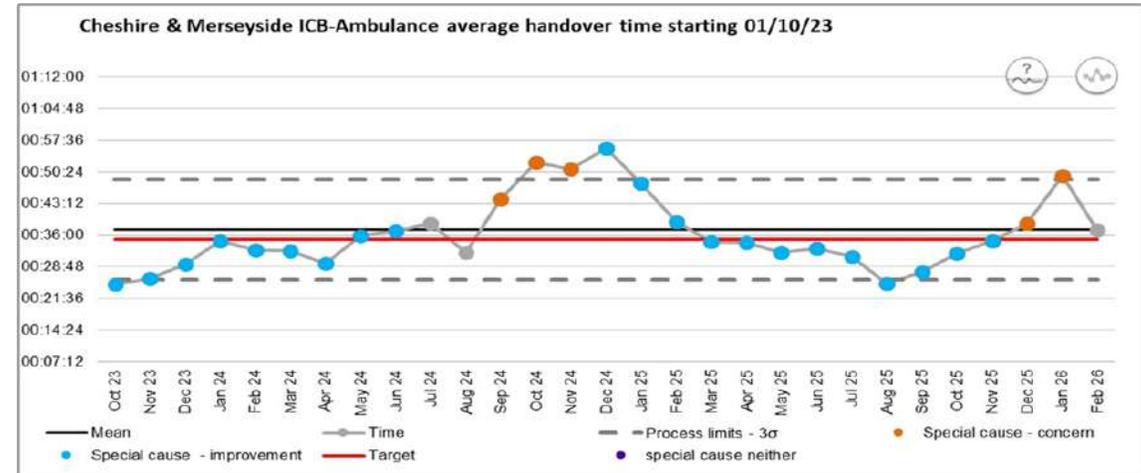
**00:37:08**

National Ranking

**29/42**

ICB Trend (Feb-26)

**Improved**



#### Issue

- Mean handover time is 00:37:08, with a national ranking of 29/42.
- This represents an improvement from previous winters, although performance remains above the 30-minute expectation.
- Variation persists across sites, with periods of escalation linked to ED congestion, bed occupancy, and acuity.

#### Actions

- NWS and system partners maintaining active stack management, with clinical prioritisation of long waits and peak demand management.
- Improved coordination between ambulance service, ED, and flow teams.
- Strengthened streaming, senior decision-making, and SDEC utilisation to reduce ED congestion.
- Dedicated flow roles and breach management processes to support timely ambulance offload.

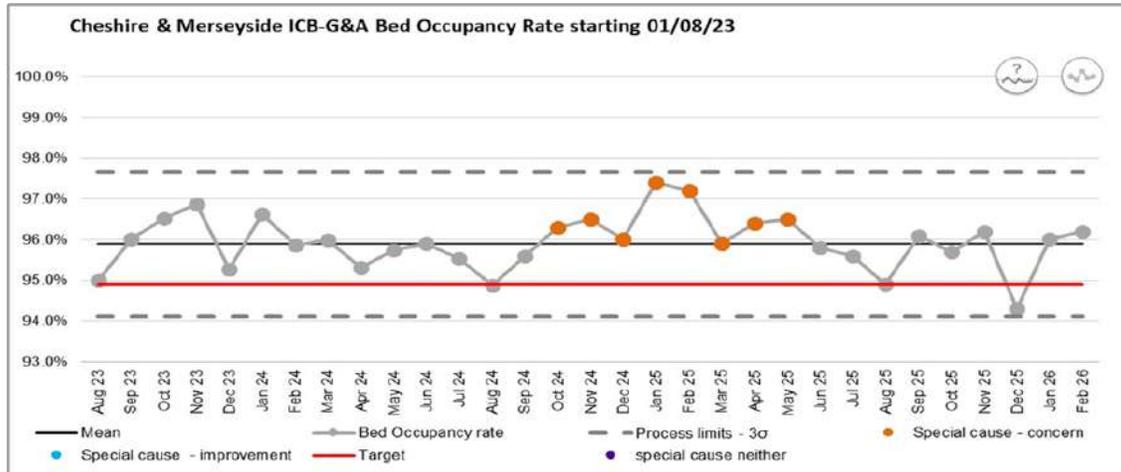
#### Delivery

- The improvement in ambulance handover time reflects increased operational grip and impact of system actions around flow and escalation processes. Sustained improvement will depend on maintaining flow gains and reducing variation across sites.

## 5. Exception Report – Urgent Care

### Adult G&A bed occupancy

Latest ICB Performance (Feb-26)	<b>96.2%</b>	National Ranking	<b>27/42</b>
ICB Trend (Feb-26)			<b>Deteriorated</b>



#### Issue

- Adult G&A bed occupancy is 96.2%, with a national ranking of 27/42, and has deteriorated.
- Occupancy remains materially above the optimal 92–93% threshold, limiting system resilience and constraining ED flow and ambulance handovers.
- Sustained pressure is driven by high acuity, delayed discharges, and variation in discharge productivity across sites.

#### Actions

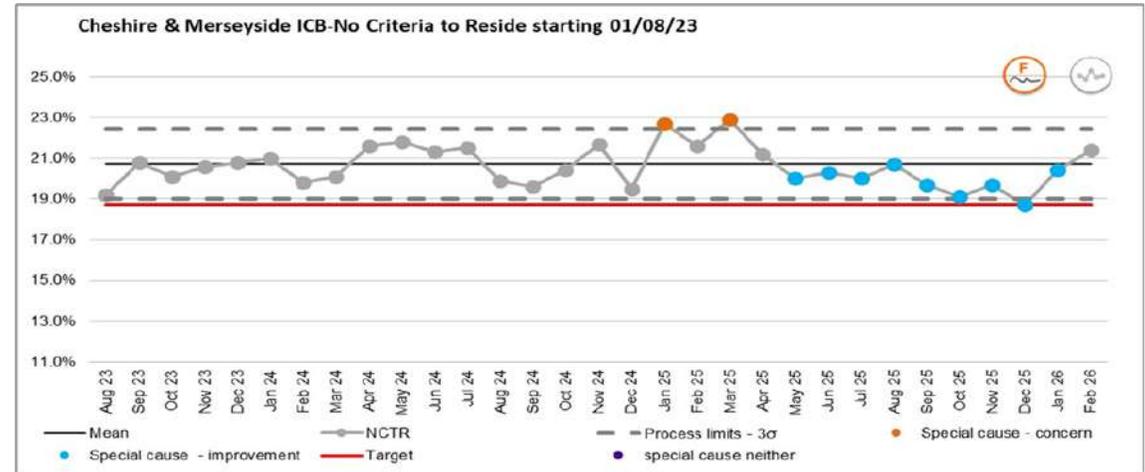
- March Sprint / Perfect Month actions focused on flow recovery, including:
  - MADE / RESET events targeting discharge acceleration and LOS reduction
  - Daily LLOS cohort reviews, focusing on >7 and >14 day patients
  - Board-level and executive oversight of discharge performance
- Strengthened pathway management, particularly:
  - Escalation of Pathway 1 and Pathway 3 capacity constraints
  - Improved alignment with community and intermediate care services
  - 7-day discharge model reinforced, including weekend decision-making and discharge lounge utilisation

#### Delivery

- Deterioration confirms discharge flow remains the primary constraint on system performance.
- The March Sprint is increasing operational grip, with daily SCC oversight and clear accountability.

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

Latest ICB Performance (Feb-26)	<b>21.4%</b>	National Ranking	<b>n/a</b>
ICB Trend (Feb-26)			<b>Deteriorated</b>



#### Issue

- NCTR is 21.4% and has deteriorated further, remaining well above the 12% system ambition.
- This reflects persistent delays for clinically optimised patients, indicating ongoing constraints in discharge pathways.
- Elevated NCTR is directly contributing to high bed occupancy and front-door congestion.

#### Actions

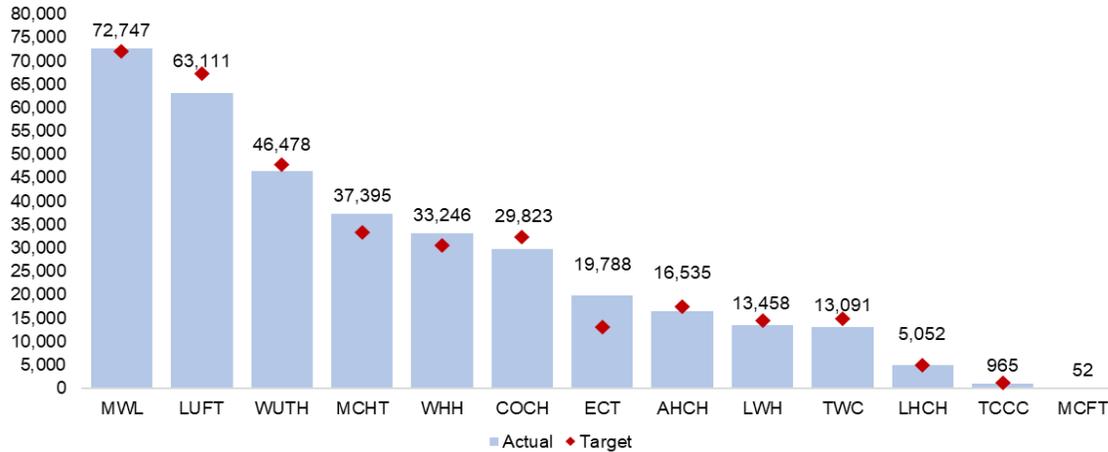
- Daily NCTR escalation calls, targeting high-volume delay categories and long-stay cohorts.
- SCC support to NCTR long stay reviews .
- Expansion of Trusted Assessment / Discharge to Assess models to accelerate discharge decisions.
- GIRFT supported reviews of long-stay patients and pathway conversion delays.
- Focused improvement on Care Transfer Hub performance, including brokerage and therapy timeliness

#### Delivery

- NCTR performance is monitored daily through SCC, with OPEL-aligned escalation and site-level accountability.
- A system-wide review of intermediate care capacity and utilisation is underway, aligned to new community bed guidance.
- Delivery is focused on reducing discharge delays, improving pathway flow, and unlocking bed capacity to support wider UEC recovery.

## 5. Exception Report – Planned Care

Total incomplete Referral to Treatment (RTT) pathways			
Latest ICB Performance (Jan-26)	346,862	National Ranking	n/a
Provider Breakdown (Jan-26)			Improved



#### Issue

- The total waiting list size in January was 341,889. This is 35,599 less than a revised trajectory of 377,487 (following revision of Sep, Oct & Nov trajectories requested by NHSE (not shown above)).
- There has been waiting list growth at Mid Cheshire and East Cheshire Hospitals as a result of implementation of their new Digital Clinical System. Data Quality issues account for approx. 60% of growth, with reduced levels of activity accounting for approx. 40% of growth, and targeted validation activities are ongoing at both Trusts to resolve data quality related issues.

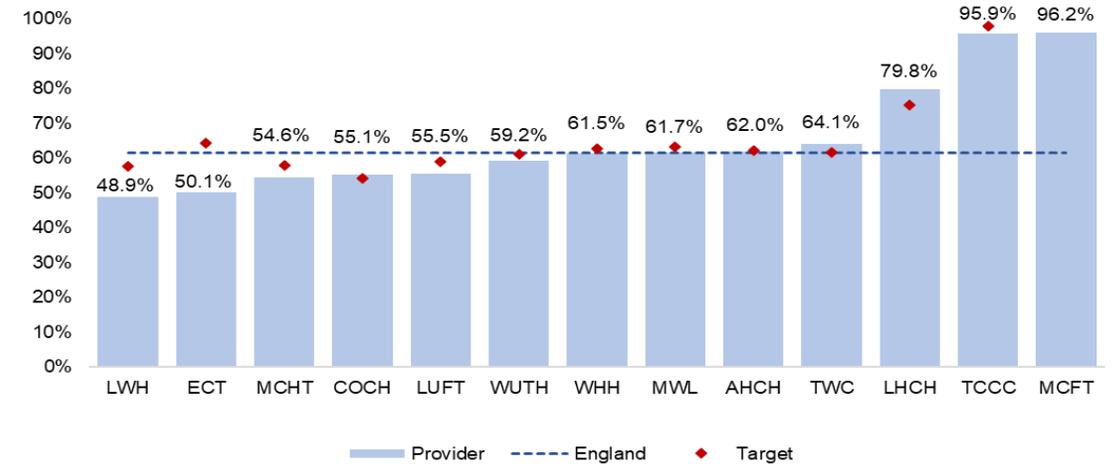
#### Action

- Recovery plans to reduce the total waiting list position are ongoing at Mid and East Cheshire Trusts inclusive of the mobilisation of additional validation capacity.
- The C&M Q4 Elective Recovery plan with additional NHSE funding to support increased clinical triage of patients waiting >27wks is underway across multiple specialties and is achieving between 20 to 30% removals.
- A System Capacity Management Process is being implemented to increase utilisation of elective hubs and inter-organisational support. Additional regional funding will be used to provide increased capacity across the system to help reduce long waiters and WL size.

#### Delivery

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

The % of people waiting less than 18 weeks on the waiting list			
Latest ICB Performance (Jan-26)	58.8%	National Ranking	32/42
Provider Breakdown (Jan-26)			Improved



#### Issue

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

#### Action

- 6 Trusts are currently in NHSE Tiering with improvement plans in place and regular oversight meetings. CMPC & ICB representatives attend and provide support where required.
- The CMPC Elective team hold two-weekly calls with all providers to review performance and to provide support for any escalated actions.
- All providers are participating in the national Q4 validation and additional activity sprints to help manage demand and improve performance.
- The funded Q4 clinical triage activities have been implemented to manage demand and increase capacity to improve performance for the year-end RTT position.
- The Q4 additional activity sprint is focused on additional activity to improve RTT performance by March 2026, of which, all C&M Trusts are participating with stretch targets agreed in the plan submissions.

#### Delivery

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

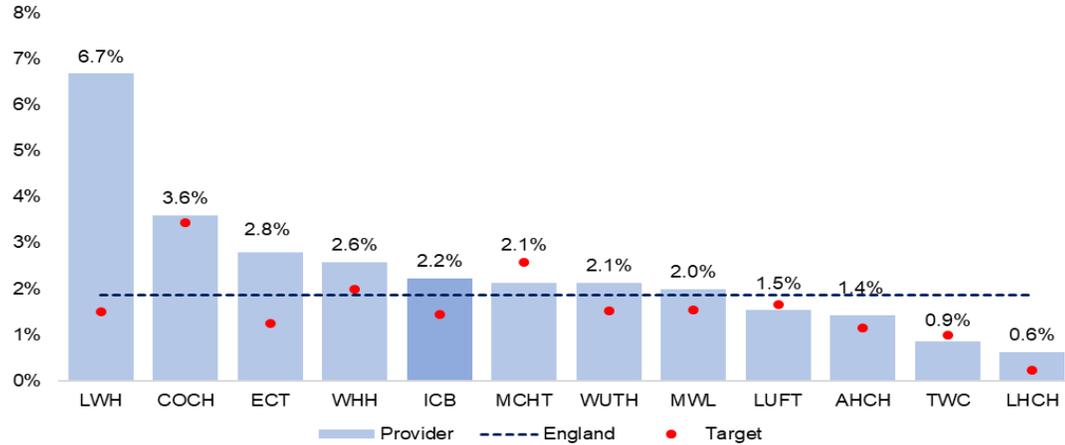
## 5. Exception Report – Planned Care

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

Latest ICB Performance (Jan-26)	<b>2.2%</b>	National Ranking	<b>34/42</b>
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Provider Breakdown (Jan-26)

**Improved**



#### Issue

- While the current performance is behind plan, performance has improved (1.9% as of 01<sup>st</sup> March 2026). In January 26, there were 8,456 patients waiting over 52 weeks.
- Liverpool Women's is furthest off plan (+3.7%) due to cessation of insourcing earlier in the year.
- Mid Cheshire & East Cheshire Trusts are deploying new trust-wide EPR systems, both providers are experiencing challenges due to DCS implementation.

#### Action

- 6 Trusts are currently in NHSE Tiering with associated improvement plans and regular oversight meetings. The CMPC Elective team hold two-weekly calls with all providers to review performance and to provide support for any escalated actions.
- The C&M Q4 Elective Recovery plan with additional NHSE funding to support increased clinical triage of patients waiting >27wks is underway across multiple specialties and is achieving between 20 to 30% removals.
- A System Capacity Management Process is being implemented to increase utilisation of elective hubs and inter-organisational support. Additional regional funding will be used to provide increased capacity across the system to help reduce long waiters and WL size.

#### Delivery

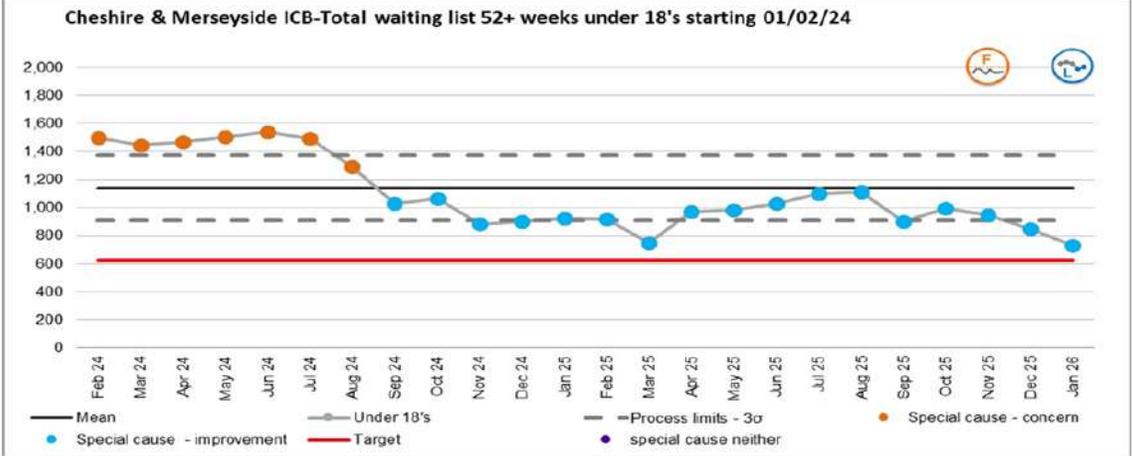
- Delivered via C&M Clinical Operational Group, monitored via CMPC COO Group & Delivery Board.

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

Latest ICB Performance (Jan-26)	<b>731</b>	National Ranking	<b>n/a</b>
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ICB Trend (Jan-26)

**Improved**



#### Issue

- Several organisations are off plan in relation to their 52 week-long waits position. In January 2026 there are 731 CYP patients waiting over 52 weeks (52wk performance for CYP is marginally better than for adults).

#### Action

- The elective reform team have bi-weekly meetings with all C&M providers to review their plan vs actual position, to ensure specific recovery actions are managed and overseen with system support in place when required.
- Managing long waits across some key specialties at system level continues to be challenged, with all providers reporting challenges within ENT and Dental pathways.
- Significant improvements in the current waiting position were delivered in FY 24/25 with a continued focus in 25/26, in comparison to the neighbouring systems in the North West.
- The Q4 Elective Recovery Plan described opposite is inclusive of CYP and will include specific actions for CYP long waiters in ENT and dental.

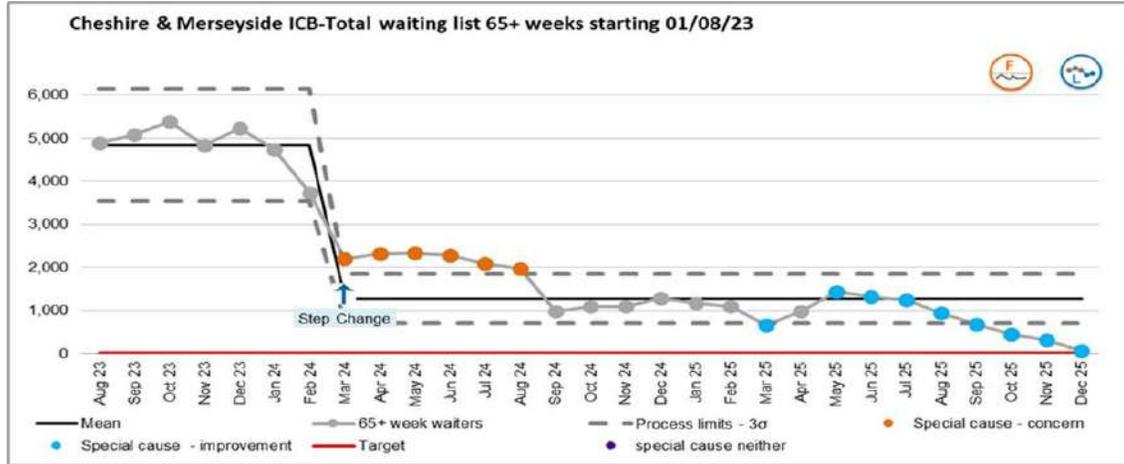
#### Delivery

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

## 5. Exception Report – Planned Care

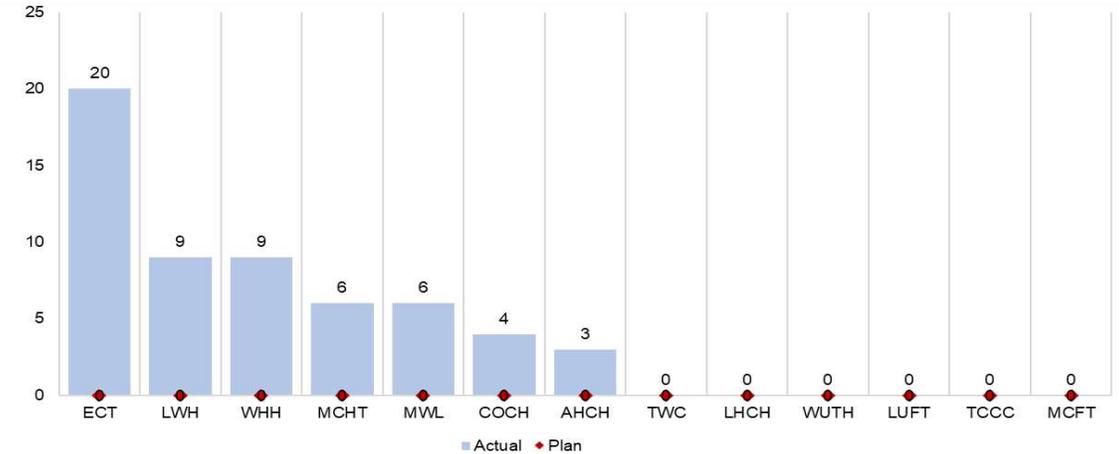
### ICB incomplete RTT pathways of 65 weeks or more

Latest ICB Performance (Jan-26)	58	National Ranking	n/a
ICB Trend (Jan-26)		Improved	



### Trust incomplete RTT pathways of 65 weeks or more

Latest ICB Performance (Jan-26)	58	National Ranking	n/a
Provider Breakdown (Jan-26)		Improved	



#### Issue

- There were 41 patients waiting 65wks+ as of January 26 month end, which is a significant improvement from the position reported over the previous months.
- The largest proportion is at East Cheshire (11), however, the position has started to reduce in the Trust now with lower numbers reported in February and expected in March,
- Data quality and accurate forecasting to underpin improvement work has been a challenge. Significant improvements have been made across all providers.

#### Action

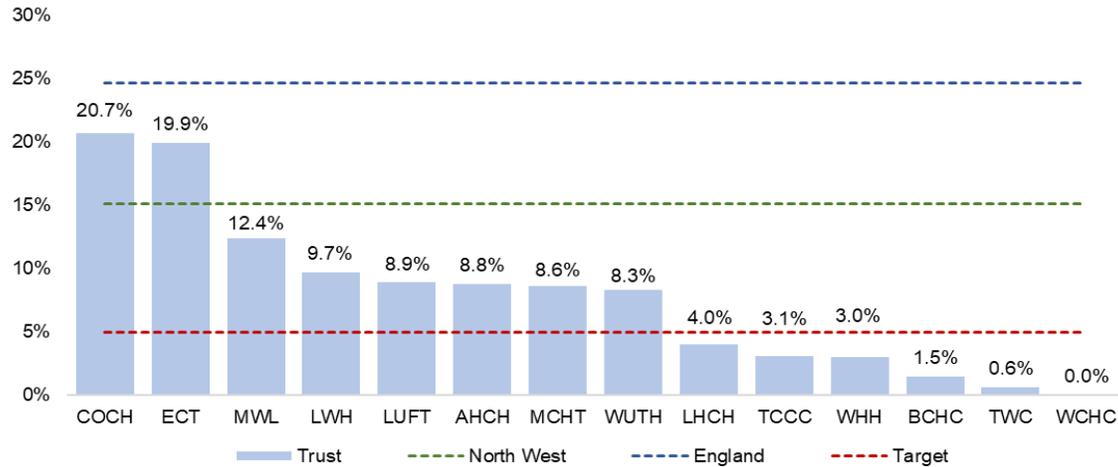
- Weekly Performance & Delivery meeting continue which all providers attend to update on their current position, escalate issues and request mutual aid. This has delivered significant improvements in 65wk performance during previous months.
- 6 Trusts are currently in NHSE Tiering with improvement plans in place and regular oversight meetings. CMPC & ICB representatives attend and provide support where required.
- The elective programme is working closely with providers to ensure that mutual aid and operational tactical measures are explored and expedited.
- CMPC continues to prioritise validation activity with current performance reporting at 12-weeks 64.93%, 26-weeks 74.37% (6 providers reporting above national ambition of 90%) and 52-weeks 91.79%, (with 8 providers reporting above the national ambition of 90%)
- The implementation of the C&M Q4 Elective Recovery Plan and additional capacity initiatives will support further improvements in 65wk performance and mitigate future risks for further 65wk breaches.
- 65-weeks breaches in C&M have been reduced from a position of 1,311 in July 2025 to 41 at the end of January 2026.

#### Delivery

- There is a continued focus on eradicating 65 week waits and to model the delivery of 52 and 18 weeks for future planning.
- This will be monitored via the CMPC COO Group and Delivery Board
- CMPC continues to report into region on current performance and plans for immediate recovery.
- 65-weeks is a key focus area in the weekly System Performance and Delivery meetings chaired by the programme Lead COO.

## 5. Exception Report – Diagnostics & Cancer

Patients waiting more than 6 weeks for a diagnostic test			
Latest ICB Performance (Jan-26)	10.7%	National Ranking	3/42
Provider Breakdown (Jan-26)			Deteriorated



#### Issue

- C&M remain in the top 3 ICBs nationally for diagnostic performance and continue to perform better than most ICBs in England.
- C&M ICB performance includes patients waiting for a test at both C&M and non-C&M Trusts. Each month, C&M provider performance continues to perform better than ICB performance (which includes non-C&M Trusts). C&M Provider performance is what we have influence and control over as a Diagnostic Programme.

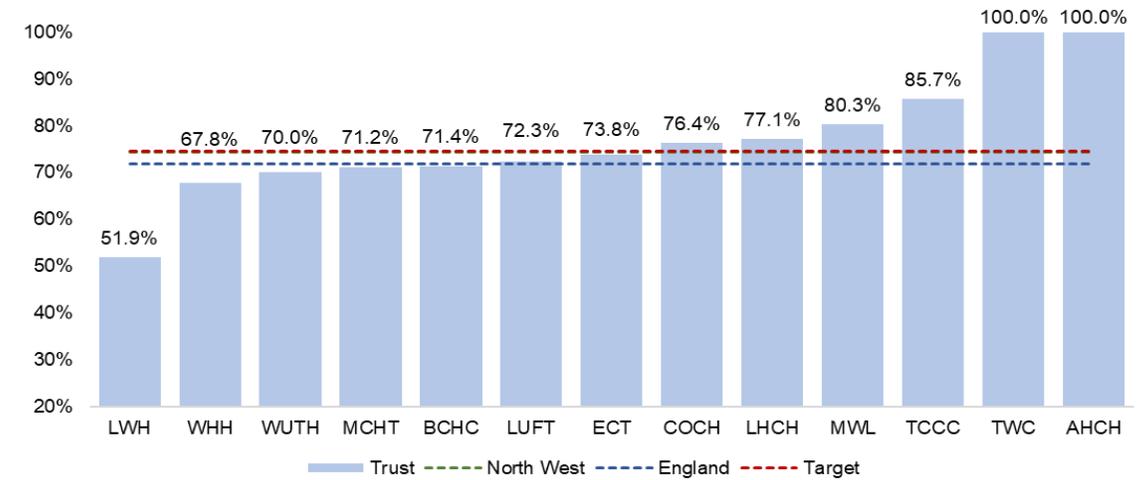
#### Action

- Mutual Aid Process – support continuously being provided by C&M Providers to support neighbouring Providers. Over 1500 tests delivered via this process YTD in 25/26 which is a 188% increase in comparison to the previous year.
- Expansion of Diagnostic Activity – Recent round of capital bid requests have been shortlisted and awaiting outcome from NHSE, several bids will increase diagnostic activity including potential for new CDC sites and expansion of existing CDC sites.

#### Delivery

- No national diagnostic performance target set by NHSE for 25/26. However, aiming to achieve 95% by the end of the financial year. C&M performance has increased for the sixth consecutive week in the WLMDs (weekly) data .

2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer			
Latest ICB Performance (Dec-25)	74.6%	National Ranking	14/42
Provider Breakdown (Dec-25)			Improved



#### Issue

- C&M not yet achieving the 85% 62-day combined standard required. This is 75% at the end of year point for 25/26. The figure of 74.6% is significantly ahead of England and represents good performance given the end of year ambition of 75%.

#### Action

- December performance is at trajectory. Capacity and demand exercises for 25/26 are addressing delays and short-term investment is being made by the Cancer Alliance in key areas however, this is limited due to reduced alliance funding in 2025/26.
- An operational improvement plan was submitted to NHSE as part of alliance assurance.
- Q4 additional funding secured via region deployed across C&M

#### Delivery

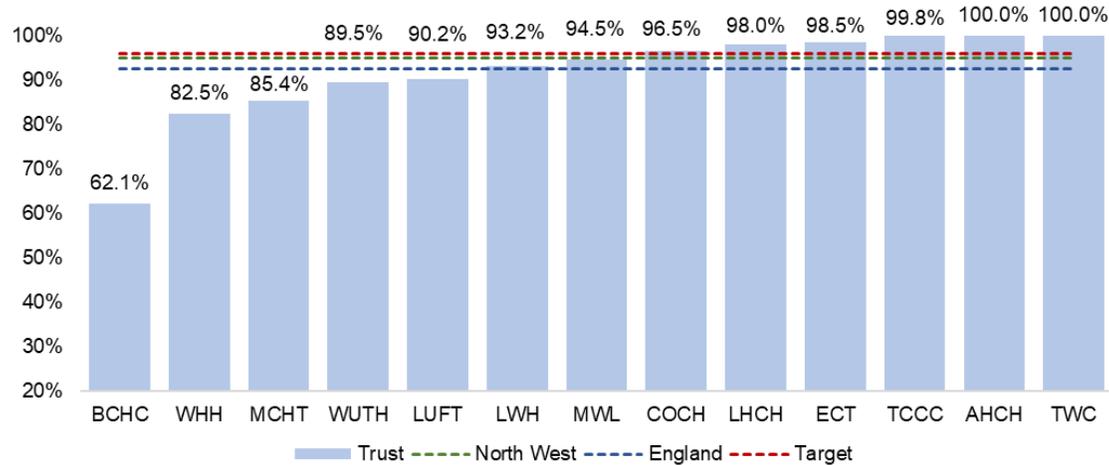
- C&M expects to meet the 75% and 85% ahead of England as a whole and expects to achieve the end of year trajectory position for 62-day performance.

## 5. Exception Report – Cancer

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

Latest ICB Performance (Dec-25) **95.3%** National Ranking **12/42**

Provider Breakdown (Dec-25) **Improved**



#### Issue

- C&M not yet achieving the 96% 31-day combined standard required. However, the figure of 95.3% is ahead of England and represents good performance in relative terms. 95.3% is above the MTP 26/27 planned end point and performance has been maintained from Oct-Dec.

#### Action

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

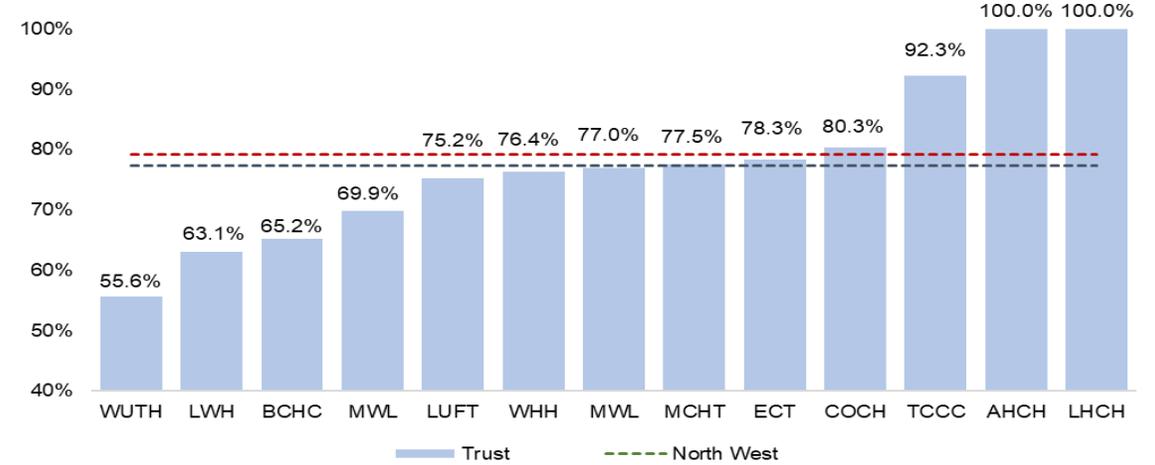
#### Delivery

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

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

Latest ICB Performance (Dec-25) **75.3%** National Ranking **30/42**

Provider Breakdown (Dec-25) **Improved**



#### Issue

- C&M Faster Diagnosis Standard (FDS) performance remains below the operational standard (77%, rising to 80% by March 26). This metric has improved again in December. Previous years indicate we should expect a January dip in line with England and then a significant recovery to meet end of year in Feb and March based on local intelligence.

#### Action

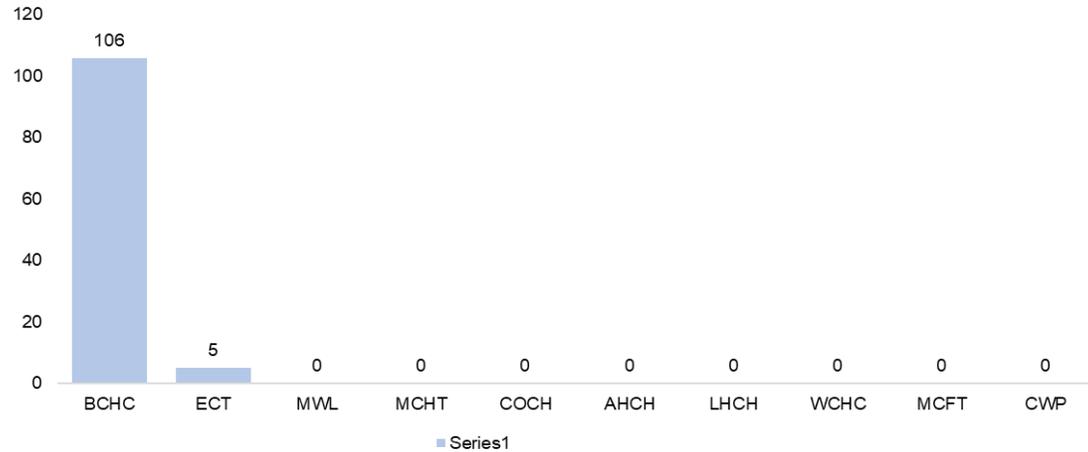
- CMCA has produced bespoke improvement trajectories for each provider which are linked to improvement plans managed via the CMCA performance forum.
- The Pathways Improvement Programme continues to work across the nationally mandated priority tumour sites, implementing 'in depth reviews' to assess underlying performance drivers for cancer pathways (LGI, Breast, Skin, Gynae, Urology).
- A range of cross-cutting initiatives are underway such as an MDT bank, CDC optimisation group and single-queue diagnostic work.
- Monthly performance forums maintain strong grip led by CMCA and Q4 additional funding is also in place for short-term activity increases to meet the end of year target.

#### Delivery

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

## 5. Exception Report – Community

Community Services – Adults waiting over 52 weeks			
Latest ICB Performance (Dec-25)	219 *	National Ranking	n/a
Provider breakdown (Dec-25)			



### Issue/Action

- **BCHC Dermatology:** A recovery plan is in place to ensure all first-appointment waiters are under 52 weeks by the end of March 2025. The team is progressing at pace with weekly reviews of the waiting list, appointment optimisation, and DNA management. Consultant Connect is supporting review and validation of patients over 40 weeks.
- **BCHC Podiatry (Halton & Warrington):**
- **Halton:** As of M9, 49 patients are waiting over 52 weeks. Numbers have already reduced through criteria changes, with further reductions expected as the revised eligibility criteria are applied to recent referrals.
- **Warrington:** As of December, 40 patients are waiting over 52 weeks. Recruitment to vacancies is complete, new starters taking up posts in January 26.

### Delivery

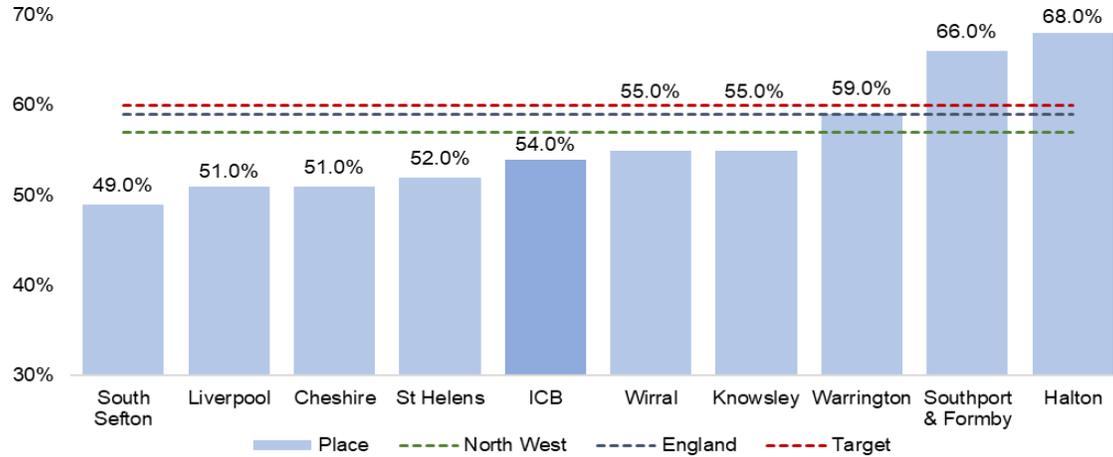
- Recovery plans are in place for both Warrington and Halton to ensure all patients over 52 weeks will be seen by the end of the financial year

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

## 5. Exception Report – Mental Health

### People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months

Latest ICB Performance (Q3-25/26)	<b>54.0%</b>	National Ranking	<b>33/42</b>
Place Breakdown (Q3-25/26)			<b>Deteriorated</b>



#### Issue

- ICB performance is below the minimum 60% target. National ambition is to work towards 75% of people with SMI receiving all 6 physical health checks.

#### Action

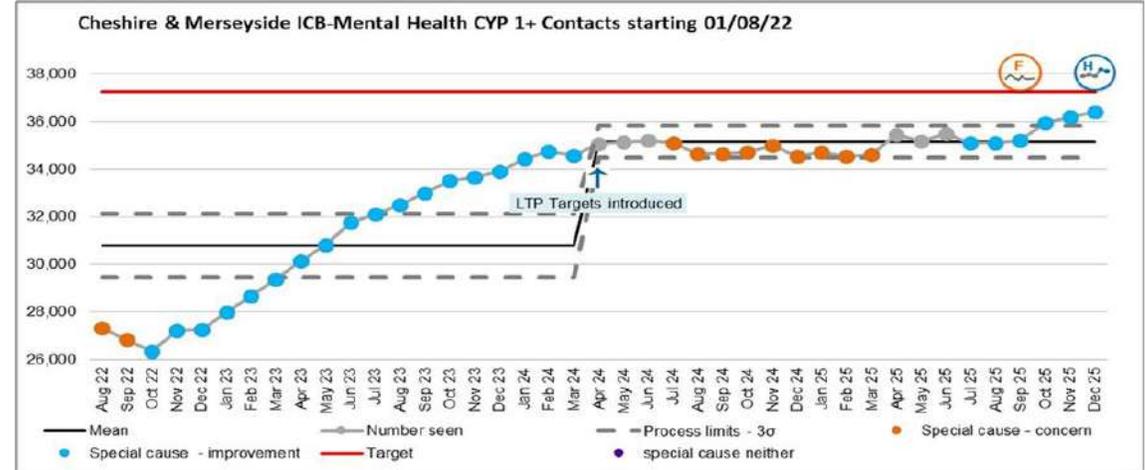
- Places to consider continuation of existing outreach schemes which promote and encourage uptake of physical health checks and note the risk of adverse impact if serving notice.
- Consideration given to how monitoring of physical health in SMI will be incorporated in business-as-usual processes to satisfy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

#### Delivery

- Only 1 place met the minimum 60% target this quarter compared with 6 out of 9 places in Q4 of 2024/25.
- Compared with the same quarter 3 position last year, there has been a 2% increase in the number of SMI patients receiving all 6 health checks
- Historic trends generally indicate below plan performance in the first 3 quarters of the year with significant numbers of health checks undertaken in quarter 4. Forecast out-turn is therefore expected to meet the national standard of 60%.

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

Latest ICB Performance (Dec-25)	<b>36,410</b>	National Ranking	<b>n/a</b>
ICB Trend (Dec-25)			<b>Improved</b>



#### Issue

- There has been a further 1% improvement in planned access rates since Nov 25, however rates remain circa 1,200 below target at 97% delivery of the LTP trajectory. Not all VCSE services are able to flow data to the national dataset so this activity is not captured in its totality, meaning the C&M position is understated.

#### Action

- Request made for “in-month access” report to be added to BIP as 12-month rolling activity can be misleading. Aim to identify in-month changes more quickly and address areas of concern.
- ICB place leads to develop a VCSE data improvement plan to address gaps in non-NHS funded activity, recognising digital and infrastructure variation across the sector. However, capacity to support VCSE onboarding limits progress.

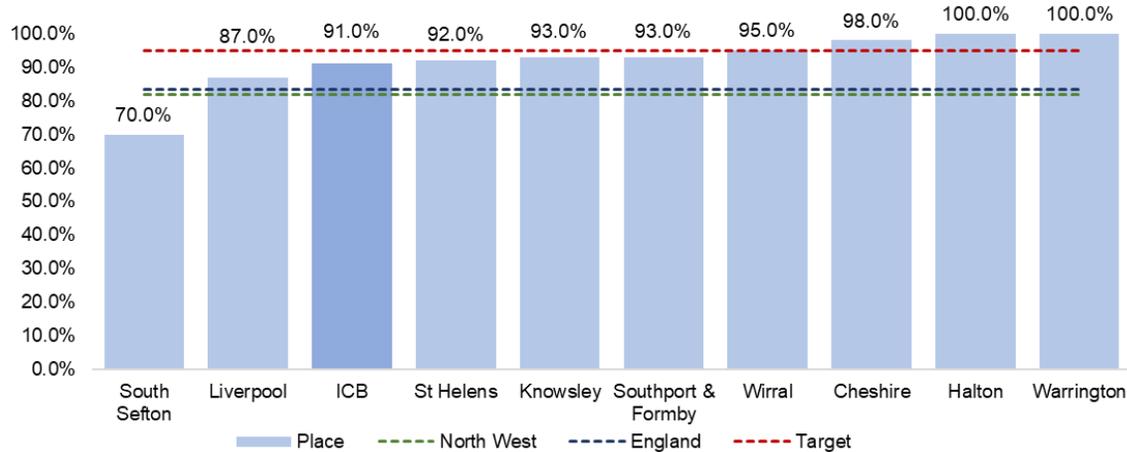
#### Delivery

- There has been an incremental increase in overall C&M access rates in recent months as some VCSFE providers are onboarded to MHSDS and starting to flow data nationally.
- Further incremental increase is anticipated in quarter 4 but may not be sufficient to achieve target
- The establishment of new MH Support Teams in Schools in 2026/27 will further contribute to improved access rates and achievement of national targets is expected by March 2027.

## 5. Exception Report – Mental Health

### CYP Eating Disorders Routine

Latest ICB Performance (Dec-25)	<b>91.0%</b>	National Ranking	<b>3/42</b>
Place Breakdown (Dec-25)			<b>Deteriorated</b>



#### Issue

- National data indicates a 1% deterioration in performance since Nov 25 and the ICB remains below the standard of 95%. Local data is being reviewed to confirm accuracy.
- Alder Hey have had specific internal challenges related to timely receipt of referrals, which has impacted on waiting times, and also experienced capacity gaps due to sickness. This has impacted on Liverpool and Sefton performance.

#### Action

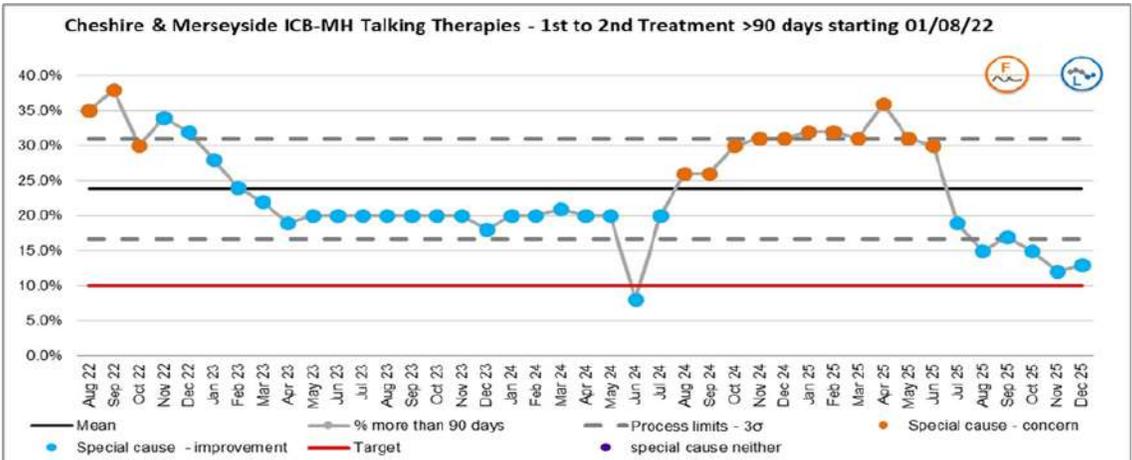
- MCFT have developed local 'live' reports to track the MHSDS data set as national reporting does not appear to be reflective of their local data.
- Alder Hey are reviewing demand and skill mix to ensure appropriate assessment and treatment capacity going forwards.

#### Delivery

- Alder Hey confirm achievement of 90% and report a risk that 95% may not be achieved by Mar 26.
- CWP nationally reported data indicates 95% of patients are seen within 4 weeks and likely to meet the standard at year end.
- Mersey Care nationally reported data indicates 86% of CYP are seen within 4 weeks. This is a 4% reduction compared with the previous month. National data is unlikely to reflect achievement of 95% by year end although local delivery of the standard is expected.

### Talking Therapies 1st to 2nd Treatment >90 days

Latest ICB Performance (Dec-25)	<b>13.0%</b>	National Ranking	<b>6/42</b>
ICB Trend (Dec-25)			<b>Deteriorated</b>



#### Issue

- The proportion of people who wait more than 90 days between 1<sup>st</sup> and 2<sup>nd</sup> treatment should not exceed 10%. Significant reductions have been reported in recent months, with nationally published data indicating delivery of 13%, however, this may not be accurate.
- Wirral Talking Therapy provider, Everyturn MH, had a system migration in Jul 2025 and no data was submitted for 2 months. This will impact on the overall ICB position for ~12 months. Everyturn reported 32% of patients waiting >90 days in their Jun 25 submission and 3% in Dec 25.

#### Action

- Wirral data submissions have recommenced, however, waiting times require validation.
- Group or e-therapy first model being implemented – with staggered starts to groups to create less wait time for a course to start.
- Review of waiting lists and reduction in waiting times.
- Greater provider engagement with data to support improvement within services.

#### Delivery

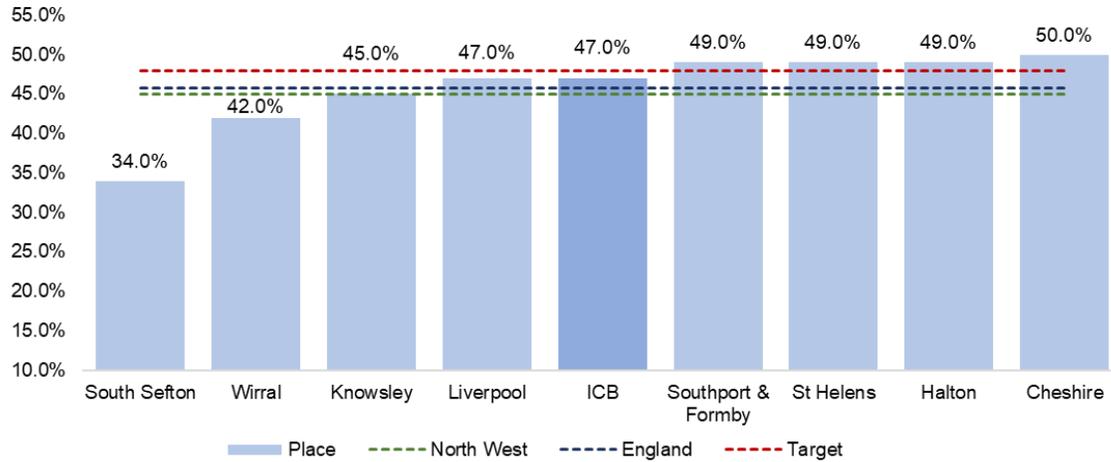
- The percentage of people reported as waiting >90 days between treatment varies between 36% and 3% across Cheshire and Merseyside's 5 local providers.
- At place level variances are between 32% in Warrington & 36% Sefton (both services provided by MHM) and 3% in Wirral. Shared learning via C&M TT Steering Group underway to address variation.

## 5. Exception Report – Mental Health

### Talking Therapies Reliable Recovery

Latest ICB Performance (Dec-25) **47.0%** National Ranking **25/42**

Place breakdown (Dec-25) **No change**



#### Issue

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

#### Action

- Shared learning via C&M Talking Therapies Steering Group underway to address variation
- Wirral data submissions have resumed following system migration.
- Planning to rebalance the ratio of low intensity to high intensity therapists to improve reliable recovery and reliable improvement rates, aligned with national guidance.
- Increased workforce will facilitate increased session numbers to improve reliable recovery and work towards national ambition of 53% reliable recovery by 2028/29.

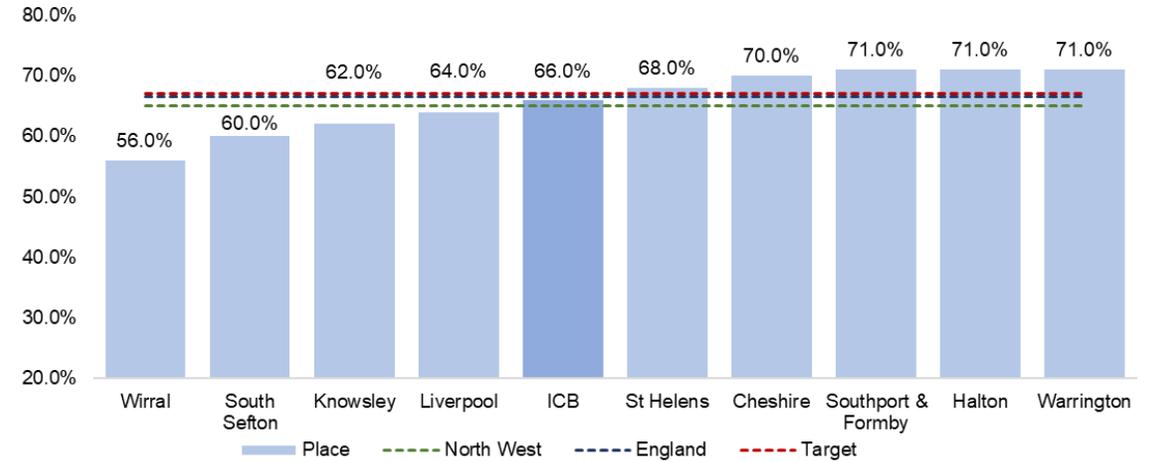
#### Delivery

- Although the overall ICB position is static at 47%, Cheshire is now achieving target and St. Helens and Halton places have reduced to 1% below target since Nov 25.
- Reliable recovery rates are forecast to remain below national standard by year end with rates delivered in 2026/27.

### Talking Therapies Reliable Improvement

Latest ICB Performance (Dec-25) **66.0%** National Ranking **26/42**

Place breakdown (Dec-25) **No change**



#### Issue

- Nationally reported data indicates that reliable improvement rates have remained static this month; 1% below plan. The Wirral provider, Everyturn MH, has recently migrated to a new system and did not submit data in July and Aug. Submissions made between Sep and Dec 25 may not be accurate for Everyturn and this is impacting on the overall ICB rates

#### Action

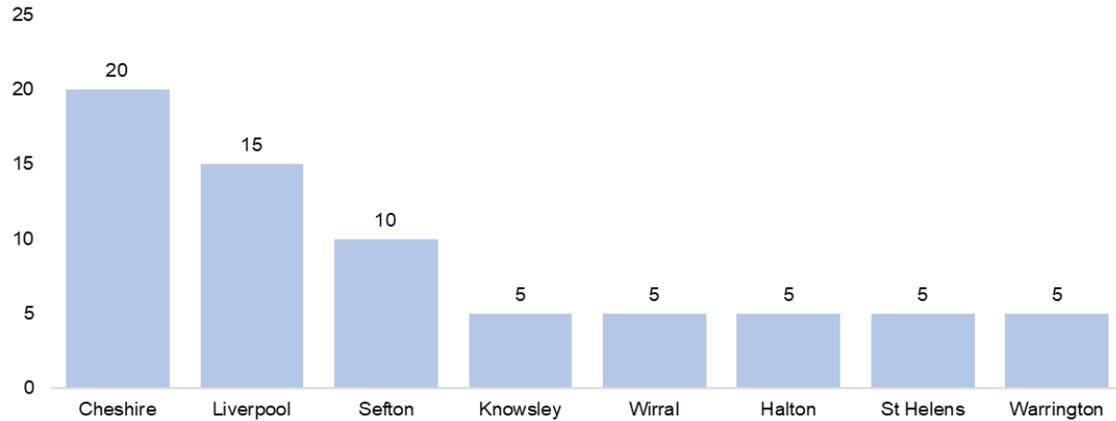
- Wirral data submissions have resumed following system migration but likely to impact on performance for a number of months as unable to resubmit missing/inaccurate data
- Planning to rebalance the ratio of low intensity to high intensity therapists to improve reliable recovery and reliable improvement rates, aligned with national guidance.

#### Delivery

- CWP, Big Life Group, East Cheshire, and Mental Health Matters for Warrington all achieved reliable improvement rates in this month.
- Mersey Care achieved 66% across 4 place teams.
- Everyturn, Wirral achieved 56%, a deterioration of 5% from Nov 25.
- Mental Health Matters delivered 64% for Sefton place.
- Reliable improvement rates are forecast to meet the national standard at year end.

## 5. Exception Report – Learning Disabilities

Adult inpatients with a learning disability and/or autism			
Latest ICB Performance (Dec-25)	70*	National Ranking	16/42
Place Breakdown *(Dec-25)			Improved



### Issue

- There were 70 adult inpatients, of which 44 are NHSE Specialised Commissioning (Spec Comm), and 26 ICB commissioned. The target for C&M (ICB and Spec Comm) is 46 LD/A or fewer by the end of Q4 2026.

### Action

- The Transforming Care Partnership (TCP) has scrutinised those clinically ready for discharge. Of those 70 adults, 10 individuals are currently on Section 17 Leave. It is expected that some of the existing section 17 leave individuals will be discharged in Q4 pending MOJ Clearance and transition progress. 36 people have been discharged since April 2025.
- Data quality checks continue to be completed on Assuring Transformation to ensure accuracy.
- 2-weekly C&M system calls ongoing to address Delayed Discharges with Mersey Care and CWP.
- Housing Navigators continues to work to find voids which can accommodate delayed discharges.
- Desktop reviews to address section 17 leave progress and those identified for discharge.
- Transforming Care Lead is linking into Provider MADE calls.
- The decommissioning of Alderley Unit will mean further discharges/transfer of care in Q3 and Q4.

### Delivery

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

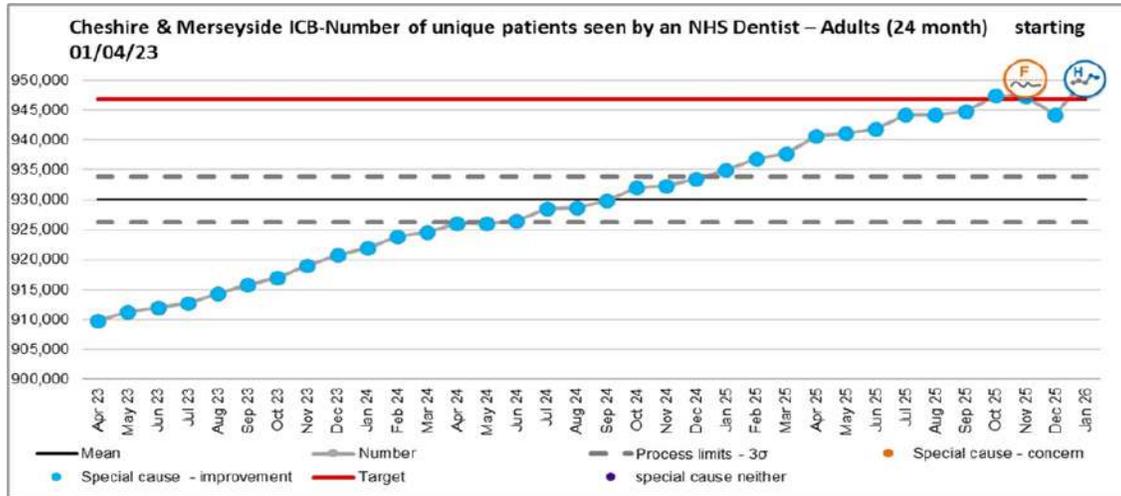
\* Data rounded up/down to nearest 5: therefore, Place subtotals may not add up to the ICB total

## 5. Exception Report – Primary Care

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

Latest ICB Performance (Jan-26) **950,227** National Ranking **n/a**

ICB Trend (Jan-26) **Improved**



#### Issue

- C&M is currently above target and expect year end performance to show a continued increase. Overall access has continued to increase since April 2023.

#### Action

- Continue to support network of providers to see new patients who require an NHS dentist delivering Pathway 1/2/3 in local dental plan 25/26.
- Working with providers to ensure accurate and timely submission of data to BSA.
- Full evaluation of Proof of Concept will be undertaken to understand full 12 months activity

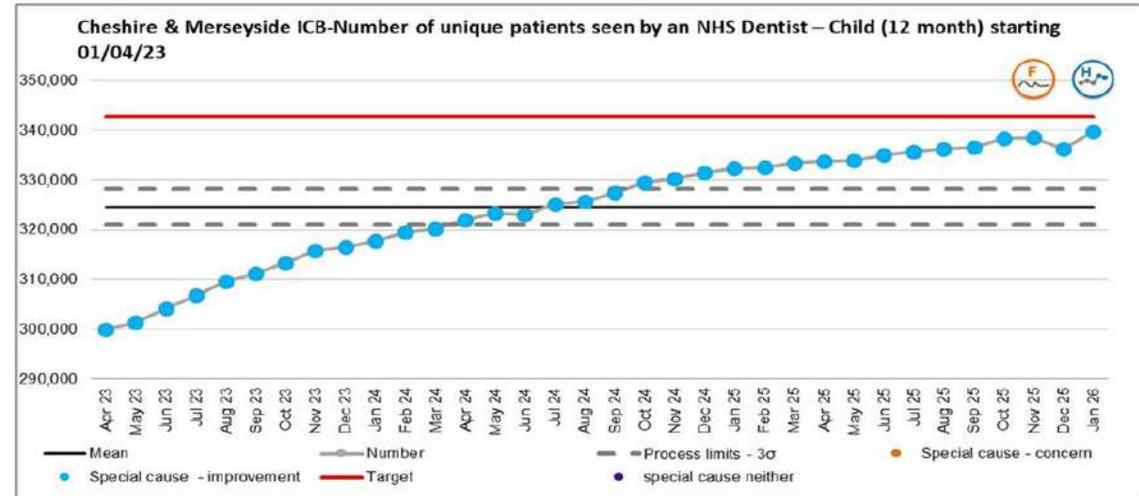
#### Delivery

- Commissioners are using flexible commissioning arrangements to improve activity and working with national team to understand 26/27 contract reforms.
- By year end we would expect to see the performance back on track with previous trend as a data reporting issue confirmed by the BSA in January had been resolved.

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

Latest ICB Performance (Jan-26) **339,791** National Ranking **n/a**

ICB Trend (Jan-26) **Improved**



#### Issue

- C&M is currently below target. We may see a year end flurry of activity that may take performance closer to the target. Overall, we have seen a continued increase in access for 25/26 and since April 2023.

#### Action

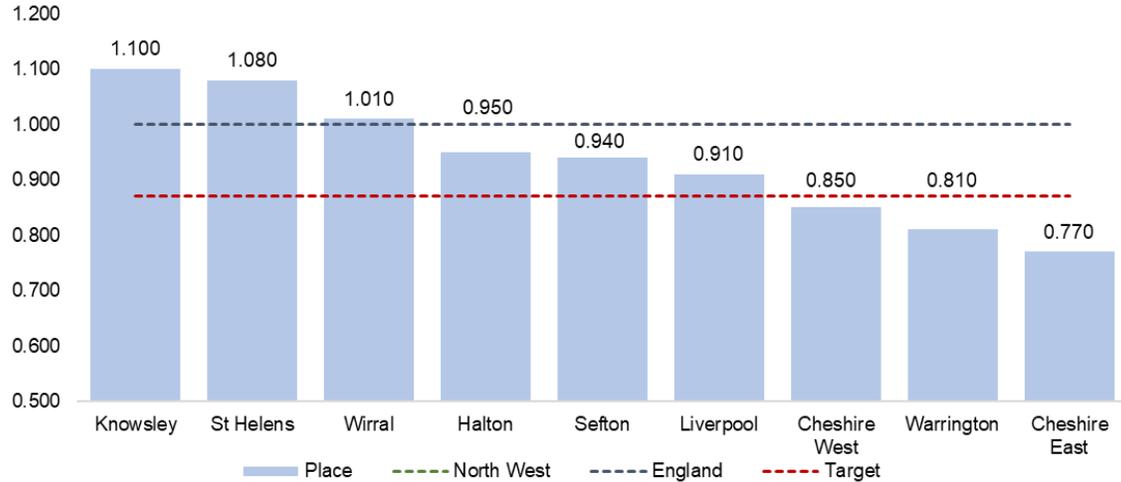
- Continue to support network of providers to see new patients who require an NHS dentist delivering Pathway 1/2/3 in local dental plan 25/26.
- Working with providers to ensure accurate and timely submission of data to BSA.
- Full evaluation of Proof of Concept will be undertaken to understand full 12 months activity

#### Delivery

- Commissioners are using flexible commissioning arrangements to improve activity and working with national team to understand 26/27 contract reforms.
- By year end we would expect to see the performance back on track with previous trend as a data reporting issue confirmed by the BSA in January had been resolved.

## 5. Exception Report – Primary Care

Total volume of antibiotic prescribing in primary care			
Latest ICB Performance (Nov-25)	<b>0.91</b>	National Ranking	<b>n/a</b>
Place breakdown (Nov-25)			<b>Improved</b>



### Issue

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

### Action

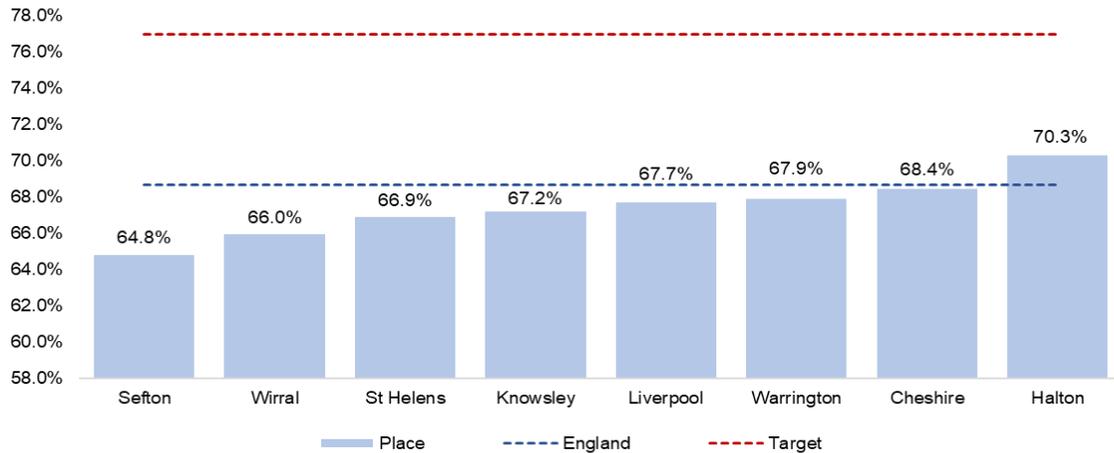
- All Places continue the cascade of education, public communication work, reviewing prescribing data and decisions in relation to antibiotic prescribing.
- Recruitment continues for two AMR Consultant Pharmacists to lead system-level AMS work.
- NHS England letter shared a letter in November 2025, joint AMR/IPC report to go to NHS Q&P on 12/3/26 with 3 key priorities.
- Single AMR element across all place incentive schemes for 26/27 completed. Chosen metric is to increase 5/7 course lengths of amoxicillin and doxycycline.

### Delivery

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

## 5. Exception Report – Health Inequalities & Improvement

% of patients (18+), with GP recorded hypertension, BP below appropriate treatment threshold			
Latest ICB Performance (Q2-25/26)	67.42%	National Ranking	29/42
Place Breakdown (Q2-25/26)			Improved



### Issue

- There remains considerable variation between Places. C&M does not currently meet the national target ambition. However, performance has improved since last quarter.

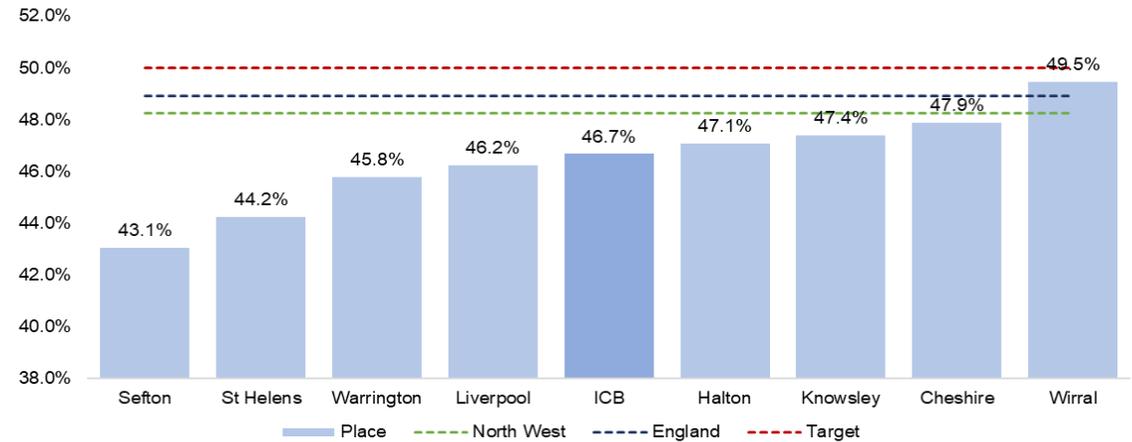
### Action

- Hypertension case finding in optometry pilot continues with 60 opticians and representation from each Place. Over 1200 readings taken, with 28.2% being referred for further investigation, in line with estimated local prevalence. The national evaluation is out for consultation, ready to be shared Q4, and a blueprint for Local Optometry Committees is in development.
- Cycle 3 of the CLEAR CVD Prevention programme is underway, with the last 6 of the chosen PCNs. 26/27 will start with the 6 month and 1 year reviews for PCNs who underwent cycle 1.
- Happy Hearts (local CVD Prevention website) currently hosted by LHCH, will be brought under CHAMPS, focussing on professional resources to support CVD prevention risk factor management.
- A Clinical Pharmacist is leading on the development and dissemination of recommendations of the BP optimisation project, toolkits and resources will be hosted on Happy Hearts.
- EOI submitted to NHSE to become a CVD Prevention Accelerator Site with a focus on BP; 'Prevent it, Detect it, Treat it' will target all parts of the BP pathway. Awaiting bid outcome

### Delivery

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

CVD treated to cholesterol threshold: LDL-cholesterol less than or equal to 2.0 mmol/l or non-HDL cholesterol less than or equal to 2.6 mmol/l			
Latest ICB Performance (Q2-25/26)	46.7%	National Ranking	30/42
Place Breakdown (Q2-25/26)			Improved



### Issue

- Considerable variation exists between Places and between ICBs. There is not currently a national target ambition for this metric. Performance has improved since last quarter.

### Action

- Clinically led C&M Lipid Management group leads this work. A mapping exercise is being undertaken to understand the barriers and opportunities in both primary and secondary care to improve care and outcomes related to secondary prevention lipid management. Key recommendations will be disseminated Q4, with the lipid management group leading on developing an approach to change.
- Continued development of a suite of user-friendly resources and educational opportunities for primary care colleagues to better support Lipid management. The third in a series of webinars is planned for February on FH, and the patient toolkit is ready to be launched when the Happy Hearts website is in a position to host it.
- Cycle 3 of the CLEAR CVD Prevention programme is underway, with the last 6 of the chosen PCNs. 26/27 will start with the 6 month and 1 year reviews for PCNs who underwent cycle 1.

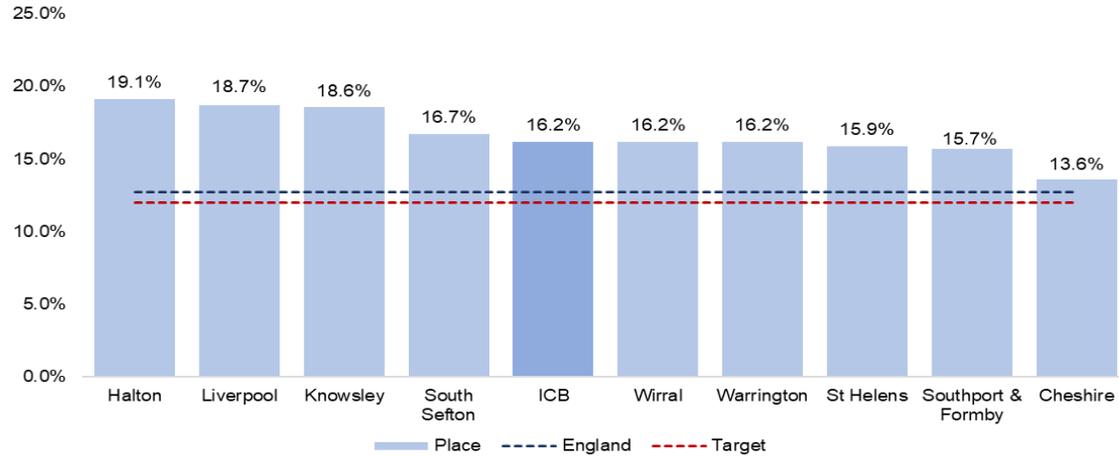
### Delivery

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

## 5. Exception Report – Health Inequalities & Improvement

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

Latest ICB Performance (Feb-26)	<b>16.2% *</b>	National Ranking	n/a
Place Breakdown (Feb-26)			Improved



#### Issue

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

#### Action

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

#### Delivery

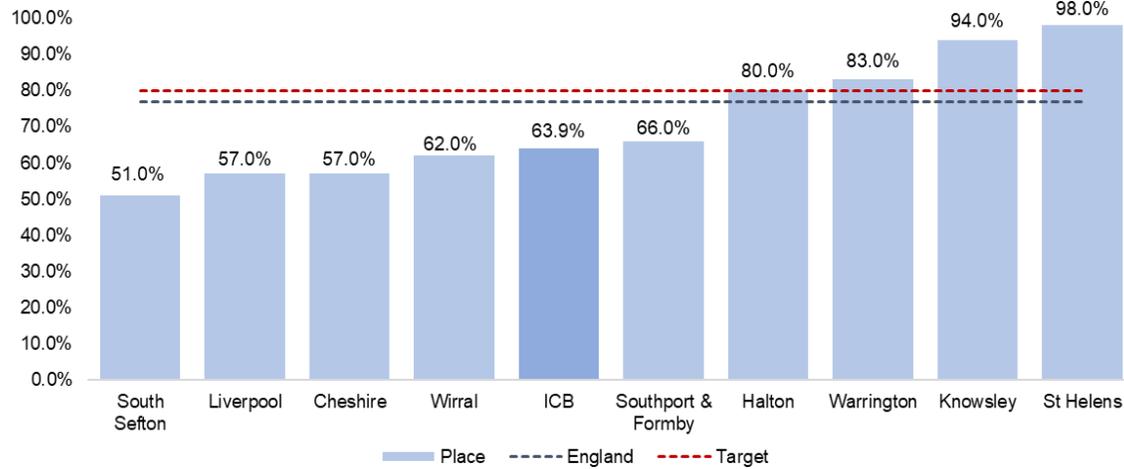
- It is anticipated that performance will continue to improve during 25/26 but the reduction in prevalence rate will be small with ongoing variation across Places. Supporting smokers to access specialist smoking cessation services to support them to quit should remain a key priority for all staff working in the NHS and implemented systematically across all providers.

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

## 5. Exception Report – Continuing Healthcare

### Standard Referrals completed within 28 days

Latest ICB Performance (Q3-25/26)	<b>63.9%</b>	National Ranking	<b>34/42</b>
Place Breakdown (Q3-25/26)			<b>Deteriorated</b>



#### Issue

- Cheshire and Merseyside ICB is not currently meeting the NHS England KPI for Standard CHC referrals to be completed within 28 days. The target is 80%. Place teams repeatedly report workforce issues being the driver for the inability to meet KPIs.

#### Action

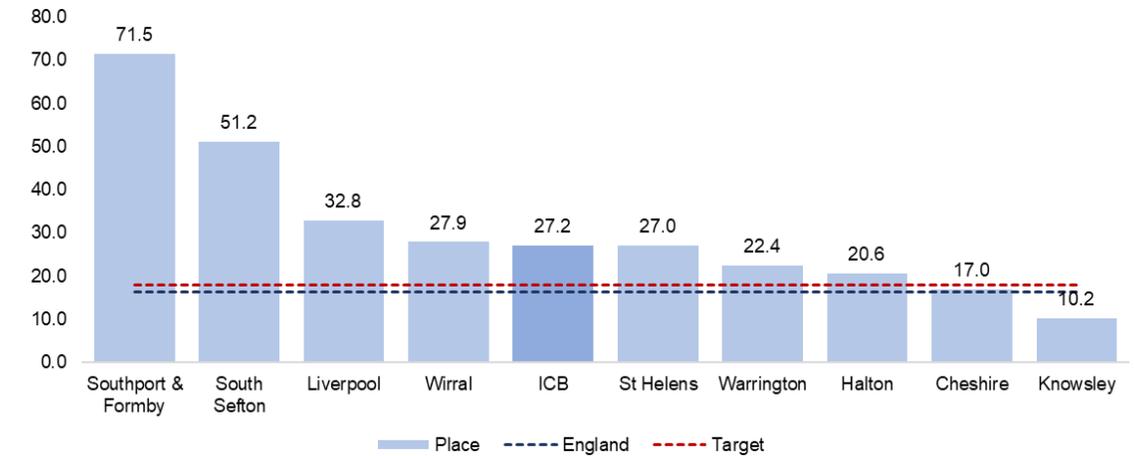
- A review of AACC delivery is being undertaken as part of the wider NHS/ICB service changes.
- Cheshire East and West continue to report a deteriorating position with performance due to the number of voids in the team (vacancy freeze/ staff absence/SW vacancies); further scrutiny of this is being monitored via NHS England.
- Additional scrutiny of the AACC delivery is in place via monthly Place Assurance Meetings.

#### Delivery

- The ICB delivery did not achieve the quarterly trajectory agreed with NHS England for Q3. The projection was  $\geq 78\%$  to 80%. Workforce issues would suggest that an improvement is not anticipated until this is addressed. NB The NHSE workforce modelling tool illustrates that the team is under resourced for the current activity levels.

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

Latest ICB Performance (Q3-25/26)	<b>27.19</b>	National Ranking	<b>40/42</b>
Place Breakdown (Q3-25/26)			<b>Deteriorated</b>



#### Issue

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

#### Action

- NHS C&M ICB are producing a suite of supportive policies and procedures to support teams in delivering consistent delivery and application of NHS CHC across the C&M system. Some are already operational and published whilst others are in various stages of ratification and development. Fast Track forms part of the AACC recovery scheme for AACC. PWC are specifically supporting a Fast Track Standard Operating Procedure.
- The ICB have approved a business case for Cheshire East and West so that up to 90% of Fast Track cases to support people in their own homes will now be a commissioned service rather than commissioned individually. This will improve the responsiveness and value for money of the service.

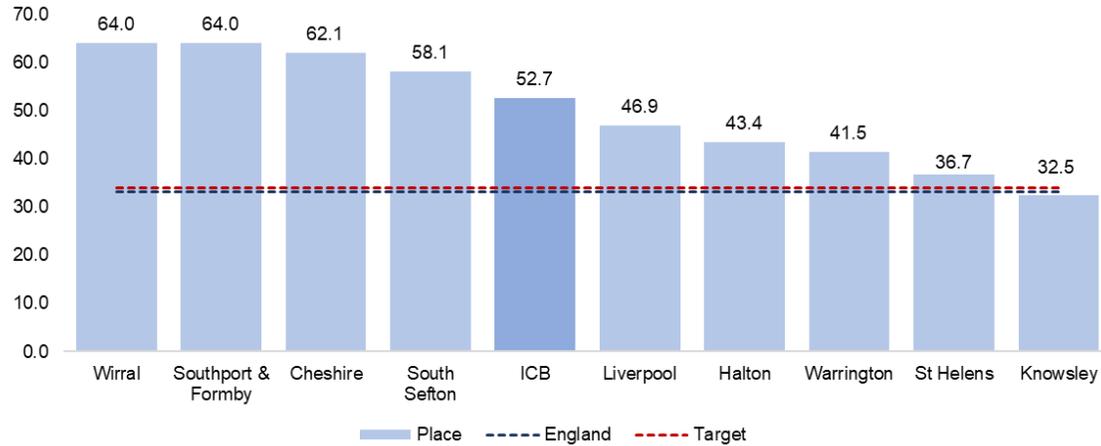
#### Delivery

- The Fast Track pilot in South Sefton continues to show positive results and is being rolled out for further testing in North Sefton. The findings are being shared across the wider AACC team in C&M for adoption and implementation with the intention that some improvement should be seen in early 2026/27.
- There is an overall deterioration for this metric within C&M.

\*snapshot at end of quarter

## 5. Exception Report – Continuing Healthcare

Number eligible for standard CHC per 50,000 population *			
Latest ICB Performance (Q3-25/26)	<b>52.7</b>	National Ranking	<b>40/42</b>
Place Breakdown (Q3-25/26)			<b>Improved</b>



### Issue

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

### Action

- The main outliers for this metric are Wirral, Southport and Formby, Cheshire and Sefton. Contract meetings are being held with the outsourced service in Wirral. A 'perfect week' is planned for Cheshire to better understand the referral sources and whether variation is warranted or not.

### Delivery

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

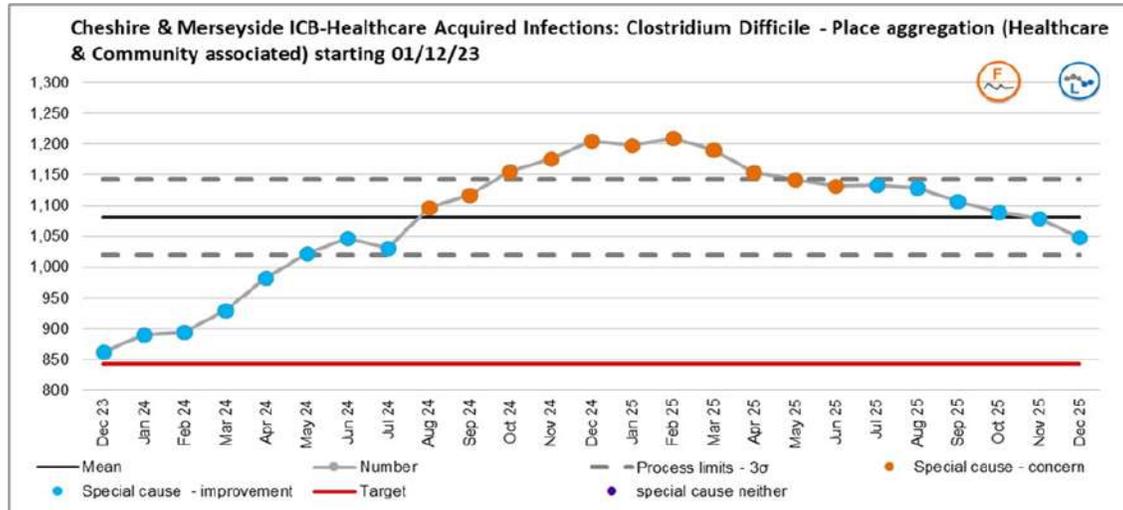
\*snapshot at end of quarter

## 5. Exception Report – Quality

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

Latest ICB Performance (12 months to Dec-25) **1,049** National Ranking **n/a**

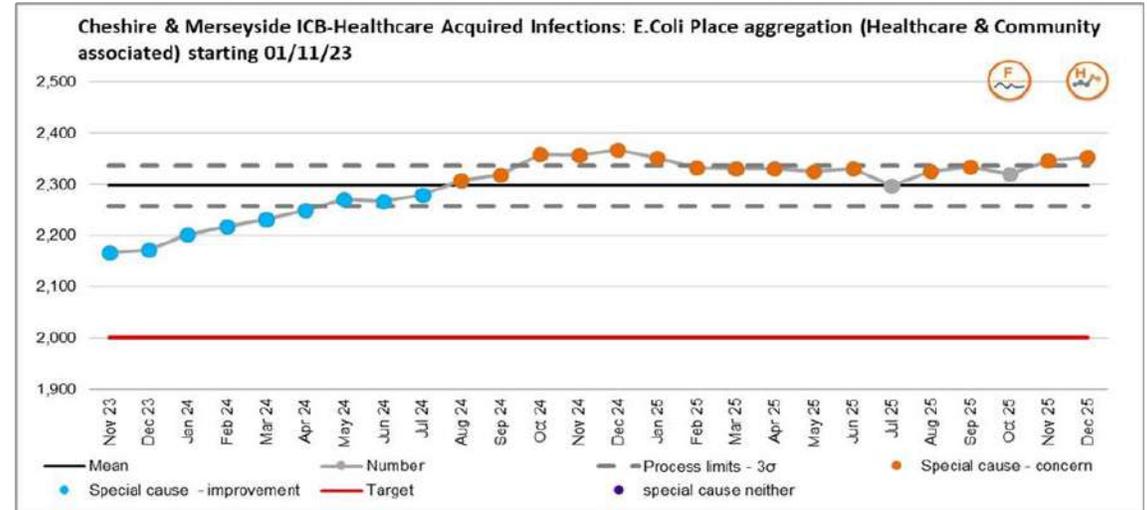
ICB Trend (rolling 12 months to Dec-25) **Improved**



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

Latest ICB Performance (12 months to Dec-25) **2,353** National Ranking **n/a**

ICB Trend (rolling 12 months to Dec-25) **Deteriorated**



#### Issue

- The C&M rate of CDI has continued to show an improvement, almost consistent monthly improvement through 2025.
- The Q3 data does not have any high outlier alerts, this is due to a further reduction at WUTH. The annual position continues to recognise both WUTH and COCH as a high outlier. Alongside these high outliers, we are now seeing low outlier alerts for MCHT in Q3 and AHCH, ECT, LHCH, LUFT and WHH in annual reporting.
- The C&M rate of E. Coli has fluctuated month on month without any specific cause variation. Within the outlier reporting, annually LUFT and CCC remain high outliers and AHCH, and LHCH both remain low outliers.

#### Action

- The implementation and monitoring of the CDI tool kit continues to be a priority, alongside local improvement plans at WUTH and COCH.
- The progress of the improvement plan at LUFT continues to be a focus at quality contract discussions.

#### Delivery

- The ICB tolerance for both CDI and E. Coli remains at risk with Q3 rates approaching nationally set tolerances and both expected to breach in Q4. CDI tolerances have breached annual tolerance at month 9 at AHCH, ECT, LHCH, CCC, TWC and LWH. E. Coli tolerances have breached at AHCH, LHCH, LWH, CCC and TWC.

## 5. Exception Report – Quality

### Never Events

Latest ICB Performance (Jan-26)

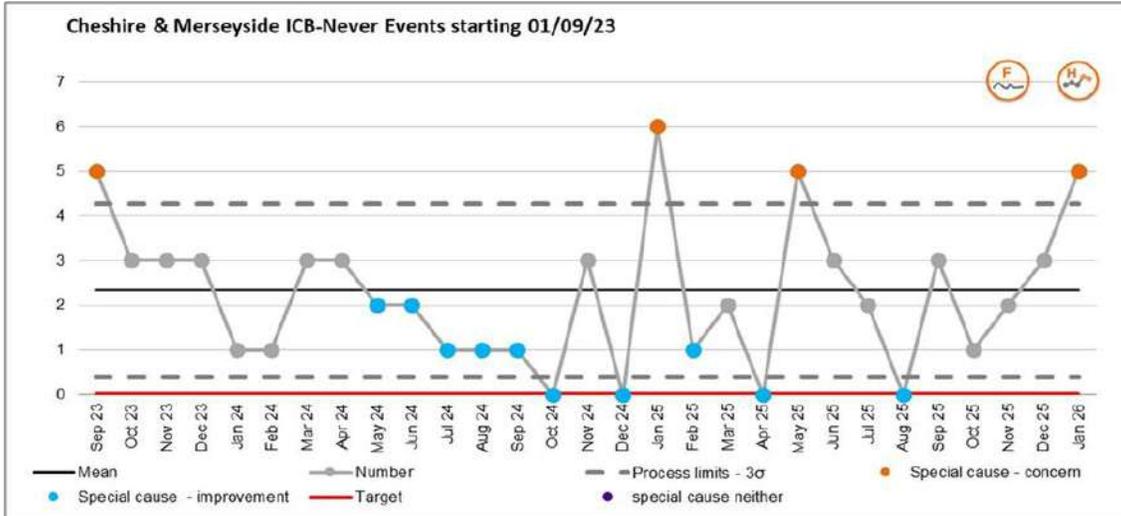
5

National Ranking

n/a

ICB Trend (Jan-26)

Deteriorated



### Issue

- C&M continues to see a high rate of Never Events across the system with 5 reported in January. The rolling 12-month position at 27 cases has seen dropped by one from last month but continues to see an overall increase.
- The Never Events in January were related to wrong site surgery (2), wrong prosthesis / implant (2) and an insulin overdose due to incorrect abbreviations.
- Never events occurred at COCH, ECT, MWL, LHCH and MCHT.

### Action

- The ICB is conducting a deep dive into surgical safety procedure assurance received from each trust across C&M and reporting back to QPC.
- The review is intended to describe priority improvements and trajectories to monitor across all surgical providers.

### Delivery

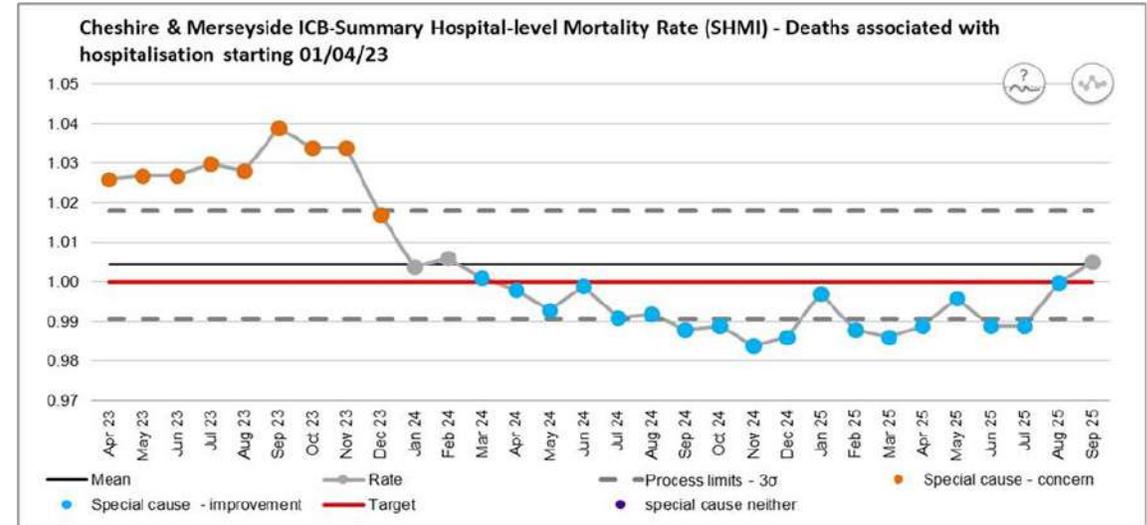
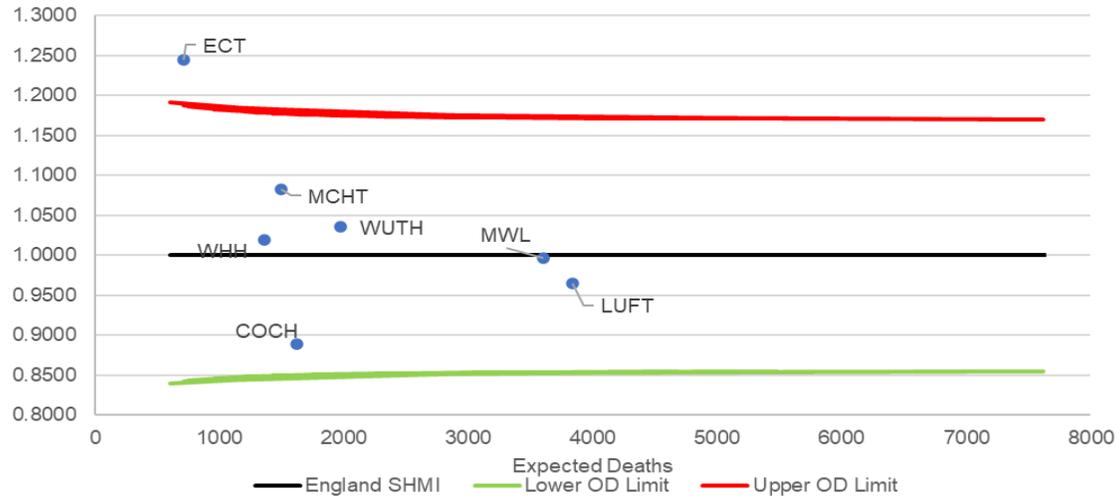
- Current rates are deteriorating.

## 5. Exception Report – Quality

### Summary Hospital-level Mortality Indicator (SHMI)

Latest ICB Performance (Sep-25)	<b>1.005</b>	National Ranking	<b>n/a</b>
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#### Provider Breakdown (Sep-25)\*



#### Issue

- C&M trusts are within expected tolerances except ECT, with a current value of 1.2440 against the upper control limit for ECT of 1.1874.

#### Action (ECT only)

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

#### Delivery

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

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

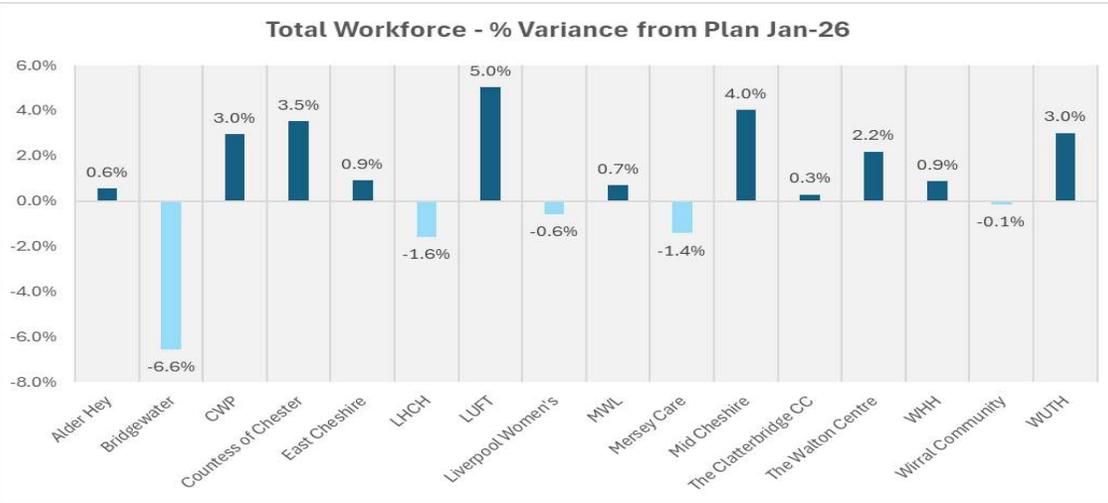
## 5. Exception Report – HR/Workforce

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

C&M ICB Performance (Jan-26)

1.7%

#### Provider Breakdown (Jan-26)

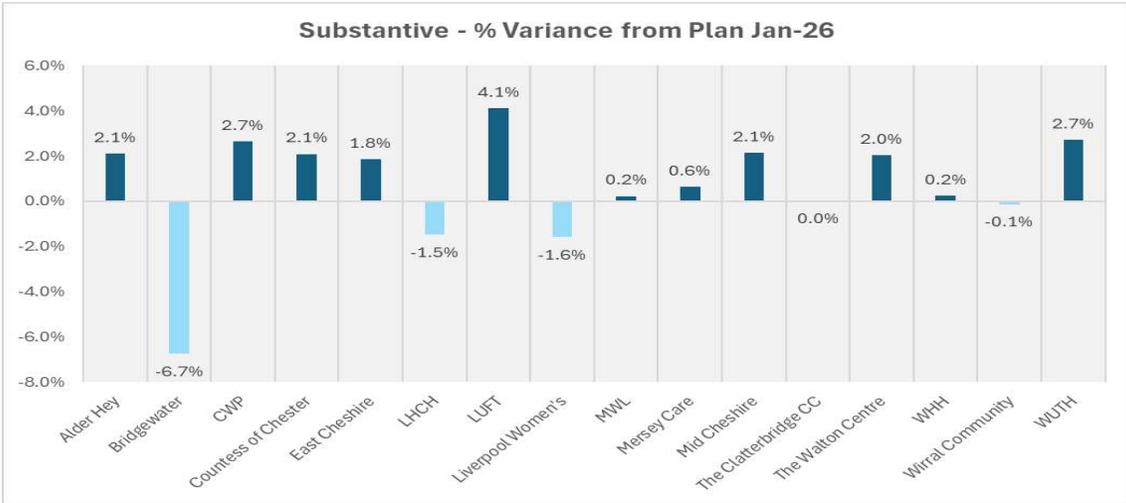


### Substantive Variance from Plan % - via PFRs

C&M ICB Performance (Jan-26)

1.5%

#### Provider Breakdown (Jan-26)



#### Issue

- In Jan-26, eleven of the sixteen C&M Trusts reported their total workforce WTEs were above their planned figure as at M10, with a C&M variance above plan of 1.7% (1,308.1 WTE), versus 0.9% (685.9 WTE) higher than plan last month. These variances are based on the 2025/26 Workforce Operational Plan submissions with monthly forecasts for WTE for 25/26 as submitted to NHS England. Provider WTE run rate has been static over the last 5 months with overall pay higher than plan – with Industrial Action in M4 & M8.
- Eleven of sixteen C&M Trusts reported substantive staff in post numbers higher than that forecast in their operational workforce plans. The total system performance was a variance from plan of 1.5%. At a system level, substantive staff utilisation decreased by 56.4 WTE / -0.1% from the previous month.

#### Action

- Greater scrutiny of workforce and pay costs data at organisational and system level is now taking place. The workforce WTE monitoring dashboard is shared with Trusts monthly – for review and feedback; where individual performance can be interrogated in terms of WTE numbers & assumptions for the coming quarter / financial year, and impact on specific professional groups in service pathways.

#### Delivery

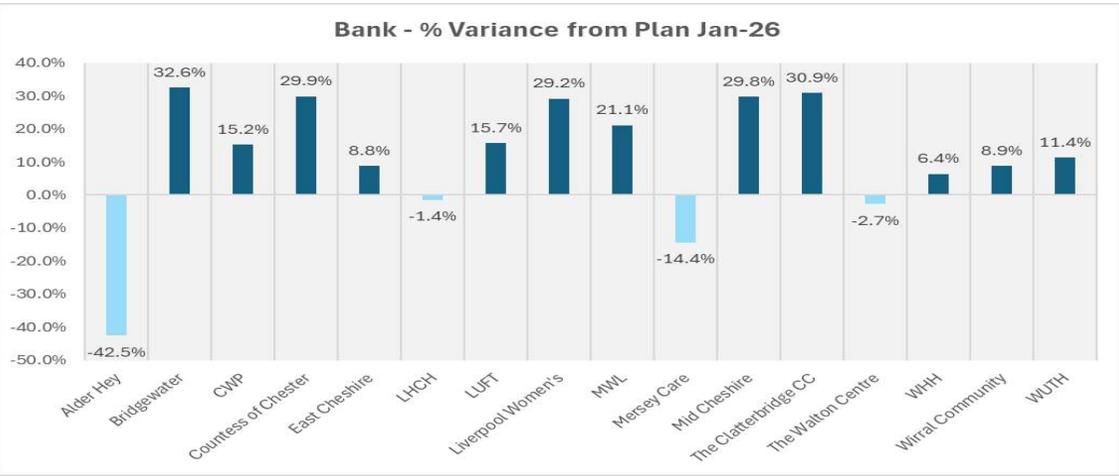
- Workforce workstreams for Sustainable Nursing Workforce Changes & Medical Workforce Changes continue to form the basis for multi-year planning baselines for C&M NHS Trusts.

## 5. Exception Report – HR/Workforce

### Bank Variance from Plan % - via PFR

C&M ICB Performance (Jan-26) **9.2%**

#### Provider Breakdown (Jan-26)



**Issue**

- Twelve of sixteen C&M Trusts had Bank usage higher than that forecast in their operational workforce plans for the month of Jan-26. The total system performance was a variance from plan of 9.2% / 382.9 WTE.
- At a system level, the total bank usage increased by 259.7 WTE / 6.1% from the previous month. Bank spend of £23.8m in month (across all C&M Trust Providers)

**Action**

- All Trusts are reviewing their internal workforce resourcing processes & specific organisational actions around temporary staffing data, premium staffing costs (WTEs Utilised and Rates Charged) & cross-checks between financial & workforce returns, which continues to be a focus for all Trusts, as part of the 25/26 planning process & financial recovery.
- Year-end delivery for 25/26 on WTE reductions across C&M Trusts is variable & will be factored into baselines & forecasting for the 26/27 Medium-Term Plans.

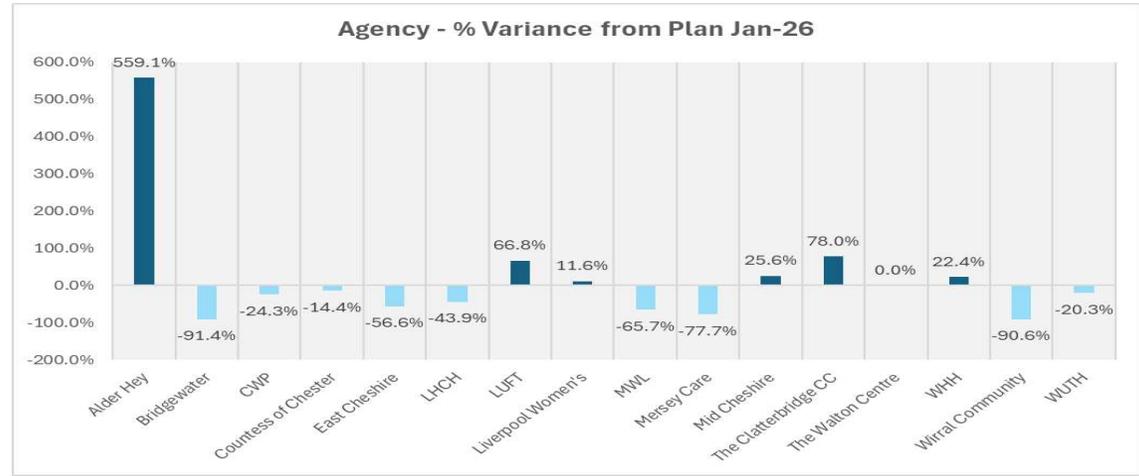
**Delivery**

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

### Agency Variance from Plan % - via PFR

C&M ICB Performance (Jan-26) **-31.8%**

#### Provider Breakdown (Jan-26)



**Issue**

- Nine of sixteen C&M Trusts had Agency usage lower than that forecast in their operational workforce plans for the month of January. The total system performance was a variance from plan of -31.8% / -193.9 WTE
- At system level, Agency usage reduced by -2.8 WTE / -0.7% from the previous month; this is -333.3 WTE from the Mar-25 baseline
- Agency £3.8m in month – lowest month in last 12mths – and below plan (£3.9m YTD) and below NHSE Ceiling

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

**Action**

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

**Delivery**

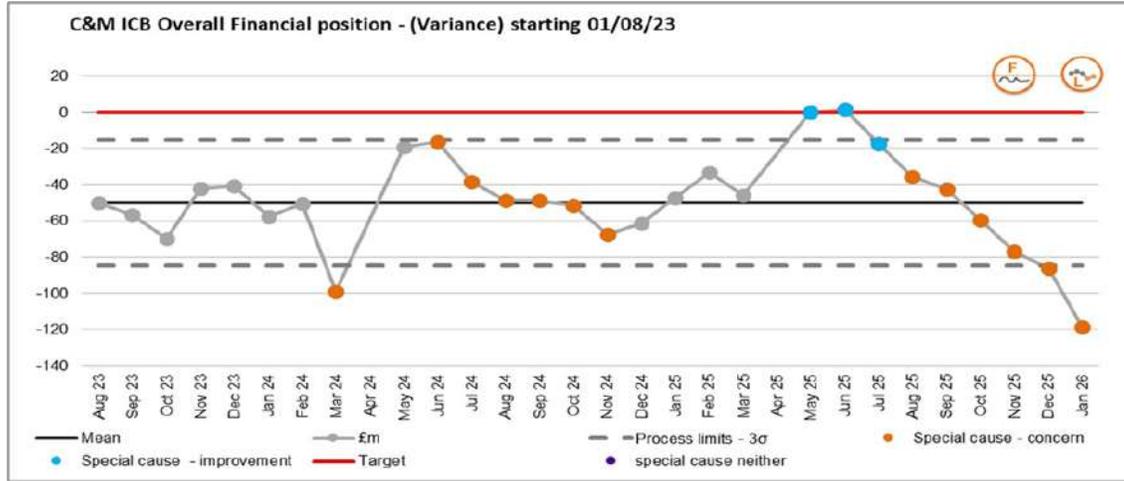
- Proactive communication to Chief People Officers, Workforce & Resourcing Teams about Off-Framework and Agency Spend data (by staff group) is shared monthly with additional input provided by NHSE North West – year-end delivery is in line with NHSE targets (a reduction of 30% WTEs / Spend).

## 5. Exception Report – Finance

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

Latest ICS Performance (Jan-26)	-118.4	National Ranking	n/a
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#### ICS Trend (Jan-26)



#### Issue

- System reported deficit of £200.4m against a year-to-date deficit plan of £82.1m as at M10 (ICB - £23.7m surplus, providers £224.2m deficit). This is an adverse system variance of £118.4m.
- The reported YTD position includes the negative impact of the system not being in receipt of deficit support funding (DSF) for months 4-10, which has an adverse YTD impact of £104m on provider positions.
- During month 10 the system has agreed an adjustment to the reported forecast and is reporting a total deficit of £245m against a breakeven plan. (ICB overspend of £50.4m, providers overspend of £194.6m)
- Unallocated Q2 – Q4 deficit support funding may be received for providers who are forecasting to achieve their plan for 25/26 and submit compliant plans for 26/27 which will reduce the forecast deficit. The current value not allocated to providers is £133.7m.
- This revised forecast has been discussed and agreed with NHSE. The system must now mitigate any remaining and emerging risks to deliver the revised forecast as no variation will be permitted.

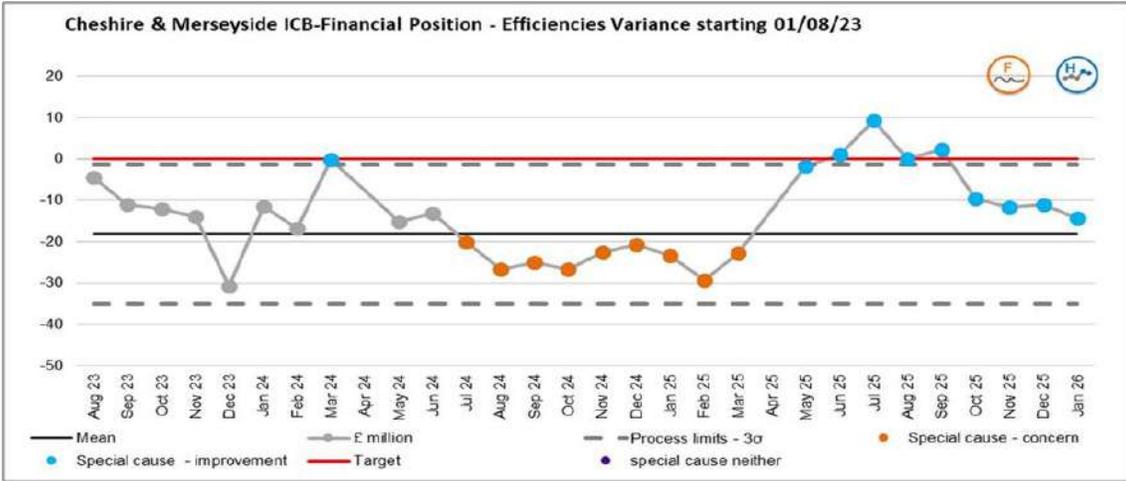
#### Action

- PwC and Simon Worthington are working alongside the region and ICB to assist delivery.
- Adverse movement on ICB forecast includes cost of redundancy in excess of allocation
- Activity management plans being implemented to manage independent sector pressures.

### Efficiencies Variance (£m)

Latest ICS Performance (Jan-26)	-14.3	National Ranking	n/a
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#### ICS Trend (Jan-26)



#### Issue

- System delivered £420.5m of efficiencies as at month 10 against a plan of £434.7m therefore reporting a shortfall in delivery of £14.2m.
- The ICB reports a shortfall of £4.2m on delivery, with providers delivering a shortfall of £10m
- System is forecasting £575m efficiency delivery against a total plan of £572m, exceeding the initial plan by £3m.
- As at month 10, 73% of the annual efficiency savings target has been delivered. Savings must continue to accelerate in the final 2 months of the financial year in order to deliver the forecast savings. This does largely reflect the profiling of the efficiency plan.
- While the system reports that efficiency savings have largely been delivered in line with plan, operational budgets have consistently overspent throughout the year due to other factors.

#### Action

- FCOG group continues to monitor progress against efficiency plans.

#### Delivery

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

# Meeting of the Board of NHS Cheshire and Merseyside

## 26 March 2026

### Highlight report of the Quality & Performance Committee

**Agenda Item No:** ICB/03/26/18



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# Highlight report of the Chair of the Quality & Performance Committee

<b>Committee Chair</b>	Tony Foy
<b>Terms of Reference</b>	<a href="https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/">https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/</a>
<b>Date of meeting(s)</b>	12 February 2026, 12 March 2026

## Key escalation and discussion points from the Committee meeting

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

### ALERT – Key Risks, Concerns and Issues Requiring Escalation

#### All Age Continuing Healthcare

- The Committee reviewed the quarterly update at its March meeting, noting significant operational pressures, workforce challenges and ongoing reform work across the service. The update highlighted that AACC continues to experience high demand, deterioration in performance and significant sickness absence (10.8%). WTE numbers have increased this financial year by around 10%.
- The Committee recognising that AACC operating under sustained pressure requires prioritised organisational development support.
- Deteriorating performance - in relation to assessment timeliness, case review backlogs and consistency across places. Fragmented digital systems continue to hinder efficient working. Seven out of nine place teams are now progressing towards adopting a single system to improve data reliability and consistency.
- Committee members recognised the need for financial control, however, raised an important point about the need to be more patient centric in our reporting, considering outcomes for patients and urgent improvement for those who have not had assessments.
- A priority decision was brought to the Committee concerning the temporary pause of routine funded nursing care (FNC) reviews, justified by insufficient workforce capacity. Members agreed to a time-limited six-month pause but registered a concern that urgent and on-demand reviews must continue and that any emerging risks must be closely monitored.

#### Next Steps

The committee supported a range of plans to,

- Prioritise OD support for AACC staff
- Clarify the causes of variation and 'outlier status' to inform future restructuring and to support development of a unified service model.
- Develop a system-wide workshop to define the future AACC model.
- Enhance collaboration with local authorities, aiming to resolve long-standing tensions around funding and responsibilities.

### ADVISE – Key Points for Board Awareness and Action

#### Mental Health Improvement Plan

- Significant progress has been made since implementation began in October , particularly through the introduction of parallel mental health and physical health assessments within Emergency Departments and the development of dedicated crisis assessment services, including a pilot at Hollins Park.
- The plan to achieve a 50% reduction in 12-hour ED mental health breaches has shown early improvement. However, data remains affected by inconsistent definitions and historic inaccuracies within the Emergency Care Data Set (ECDS). National work on data cleansing is underway to support accurate performance measurement.

- The Committee noted the positive impact of Mental Health Escalation Action Cards, which have reduced the number of critical escalations, although children, young people and out-of-area cases continue to create system pressures.
- The Committee reviewed progress on the Intensive and Assertive Outreach (IAO) programme, reinstated following the Nottingham killings in 2023. Both mental health trusts have now standardised their approach, ensuring each identified individual has a named professional, a personalised risk management plan, and access to consistent escalation pathways. This represents significant improvement from earlier periods when responsibility and oversight were inconsistent. Several constraints were noted - high caseloads, workforce shortages, sickness levels present ongoing risks to the sustainability of IAO. Clinicians reported that disengagement by service users, rather than clinical skill gaps, poses the greatest challenge

### Maternity (February)

**East Cheshire Maternity Review**, A detailed review was presented following the 12 January site visit supported by regional teams. Key issues identified:

#### Governance and Documentation

- Gaps in documentation quality
- Weak MDT communication in complex cases
- Inconsistent reporting of perinatal deaths or near misses

#### Workforce and Training

- Concerns regarding home birth safety
- High levels of elective caesarean requests and home birth requests, linked to local population expectations. Multiple births, high BMI, or complex medical needs requesting home births created significant risk for a small unit without sufficient on-call capacity
- Additional midwifery recruitment is underway, but the service remains fragile
- East Cheshire lacks an on-site endocrinologist, resulting in women flowing to GMEC for diabetes management and maternal medicine
- Despite these risks, the Trust received a Good rating for maternity from the CQC, though the Committee emphasised this reflected a single point in time

### SEND update

Cheshire West, St Helens and Halton have undergone full or monitoring inspections within a short period. None of the inspected places achieved a “typically positive experiences” outcome; instead, results ranged from “inconsistent experiences” to “systemic failings,” requiring statutory Priority Action Plans.

Across the Northwest common themes have been identified.

- Strategic Leadership and Governance - Inspectors repeatedly found weaknesses in strategic oversight, decision-making and partnership
- Communication with Families - Families consistently reported poor communication from services, especially during extended waiting periods.
- Joint Commissioning Gaps - Many areas lacked effective joint commissioning arrangements between the ICB and local authorities, particularly for therapies and neurodevelopmental support.
- Education, Health and Care (EHC) Plans - Concerns were raised regarding the quality and consistency of EHC plans.
- Long Waits for Specialist Health Services - Neurodevelopmental assessments, Speech and Language Therapy, Occupational therapy, CAMHS access. These delays form a major factor in inspection outcomes and often limit the possible grade.
- Hidden Waiting Times - Inspectors are now closely scrutinising “hidden waits” between Referral and triage, Triage and assessment, Assessment and follow-up. These hidden



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waits are often not reported and may substantially increase the true waiting time experienced by families.

**Service Model Challenges** - The Committee recognised that the current system of localised commissioning creates unacceptable variation, resulting in a postcode-dependent experience for children and young people. Members discussed the importance of adopting a “do once and do well” approach to commissioning key pathways such as speech and language therapy and neurodevelopmental assessment, while still allowing local flexibility for service delivery.

- The Committee endorsed the need for a systemwide approach to SEND commissioning, particularly in speech and language therapy and neurodevelopmental pathways.
- Members agreed that SEND inspection learning must be consolidated and shared across all Places.

**Anti-microbial resistance**

The Committee received an update on the IPC paper, which included an overview of the system’s responsibilities around antimicrobial resistance (AMR). The Committee reiterated the importance of AMR as a strategic priority, acknowledging the need to strengthen alignment between IPC teams, national expectations and internal reporting processes.

- The report identified areas of strength including oversight of provider IPC through contract management, collaboration across the provider collaborative to establish a C.Difficile Infection toolkit, proposal development for a stronger outbreak response and continued reduction in antimicrobial over-prescribing.

**ASSURE – Positives, Progress and Areas of Strength**

**Urgent and Emergency Care** (Corridor Care standards)

The Committee received the latest systemwide assurance report on the implementation of the Red Lines Toolkit. The toolkit has now been in use for three quarters under the NHS Standard Contract requirements and continues to provide important visibility of risks across all acute providers.

Place-based teams had completed local assurance reviews, confirming mixed levels of compliance: Alder Hey and East Cheshire reported as having full assurance, Other Trusts demonstrated a combination of partial and limited assurance, influenced by local estate constraints, operational pressures, and high numbers of patients managed in escalation areas.

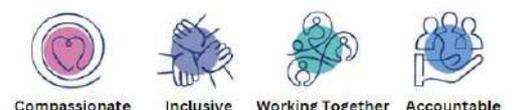
Patient Experience Concerns across multiple trusts; the following recurring deficits were identified in non-clinical spaces:

- Privacy and Dignity - Patients cared for in corridors or escalation zones frequently experience a lack of privacy and dignity, particularly during personal care or confidential conversations.
- Hydration and Nutrition - Gaps were found in provision during out-of-hours periods, with some patients left without adequate fluids, food or comfort monitoring.
- Comfort and Risk Management - Concerns continue around the comfort and safety of patients waiting long periods on trolleys, with particular risk to frail older adults and those arriving via ambulance.

The Committee stressed that corridors, by definition, cannot support the standard of dignity or monitoring that constitutes safe care which underscores why the toolkit must be applied rigorously. Role of Healthwatch - The Committee welcomed increased involvement from Healthwatch, who are now using the Toolkit as part of their enter-and-view visits.

Future Priorities Identified

The following areas were highlighted for system improvement:



- Prioritisation of patients aged 75+, given clear evidence of increased harm from prolonged ED waits to be reinforced in the local version of the toolkit
- Alignment with new national emergency care guidance, with a particular need to reflect emerging principles on appropriate waiting spaces.
- Cross-checking patient experience themes with complaints, incidents and Healthwatch reports to ensure triangulated oversight.

### Performance (February)

The committee reviewed system-wide urgent and emergency care (UEC) performance and noted that although significant challenges remain, performance this winter has been comparatively stronger than last year.

- Improvements were observed across almost all indicators when comparing December year-on-year. Key system pressures- bed occupancy, ambulance handover delays, and four-hour access standards still fall short of desired levels, but the direction of travel is positive.
- Improving position across, planned care, cancer and diagnostics had strengthened year-on-year, but remain fragile due to ongoing operational and financial pressures.
- The system remains focused on achieving the elimination of 65-week waits by March, with confidence increasing that this target will be met, supported by a narrowing gap towards the 52-week standard.

Although performance had improved compared with the previous winter, members acknowledged that this progress had required significant additional effort and may not be sustainable without further system redesign. A formal winter debrief to April meeting to embed learning.

### Patient Safety (March)

Quarter 2 and Quarter 3 Patient Safety Reports provided an overview of progress in delivering the NHS Patient Safety Strategy across Cheshire and Merseyside outlining developments in workforce training, patient-safety governance, incident management, emerging risks, and the creation of a new patient-safety performance dashboard.

- Workforce training compliance is improving, with the expectation that 90% of staff will complete the national patient safety syllabus by year-end. Additional training in Quality Impact Assessments (QIAs) and Equality, Diversity and Inclusion has also expanded, with 37 members of staff completing QIA training this quarter.
- The Committee discussed the importance of embedding patient-safety thinking into all commissioning decisions. They reviewed instances where programmes had been approved despite high-risk QIA scores, with assurances that mitigations had been applied and that benefits outweighed risks. Members requested further clarity in future reports to show the volume of QIAs scoring above 12 and the rationale for progression.
- Work has commenced towards an agreed list of incidents of interest for direct alerting to the ICB. Whilst the full development of this process is ongoing. The Avoidable Deaths and Never Events across all providers for the period Q2 and Q3 were reported to the ICB.

### Maternity

- The Maternity Outcomes Signal System (MOSS) has now been fully implemented locally. During the testing period, two alerts were triggered, one at Mid Cheshire and one at Warrington and Halton. Internal reviews found no significant safety concerns.
- The LMNS has also begun applying the Maternity and Neonatal Equalities Dashboard, which highlights disparities in outcomes for women from ethnic minorities and those living in areas of deprivation. Work is underway with trusts to ensure the data informs targeted improvement initiatives.



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- The Committee discussed the implications of the interim Amos Review, which identified unsafe and inconsistent care, racism, leadership failings, workforce shortages and infrastructure issues across maternity services nationally. The LMNS has started a gap-analysis exercise and confirmed that although no Cheshire and Merseyside providers were included in the review sample, the system must ensure full readiness for future inspection and compliance with expected national actions. To be reported to QPC and Board when complete.
- Performance data was reviewed, showing continued strengths (better than England and Northwest ICBs) in stillbirth, post-partum haemorrhage, C-sections and brain-injury rates, as well as excellent performance in pre-term birth prevention. Exceptions were noted in relation to births not occurring in the intended setting, induction-of-labour trends, and breast milk at first feed. C&M remains below the England average for this, however, latest data shows improvement, driven particularly by an upward trend at WUTH.

**System Quality Group feedback**

The January SQG convened on 28th January 2025 and was represented by 44 health and care leaders from NHS Cheshire and Merseyside, 5 out of 16 NHS Trusts, Local Authorities and NHS England and CQC. The agenda focused on quality challenges raised which included rising concerns in invasive procedure and surgical safety including Never Events, system quality pressures in Urgent and Emergency Care. Significant challenges in children’s pathways, long waits for neurodevelopmental assessment and inappropriate admissions.

**QIA**

The Committee received the QIA progress and assurance report covering Quarter 3 performance. A total of 20 QIAs were received during the period, reflecting activity across clinical policy development, service transformation, and commissioning decisions. Six QIA panels were held, including a return panel for the Equality Impact Assessment of the sub fertility policy post consultation. The Committee reviewed how the QIA process is functioning, how panels are operating, and how risks identified through QIAs are escalated and tracked.

**Paediatric Audiology**

The Committee received a comprehensive update on the national paediatric audiology improvement programme, with a focus on Mid Cheshire and Alder Hey, the two services identified during the national desktop review as requiring further investigation. The update included findings from site visits, cohort reviews, risks identified, capacity constraints, and system impacts. A range of recommended actions for the two providers was approved.

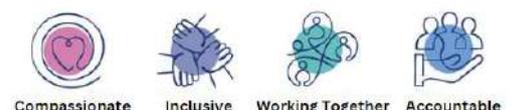
**EPRR (February)**

The Committee received the ICB’s annual Emergency Preparedness, Resilience and Response (EPRR) progress and assurance update. The ICB has been externally quality-assured by NHS England and has moved from Partially Compliant to Substantially Compliant (91%) against the national EPRR core standards. This marks significant improvement in organisational preparedness, governance structures, and system coordination compared with the previous year.

**Committee risk management**

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

Corporate Risk Register risks	
Risk Title	Key actions/discussion undertaken
The Committee received the consolidated Quality Risk Register	Members considered the risk scores, narratives, mitigations and alignment with the ICB’s developing



Corporate Risk Register risks	
in February, comprising 11 active risks.	operating model. Several risks were identified as requiring immediate refinement to ensure clarity between clinical quality risk, operational process risk, and financial risk. Q05 Neurodiversity Pathways – discussed in SEND actions Q08 a and b – staffing capacity (to be reframed) Q09 East Cheshire SHMI deteriorating – further investigation Q10 Looked After Children IHAs deteriorating Priority reporting at future meeting

Board Assurance Framework Risks	
Risk Title	Key actions/discussion undertaken
P4 potential for major quality failures	Corridor Care – ‘Red Lines’ toolkit compliance and response to operational pressures reviewed. Improved focus on frailty.
P1 Health Inequalities	Referenced in Maternity reporting

### Achievement of the ICB Annual Delivery Plan

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

Service Programme / Focus Area	Key actions/discussion undertaken
Urgent and Emergency Care	Analysis of System performance undertaken
Maternity	Review of performance standards and new alert system
Patient Safety	Quarterly update reviewed and planned improvements in incident reporting agreed

# Meeting of the Board of NHS Cheshire and Merseyside

26 March 2026

## Highlight report of the Chair of the ICB Audit Committee

**Agenda Item No:** ICB/03/26/19

## Highlight report of the Chair of the ICB Audit Committee

<b>Committee Chair</b>	Mike Burrows
<b>Terms of Reference</b>	<a href="https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/">https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/</a>
<b>Date of meeting</b>	03 March 2026

### Key escalation and discussion points from the Committee meeting

#### Alert

- **Annual Report and Accounts 2025/26:** The Committee received an update on the timetable, accounting policies and going concern assessment. While no immediate concerns were raised, members highlighted increasing delivery risk associated with organisational change, reduced capacity, and the need to maintain momentum to meet national deadlines. Particular attention was drawn to agreement of balances with NHS bodies, where some differences remain unresolved at Month 9 and may require disclosure if not cleared
- **Financial Governance Review – Interim Findings:** The Committee received the Interim Financial Governance Review. The interim review identified significant weaknesses in financial governance, including lack of clarity in budget-setting, inconsistent understanding of the Scheme of Reservation and Delegation, and gaps in procurement and contract oversight. The Committee considered these issues to represent a material control risk during transition to the new operating model and noted that responsibility for implementation oversight currently rests predominantly with the Executive
- **Board Assurance Framework:** The Committee received the Quarter Four 2025/26 Board Assurance Framework Update. While acceptable assurance is reported across all eight principal BAF risks, the Committee challenged whether the current level of assurance is sufficiently robust, given that several risks (notably quality, finance, and access/performance) remain scored as critical (20). Members expressed concern that mitigating actions may not yet be reducing risk exposure at the pace expected and requested clearer evidence of impact.
- **FOI Performance:** The Committee received the Quarter Three FOI Compliance Update report. The Committee noted compliance had reduced slightly to 90.1%, with all breaches attributable to internal delays in providing information. The Committee noted the continued risk to statutory compliance, particularly in the context of workforce change and loss of corporate knowledge through restructuring.

#### Advise

- **Strengthening Financial Governance:** The Committee supported the direction of travel set out in the interim Financial Governance Review, including the introduction of tighter controls (e.g. “no PO, no pay”), clearer application of the Scheme of Reservation and Delegation, and improved communication of decisions. The Board is advised that Non-Executive oversight will need to be

strengthened as the review concludes, particularly if changes to Standing Financial Instructions or schemes of delegation are required.

- **Cyber Security – System-wide Update** - the Committee welcomed confirmation that national cyber funding has been protected and noted the reset of the system-wide cyber programme. Members advised that future reports must move beyond narrative updates to provide clear metrics demonstrating risk reduction, strengthened assurance over commissioned providers (not just IT suppliers), and unambiguous accountability during cyber incidents, including in primary care.
- **Internal Audit Progress and Follow Up:** the Committee was informed that Internal Audit work continues broadly to plan. The Committee noted that deferral of the Continuing Healthcare review and a small number of outstanding high-risk actions may place pressure on the Head of Internal Audit Opinion and advised continued close monitoring.
- **External Audit Plan 2025/26:** The Committee noted the identified significant risks relating to management override of controls and implementation of the IFSE2 ledger system. Committee members advised that weaknesses identified through the Financial Governance Review, particularly around journal controls and financial discipline, reinforce the importance of sustained Board oversight of these areas.

### Assure

- **Annual Report and Accounts 2025/26** - the Committee received assurance on the timetable, draft accounting policies, and the going-concern assessment, with no issues identified at this stage that would prevent timely completion.
- **Information Governance Update** - the Committee received assurance that progress against the DSPT, Record of Processing Activities and IG training programme remains on track. Despite organisational change, evidence collation, governance arrangements and workload management provide confidence that information governance risks are being actively managed.
- **Declarations of Interest Update** - the Committee noted improved compliance, now at 93%, exceeding the organisational target. Training compliance also remains above threshold. No systemic issues were identified, and the Committee took assurance that arrangements remain robust.
- **Counter Fraud Update:** The Committee received assurance that the counter-fraud work programme is progressing as planned. Investigation activity remains proportionate, no material losses were reported in-period, and national standards compliance continues to be maintained
- **Internal Audit Follow-Up:** The Committee was assured that the majority of agreed actions from previous audits have been implemented or are progressing appropriately, with continued monitoring in place for a small number of overdue items.

The next meeting of the Committee is scheduled for **21 April 2026**.

# Meeting of the Board of NHS Cheshire and Merseyside

## 26 March 2026

### Highlight report of the System Primary Care Committee

**Agenda Item No:** ICB/03/26/20



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# Highlight report of the System Primary Care Committee

<b>Committee Chair</b>	Erica Morriss
<b>Terms of Reference</b>	<a href="https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/">https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/</a>
<b>Date of meeting</b>	19 February 2025

## Key escalation and discussion points from the Committee meeting

### Alert

**GP Prescribing Risk/Approach**  
Detailed analysis received of the current overspend position including ongoing efficiency plans. Steady sustained progress being evidenced although pace of change remains a challenge with stretched Medicine Management and continued demand from the public. Uncertainty remains whether overspend can be fully offset given earlier year pressures. The Committee acknowledged that prescribing remains a highly sensitive and challenging area, with limited flexibility due to clinical safety requirements and patient need.

**Primary Care Capital & Revenue Controls**  
Improved Governance process between Finance Committee and SPCC for Primary Care Capital & Revenue approvals & onward recommendations to other Committees/Board. Confirmed approvals for Primary Care Capital funds were made in accordance with the current SORD/OSORD via an ExO meeting held in February 26 and advised to Finance Committee.

### Advise

**Risks**  
The committee received an update with regards to progress and proposed actions/arrangements for the continued reporting of risks and assurance to the committee. The Committee agreed to approve the recommendation to reduce the scores of the relevant estates related risks and noted the ongoing review of digital and finance risks. The introduction of a new estates risk was also agreed. All risks will be converted to the new risk template and return to the Committee in June following the ongoing governance and risk review.

**Commissioning (Medical) – Enhanced Services Review**  
The committee received a verbal update on progress of the current work - as part of this phase of the review current schemes commissioned had been grouped, for example, into those areas for potential decommissioning, and those that could be commissioned in a more single consistent way across all practices. A more detailed presentation will return to the committee with firm proposals in due course. It was recognised that further discussion was required around existing schemes for 26/27 - and the challenge of current 'bundled' schemes which contained several elements across a full commissioned year.

**Transformation National Community Pharmacy Independent Prescribing (CPIP) Pathfinder Programme.**  
The committee considered the national end date, the limited transition funding and local financial and workforce constraints for the pilot and agreed the ending of the local sites but to continue monitoring national developments and prepare for reintegration once new commissioning frameworks are released.

**Assure**

**Pharmacy Services Regulations Committee**

The committee received and accepted the latest minutes of this committee. Examples of key factors considered when making decisions were given to highlight the level of scrutiny in line with the role of the committee.

**Finance**

The committee received an update noting details in relation to ARRS (additional roles) underspends, the ongoing prescribing pressures in the final months of the year once December data is fully analysed and further details of national funding streams awaited for 26/27. The context of the ongoing ICB financial recovery and cost efficiency programmes was noted.

**Policy and Commissioning**

The committee received an update on ongoing areas of commissioning assurance related to national contracting asks for all four contractor groups. As part of the discussion of approach and the changes to the ICB operating model, an update on the governance, decision making and alignment to priorities will be presented to a future meeting of the committee. It was noted the details of any new contract changes would need to return to the committee for assurance on implementation, once information was released nationally.

**Key Strategic Delivery Areas Neighbourhood Health**

The committee received an update on the development and implementation of neighbourhood health noting the further work on emerging metrics framework and reporting pathways – there was a reiteration of the importance of the involvement of all four primary care contractor groups and the need for clear outcomes.

**Quality**

The committee received the update from the Primary Care Quality Group and noted the ongoing work and assurance of quality oversight. The importance of ensuring a single key performance/quality metric set for primary care medical for future reporting was noted –the work for which is ongoing through quality teams.

**Digital**The Committee received a consolidated digital update covering GP IT services that cover general practice provided by Commissioning Support Units (CSUs) and the SMS messaging funding review, the latter would be further discussed at the Executive Committee. The committee also made recommendations in respect of funding arrangements for clinical system mergers associated with practice contract mergers, with the final decision being made at the Executive Committee.

**Achievement of the ICB Annual Delivery Plan**

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

Focus Area	Key actions/discussion undertaken
Neighbourhood Health	Update as above including key areas of progress and assurance on next steps – including role/involvement of primary care - and modern general practice/access as one of the core components .

## Committee risk management

Individual risk reporting will return to the Committee at the next meeting in April 26 - but a general progress update was received noted above in the paper narrative.

**Date of Next Meeting:** April 2026.

# Meeting of the Board of NHS Cheshire and Merseyside

## 26 March 2026

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

**Agenda Item No:** ICB/03/26/21



Compassionate



Inclusive



Working Together



Accountable

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

<b>Committee Chair</b>	Prof. Hilary Garratt
<b>Terms of Reference</b>	<a href="https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/">https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/</a>
<b>Date of meeting</b>	13 March 2026

### Key escalation and discussion points from the Committee meeting

#### Alert

- Significant scrutiny and public sensitivity remains in relation to the Shaping Care Together (SCT) programme, particularly from West Lancashire stakeholders, including the Joint Health Overview and Scrutiny Committee (JHOSC) and local elected members
- The Committee formally considered the Decision-Making Business Case (DMBC) for the urgent and emergency care phase, alongside the formal JHOSC response raising concerns about a preferred being option within the consultation process, travel and access impacts, primary care capacity, ambulance modelling, and perceived equity implications.
- While no new viable alternatives emerged through consultation or scrutiny, the risk of continued challenge (including reputational and potential legal risk) remains and will require ongoing system-wide engagement, transparent communication, and demonstrable mitigation as the programme progresses

#### Advise

#### At its meeting on 13 March 2026, the Shaping Care Together Joint Committee:

- **Considered** the full Decision-Making Business Case (DMBC), which brings together:
  - independent analysis of over 7,800 consultation responses,
  - refreshed clinical, workforce, estates, financial and ambulance modelling,
  - updated Integrated, Equality and Quality Impact Assessments, and
  - responses to issues raised by Overview and Scrutiny Committees.
- **Noted** the formal response from the Joint HOSC, including recommendations relating to:
  - strengthening primary and community care,
  - travel, transport and parking mitigations,
  - assurance on transition arrangements and continued use of both hospital sites, and
  - ongoing engagement with elected members.
- **Approved** the DMBC and made a final decision to proceed with the recommended option:

- Co-location of adult and children’s A&E services at Southport and Formby District General Hospital, on the basis that this option remains the most clinically safe, operationally deliverable, workforce-sustainable and financially viable.
- **Emphasised** that:
  - no final service changes are immediate, with implementation expected over several years;
  - Ormskirk Hospital will remain open and continue to develop its role, including urgent treatment, planned care and outpatient services; and
  - mitigations for travel, access and inequality impacts will be critical during implementation

**Assure**

- The Committee received assurance that due process has been followed, in line with NHS England major service change guidance, including:
  - extensive pre-consultation engagement,
  - a 13-week statutory public consultation,
  - independent analysis by the Centre for Health Communication Research, and
  - external legal and NHS England assurance checkpoints.
- Equality and health inequalities impacts have been explicitly considered, with a clear commitment to:
  - proportionate mitigations (including transport and access),
  - ongoing monitoring through defined dashboards, and
  - escalation routes should adverse impacts emerge.
- Governance and programme oversight arrangements are robust, with:
  - clear accountability through the SCT Programme Board and Joint Committee,
  - continued reporting to the ICBs,
  - and strengthened engagement with scrutiny committees and local partners during implementation.
- The Committee was assured that urgent and emergency care improvement work across the system will continue irrespective of location, including strengthening community, urgent treatment and primary care pathway