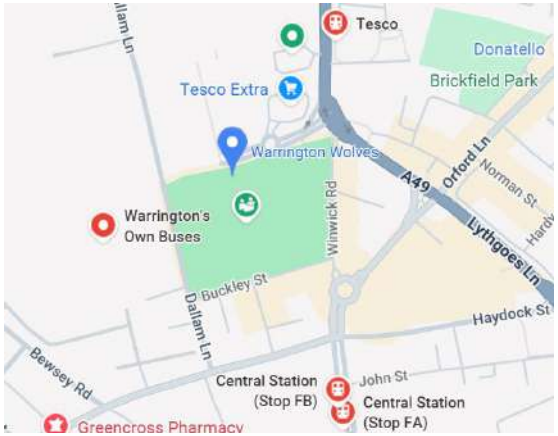
NHS
Cheshire and Merseyside

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

27 November 2025
13:00pm

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



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

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Public Notice:

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

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

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

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

Raising Questions:

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

Questions from members of the public will be responded to at the end 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 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-november-2025/

Agenda

AGENDA NO & TIME	ITEM	Format	Lead or Presenter	Action / Purpose	Page No
13:00pm	**Preliminary Business**				
ICB/11/25/01	Welcome, Apologies and confirmation of quoracy	Verbal	Sir David Henshaw *ICB Chair*	For information	-
ICB/11/25/02	Declarations of Interest *(Board members are asked to declare if there are any declarations in relation to the agenda items or if there are any changes to those published on the **ICB website**)*	Verbal		For assurance	-
ICB/11/25/03	Minutes of the previous meeting: • 25 Sept 2025	Paper		For approval	Page 6
ICB/11/25/04	Board Action Log	Paper		For approval	Page 17
ICB/11/25/05	Key issues – significant items to raise	Verbal		For discussion	-
ICB/11/25/06	Experience and achievement story	Film	-	For information	-
13:15pm	**Leadership Reports**				
ICB/11/25/07	Chairs announcements	Verbal	Sir David Henshaw *ICB Chair*	For information	-
ICB/11/25/08 **13:25pm**	Report of the ICB Chief Executive	Paper	Liz Bishop *Chief Executive*	For assurance	Page 18
ICB/11/25/09 **13:40pm**	NHS Cheshire and Merseyside Finance Report Month 7	Paper	Andrea McGee *Interim Executive Director of Finance and Contracting*	For assurance	Page 29
ICB/11/25/10 **13:55pm**	Highlight report of the Chair of ICB Finance, Investment and Our Resources Committee	Paper	Mike Burrows *Non-Executive Member* Sue Lorimer *Non-Executive Member*	For assurance	Page 40
ICB/11/25/11 **14:00pm**	NHS Cheshire and Merseyside Integrated Performance Report	Paper	Anthony Middleton *Director of Performance & Planning*	For assurance	Page 48
ICB/11/25/12 **14:15pm**	Highlight report of the Chair of ICB Quality and Performance Committee	Paper	Tony Foy *Non-Executive Member*	For assurance	Page 92
ICB/11/25/13 **14:20pm**	Highlight report of the Chair of System Primary Care Committee	Paper	Tony Foy *Non-Executive Member*	For assurance	Page 96

AGENDA NO & TIME	ITEM	Format	Lead or Presenter	Action / Purpose	Page No
ICB/11/25/14 **14:25pm**	Highlight report of the Chair of the Remuneration Committee	Paper	Tony Foy *Non-Executive Member*	For assurance	Page 100
ICB/11/25/15 **14:30pm**	Highlight report of the Chair of the Children's and Young People Committee	Paper	Chris Douglas *Executive Director of Nursing & Care*	For assurance	Page 102
14:35pm	**BREAK**				
14:50pm	**ICB Business Items**				
ICB/11/25/16	Proposal regarding an Interim Sub-Fertility Clinical Policy across Cheshire and Merseyside	Paper	Dr Fiona Lemmens *Deputy Medical Director*	For decision	Page 105
ICB/11/25/17 **15:15pm**	Safeguarding Our Workforce – NHS Cheshire and Merseyside Sexual Misconduct Policy	Paper	Mike Gibney *Chief People Officer*	For approval	Page 205
ICB/11/25/18 **15:25pm**	NHS Cheshire and Merseyside Board Assurance Framework 2025-28	Paper	Clare Watson *Assistant Chief Executive*	For approval	Page 247
ICB/11/25/19 **15:45pm**	Cheshire and Merseyside Urgent Emergency Care Strategy	Paper	Mandy Nagra *Chief System Improvement and Delivery Officer*	For approval	Page 263
ICB/11/25/20 **16:05pm**	Cheshire and Merseyside Winter Planning 2025-2026	Paper	Anthony Middleton *Director of Performance & Planning*	For assurance	Page 278
16:20pm	**Closing Business**				
ICB/11/25/21	Questions received from members of the public	Verbal	Sir David Henshaw *ICB Chair*	For information	-
ICB/11/25/22 **16:35pm**	Closing remarks and review/reflections of the meeting	Verbal		For information	-
ICB/11/25/23	Any Other Business	Verbal		For information	-
16:45pm	**CLOSE OF MEETING**				

Consent items

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

AGENDA NO	ITEM	Reason for presenting	Page No
ICB/11/25/24	Board Decision Log **(CLICK HERE)**	For information	-
ICB/11/25/25	Confirmed Minutes of meetings of the ICB Committees: • Children and Young People Committee • Finance, Investment and Our Resources Committee • Quality and Performance Committee • Quality and Performance Committee • System Primary Care Committee • Women's Hospital Services in Liverpool Committee	For assurance	**Page 287**

Date and start time of future meetings

29 January 2026, 13:00 venue tbc (Liverpool)
A full schedule of meetings, locations, and further details on the work of the ICB can be found here: www.cheshireandmerseyside.nhs.uk/about

NHS
Cheshire and Merseyside

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

25 September 2025, 1.30pm,
Authority Chamber, No1 Mann Island, Liverpool, L3 1BP

UNCONFIRMED Draft Minutes

ATTENDANCE	
Name	**Role**
Members	
Raj Jain	Chair, Cheshire & Merseyside ICB (voting member)
Cathy Elliott	Chief Executive, Cheshire & Merseyside ICB (voting member)
Tony Foy	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Andrea McGee	Executive Director of Finance (Interim), Cheshire & Merseyside ICB (voting member)
Dr Ruth Hussey, CB, OBE, DL	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Christine Douglas, MBE	Executive Director of Nursing and Care, Cheshire & Merseyside ICB (voting member)
Trish Bennett	Partner Member (NHS Trust), Cheshire & Merseyside ICB (voting member)
Prof. Rowan Pritchard-Jones	Medical Director, Cheshire & Merseyside ICB (voting member)
Adam Irvine	Partner Member (Primary Care), Cheshire & Merseyside ICB, (voting member)
Erica Morriss	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Mike Burrows	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Prof Hilary Garratt, CBE	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Ann Marr, OBE	Partner Member (NHS Trust) (voting member)
Delyth Curtis	Partner member (Local Authority) (voting member)
Andrew Lewis	Partner Member, (Local Authority) (Voting Member)
Warren Escalade	Partner Member (VCFSE) (Voting Member)
Dr Naomi Rankin	Partner Member (Primary Care) (voting member)
In Attendance	
Clare Watson	Assistant Chief Executive, Cheshire & Merseyside ICB (regular participant)
Anthony Middleton	Director of Performance and Planning, Cheshire & Merseyside ICB (regular participant)
Dr Fiona Lemmens	Deputy Medical Director, Cheshire & Merseyside ICB (regular participant)
John Llewellyn	Chief Digital Information Officer, Cheshire & Merseyside ICB (regular participant)
Prof. Paul Kingston	Chair of ICB Research and Innovation Committee, (regular participant)
Paul Mavers	C&M Healthwatch Representative (regular participant)
Prof. Ian Ashworth	Director of Population Health, Cheshire & Merseyside ICB (regular participant)
Mike Gibney	Chief People Officer, Cheshire & Merseyside ICB (regular participant)
Alison Lee	Knowsley Place Director, Cheshire & Merseyside ICB
Matthew Cunningham	Board Secretary, Cheshire and Merseyside ICB

Apologies	
Name	**Role**
Rev. Dr Ellen Loudon	Director of Social Justice & Canon Chancellor of Liverpool Cathedral, Vice Chair of C&M HCP, (regular participant)
Mandy Nagra	Chief System Improvement and Delivery officer, Cheshire & Merseyside ICB (regular participant)
Janelle Holmes	Partner Member (NHS Trust), Cheshire & Merseyside ICB (voting member)
Louise Robson	Chair, Health Innovation North West Coast (regular participant)

Agenda Item, Discussion, Outcomes and Action Points

Preliminary Business

ICB/09/25/01 Welcome, Apologies and confirmation of quoracy

The Chair welcomed the Board to the Public Board, apologies were noted, and it was confirmed that the Board was quorate.

ICB/09/25/02 Declarations of Interest

There were no declarations of interest made by members that would materially or adversely impact matters requiring discussion and decision within the listed agenda items.

ICB/09/25/03 Chairs remarks

The chair expressed gratitude to Ann Marr, who has stepped down from the ICB Board and her role as Executive Lead of the Merseyside Provider Collaborative after over 45 years of service in Cheshire and Merseyside, during which she led major health improvements. The board collectively thanks Ann for her support over the years and wishes Ann well for the future.

Janelle Holmes, Joint Chief Executive of WCHC and WUTH, has been appointed to replace Ann as a Partner Member on the Board. The Chair welcomed Janelle to her first meeting today and wished her well as a Board Member of the ICB.

To support continuity and stability during ongoing Board restructuring, Adam Irvine's term as Partner Member (Primary Care) has been extended by six months.

The Board noted the update.

ICB/09/25/04 Experience and achievement story

The ICB showcased a supported employment initiative in Cheshire West and Chester that successfully helped over 100 individuals with learning disabilities and autism into the workforce, with 60 now in paid employment; the programme, which includes tailored support such as CV building, coaching, and working interviews, not only improves individual independence and wellbeing but also contributes to reducing economic inactivity across the region, aligning with the ICB's strategic objective to strengthen the local economy through inclusive employment.

Leadership Reports

ICB/09/25/05 Report of the ICB Chief Executive

The Chief Executive presented her second board report outlining key developments and strategic initiatives in health and care within NHS Cheshire and Merseyside.

Cheshire and Merseyside ICB are addressing financial and performance challenges under NHS England's updated oversight framework, with several Trusts placed in lower performance segments. Targeted improvement plans are underway across urgent, elective, and cancer care services. Despite these challenges, most Trusts are rated Good or Outstanding by the CQC, and the ICB continues to advocate for equitable NHS funding across the North.

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Recent achievements include:

- 50 neighbourhoods targeted for expanded healthcare delivery, building on national recognition of Sefton and St Helens as pioneers.
- The Living Well bus reached a milestone in cervical screenings, improving access to preventative care.
- The All Together Fairer programme received national recognition for reducing health inequalities.
- Public health campaigns “Too Much Blue, Get a Review” (asthma), “Know Your Numbers” (blood pressure), and “All Together Smiling” (oral health) are driving measurable improvements in community health.
- Hydration pilots in Wirral and Sefton led to reductions in antibiotic use, emergency admissions, and falls among older adults.
- The ICB earned the Silver Social Value Quality Mark® and the Gold Award for supporting the Armed Forces community.
- Alder Hey Children’s Hospital installed Europe’s first 3-Tesla MRI research scanner, enhancing paediatric imaging.
- A new Primary Care Commercial Research Delivery Centre was launched to expand clinical trial access.
- Investment has been secured to automate cancer biopsy processing, aiming to reduce diagnosis delays.

Strategic developments also include a governance reset to an executive committee structure and the launch of the Valproate Patient Safety Programme to improve prescribing safety for women of childbearing age.

Future Plans and Strategic Focus
Building on the national recognition of St Helens and Sefton as pioneers, the ICB plans to expand neighbourhood healthcare across 50 neighbourhoods in Cheshire and Merseyside. This aligns with NHS guidance and the 10-year health plan. The ICB will continue to publish regular updates on NHS trust performance, including CQC ratings, to provide a balanced and transparent view of service quality. The transition to an executive committee structure is intended to strengthen decision-making and accountability within the ICB.

ICB Chief Executive welcomed Andrea McGee who has joined as Interim Executive Director of Finance and Contracting, strengthening financial recovery efforts, and thanked Mark Bakewell for his service as he transitions to NHS Lancashire and South Cumbria ICB.

The Board noted the report

ICB/09/25/06 Cheshire and Merseyside ICS Finance Month 3 Report and Month 4 Summary Update

Cheshire and Merseyside ICB Interim Director of Finance briefed the board on ICB Month 3–4 Position. ICB is facing a significant financial challenge, with a projected year-end deficit of £385 million far exceeding the planned £178 million deficit required to secure support funding. This is due to back-loaded financial plans and underdeveloped efficiency strategies with only partial delivery of cost improvement programmes, a third of which are non-recurrent.

Overspending areas: acute care (especially independent sector), mental health services (notably ADHD) and primary care prescribing

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Urgent actions required

- Plans to shift from one-off savings to sustainable cost reductions. Improve credibility and pace of delivery to accelerate recurrent efficiency
- Immediate grip needed on acute, mental health, and prescribing budgets to control in-year overspending,
- Develop and implement credible recovery plans. Engage providers in assurance and delivery tracking

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to aid system-wide recovery planning • Monitor distressed cash positions and avoid further deterioration in payment performance. Five trusts have already received £49 million in distressed funding, placing the system in a high-risk, low-confidence turnaround position that demands immediate and credible recovery planning. Next Steps October 2025: Mid-year financial review and CIP refresh. November 2025: Updated forecast and recovery assurance to NHS England. Ongoing: Weekly monitoring of run rate and provider financial risk **The Board noted the report**
ICB/09/25/07 Highlight report of the Chair of ICB Finance, Investment and Our Resources Committee
Chair of ICB Finance, Investment and Our Resources Committee provided a highlight report which reviewed meetings held in June, August, and a recent session, focusing on the escalating financial challenges facing the Integrated Care Board (ICB). NHS England has signalled the need for more detailed tracking of cost improvement plans and robust testing of remediation strategies. The committee anticipates a shift toward more forensic financial risk assessment in future agendas. Key financial figures include: • A planned system deficit of £178 million for 2025–26, which is tied to receiving equivalent deficit support funding to achieve break-even. • Current spending trends project a deficit of £385 million, significantly above plan. • Month 4 alone showed a £139.5 million deficit, indicating a worsening financial position. • The ICB must deliver £139 million in efficiencies, while providers are expected to deliver £433 million, with an additional stretch target of £235 million across the system. • Five trusts have already received £49 million in distressed cash funding. Looking ahead to 2026–27, significant concerns were raised regarding the planned reset of contract values and the expected withdrawal of deficit support funding. These changes, combined with the ICB's underlying deficit position, will require substantial technical preparation and the development of comprehensive recovery strategies to ensure financial sustainability across individual organisations. **The Board noted the report**
ICB/09/25/08 NHS Cheshire and Merseyside Integrated Performance Report
ICB Director of Performance & Planning shared integrated performance report which provided a balanced overview of ICB performance, highlighting improvements in ambulance handover times and reductions in long-wait elective patients, while acknowledging ongoing challenges in urgent and emergency care (UEC), cancer services, neurosurgery, and community health waiting lists; concerns were raised about healthcare-acquired infections and Continuing Healthcare (CHC) assessments, with actions underway to address clinical variation, workforce pressures, and data transparency across the system. **The Board noted the report**
ICB/09/25/09 Highlight report of the Chair of ICB Quality and Performance Committee
The Chair of ICB Quality and Performance Committee raised concerns through highlight report about persistent challenges in meeting statutory health assessment timelines for children in care and safeguarding issues, citing staffing shortages, rising complexity of needs, and lack of clarity from NHS England regarding future safeguarding responsibilities; in response, the ICB is developing interim solutions, engaging designated professionals, and coordinating with local authority directors to ensure

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continuity and improvement amid ongoing NHS reforms. Key Safeguarding Concerns • There is a repeated failure to meet statutory timelines for initial and repeat health assessments for children in care. This issue has been ongoing and is worsening, with concerns about its impact on vulnerable children. • Reports on domestic abuse and sexual safety highlight the need for stronger multi-agency coordination. Safeguarding teams are under pressure due to rising complexity in cases and limited capacity. • The lack of clarity around the future operating model for safeguarding under the NHS reforms (including the Model ICB Blueprint and Model Region guidance) is contributing to strategic risk and operational uncertainty. Workforce Challenges • There are significant staffing shortages in specialist safeguarding roles, particularly designated professionals, which is affecting service delivery and compliance with statutory duties. High levels of sickness and absence within safeguarding teams are compounding workforce pressures and limiting capacity to respond effectively. • Staff morale has been impacted by uncertainty around future roles and responsibilities, especially following national communications about potential changes to safeguarding functions. The ICB is working on interim measures, including peer support and temporary staffing solutions, to maintain safe and statutory safeguarding coverage while awaiting further national guidance. **The Board noted the report**
ICB/09/25/10 Highlight report of the Chair of ICB Audit Committee
Chair of ICB Audit Committee shared highlight report. The Audit Committee reviewed the 2024–25 annual report and risk register. Annual Report 2024–25 approved, covering committee activities, effectiveness, and attendance. Three high risks were noted. A fraud risk related to NHS patients was downgraded due to effective mitigation. Concerns were raised about the accuracy of current risk scores, particularly for governance and financial control (G5). Key discussions and decisions: Progress noted in Freedom to Speak Up (FTSU) awareness and ambassador recruitment. Risks identified include lack of follow-up and training gaps among senior leaders. Next steps include targeted communications and enhanced inclusion efforts. Updates provided on DSPT, ROPA, IG training, and cyber security. Emphasis placed on compliance and staff training for handling patient data. Limited progress on Cyber Security Strategy due to resource constraints and pending national funding. Key risks include Windows 11 migration and secure email accreditation. The Committee stressed the importance of cyber resilience investment. Forward Planning A comprehensive review and reset of the risk register is planned for the December meeting. Continued development of FTSU and cyber security arrangements. Ongoing focus on improving SAR and FOI response processes. Additionally, the committee addressed GP prescribing budget pressures with a detailed review planned for October and upheld a previous decision to deny a BSM pay uplift request to maintain financial discipline. **The Board noted the report**

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ICB/09/25/11 Highlight report of the Chair of System Primary Care Committee
Chair of System Primary Care Committee provided a highlight report. The Committee reviewed several key issues, including a planned deep dive into the M4 Pharmacy Budget at the October SPCC meeting, led by Susanne Lynch. Approval was given for a Local Enhanced Service for Tirzepatide (weight loss medication), and a phased approach to an Enhanced Service for adult ADHD treatment was agreed, pending financial confirmation. Governance discussions led to a thematic re-categorisation of contractor risks and a recommendation to step down risk P6, subject to Board approval. Strategic priorities such as Neighbourhood Health and Access to General Practice were discussed, with updates on governance and patient experience, including the GP Patient Survey and Healthwatch findings. Estates matters included agreement on service charges, and a 10-year APMS contract was approved. The Committee also reviewed the Blinx Paco digital pilot, with further engagement planned. Updates on primary care quality were received, including support for a unified indicator set and endorsement of the “When A Child Dies” framework. Contracting and policy updates highlighted the Ten-Year Plan and dental contract reform. All discussions contributed to the delivery of the ICB Annual Delivery Plan objectives. **The Board noted the report**
ICB/09/25/12 Highlight report of the Chair of the Remuneration Committee
Chair of the Remuneration Committee provided a highlight report. The Remuneration Committee convened to address several key matters concerning leadership transitions, organizational restructuring, and remuneration decisions within the ICB: The Committee received an update on the process to appoint a new Chair following the departure of the current Chair. An acting Chair was discussed for the interim period. The Committee was informed of the procedural requirements for appointing a new Chair, including the use of an external recruitment partner and NHS England support. An update was provided on the proposed structure of the new Executive Team. The Committee reviewed the timeline and consultation process with affected staff. The restructure aims to address financial leadership and control in light of significant financial challenges and potential redundancies. The Committee considered a request for a 3.25% pay uplift for Very Senior Managers (VSMs) for 2025/26. The request was declined, citing fairness, equity, and affordability. This decision was consistent with the stance taken at the previous meeting. A specific pay uplift request from an individual Director was also reviewed and not approved. **The Board noted the report**
ICB/09/25/13 Highlight report of the Chair of the Children’s and Young People Committee
Chair of the Children’s and Young People Committee provided a highlight report. The Children and Young Peoples Committee convened to review and discuss several key programmes and initiatives across Cheshire and Merseyside aimed at improving outcomes for children and young people (CYP). The report highlighted the following: The Committee received and noted the BEYOND annual report, emphasizing its impact and the need to

align with new national funding for local authorities.

- All Together Smiling Programme: A supervised toothbrushing initiative targeting areas with high dental decay, benefiting nearly 11,000 children in its first quarter.
- Gateway Programme: A multi-agency framework addressing complex unmet needs through timely, person-centred action and cross-professional collaboration.
- Youth in Mind Programme: Delivered via the Youth Zone in Warrington, offering accessible support for CYP aged 7–19 (up to 25 with additional needs).

The Committee considered establishing a Complex Needs forum to enhance continuous improvement and professional engagement.

CYP Mental Health Spend: A report detailed year-on-year funding growth, though spend per head remains below the national average. Concerns were raised about budget reductions and their impact on VCFSE services.

The Committee discussed the importance of capturing service aspirations in ICB commissioning discussions and the broader financial pressures affecting CYP services.

The Board noted the report

ICB/09/25/14 Highlight report of the Chair of the North West Specialised Services Joint Committee

Chair of the North West Specialised Services Joint Committee provided a highlight report. The committee focused on several strategic priorities and programme updates. Prevention and early intervention were highlighted as key areas, with a request for annual progress updates. There was also a strong emphasis on integrating cardio-renal metabolic conditions into ICB commissioning, with efforts to align with Welsh colleagues.

In women's and children's services, neonatal activity remained stable, and collaborative work with Cheshire & Merseyside continued, with a maternity services launch scheduled for October.
From a financial and commissioning perspective, Q1 surpluses were reported in Cheshire & Merseyside and Lancashire & South Cumbria, while a national costing exercise is currently underway. Key risks identified included providers' inability to meet demand and RTT targets, cost pressures in adult secure services for Greater Manchester, and staffing shortages in finance teams. To address these, ICB finance leads were tasked with ensuring specialised commissioning budgets are reflected in recovery plans, and national colleagues will be invited to future meetings.

In terms of quality and safety, concerns were raised about an MRSA outbreak at Manchester Oxford Road, delays in thrombectomy access, and neonatal retinal screening. However, improvements were noted in mental health data reporting, as well as upgrades to the environment and service status in CAMHS. For mental health and low/medium secure services (LPCs), the committee approved the extension and integration of contracts for Adult Eating Disorders, Tier 4 CAMHS, and Perinatal Mental Health. Plans were also made to develop federated models and direct awards for 2027/28.

Specialised commissioning and transformation efforts included the creation of Offices of Pan-ICB Commissioning (OfPIC), with a full transfer of specialised services, Health & Justice, and Section 7A commissioning to ICBs expected by March 2027. Additionally, revised timelines were introduced for the Neonatal Critical Care transformation programme.

Finally, governance and risk management discussions highlighted several high-scoring risks, including delays in the NW Safe and Sustainable (SAS) programme, non-compliance with neonatal service standards, and interim arrangements for Adult Critical Care Transport services. Monthly finance reporting and configuration assessments will continue to support oversight and accountability.

The Board noted the report

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ICB/09/25/15 Highlight report of the Women's Hospital Services in Liverpool Committee Chair of the Committee

Chair of Women's Hospital Services in Liverpool Committee provided a highlight report. The Committee met on 9 July 2025 to review progress on the Options Appraisal Process, noting strong engagement from clinical services, the Lived Experience Panel, Healthwatch, and voluntary sector groups, which led to refinement of the longlist of options. A member of the Lived Experience Panel praised the consistency of views across working groups. The Independent Clinical Programme Lead presented the longlist, which was evaluated against agreed criteria, and further clinical and financial analysis is underway to inform shortlisting.

The Programme Board reported ongoing work with clinicians to clarify models for critical care, emergency care, and neonatal services, alongside reassessment of estates and financial modelling supported by LUHFT and Mersey Internal Audit Agency. A clinical workshop was held in August to further test options, awaiting validation from the Clinical Reference Group.

No new risks were added to the Programme Risk Register; Risk 6 remains high, while Risk 7 has been downgraded.

The Board noted the report

ICB Business Items

ICB/09/25/16 Cheshire and Merseyside Urgent and Emergency Care Improvement Update

The ICB Deputy Medical Officer provided the Board with a detailed update on the strategic initiatives underway to improve the Urgent and Emergency Care (UEC) system across Cheshire and Merseyside, following the July 2025 Board request for deeper insight into system performance and improvement activities.

Strategic Objectives

- Reduce corridor care by 50% by March 2026
- Deliver performance improvements aligned with the national UEC plan
- Enhance value for money across UEC services
- Improve patient outcomes and experience

Key developments include implementation of strengthened oversight and governance arrangements to unify system partners and drive coordinated action and establishment of a continuous improvement approach led by the newly formed UEC Improvement Group.

Deployment of targeted improvement programmes across five localities, focusing on:

- Reducing ambulance handover delays
- Minimising long waits
- Improving clinical consistency and communication
- Addressing hidden waiting lists

The system-wide UEC Improvement Plans are being actively monitored, with early signs of benefit in areas such as corridor care reduction, improved ambulance handover times, enhanced patient experience, supported by Healthwatch engagement and data tracking improvements and frontline staff involvement

This update was supported by a presentation that outlines the operational progress and future direction of the UEC transformation programme.

Actions and next steps included:

- Continue tracking provider recovery plans, sharing best practice (e.g., Warrington's waterfall chart), and holding providers accountable for off-trajectory performance.

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• Increase engagement with specialty teams, primary care, and Healthwatch to identify and address operational obstacles and improve patient experience. • Further develop the improvement culture, standardise processes, and ensure learning is shared across the system. • Reallocate ICB resources to support UEC improvement work. • Present updates and assurance to NHS England and the Board, with ongoing monitoring of progress. **The Board noted the report and expressed support for the approach and ongoing work.**
ICB/09/25/17 Cheshire and Merseyside Winter Plan 2025-26
The ICB Director of Performance & Planning shared the ICB's winter planning report which outlined a system-wide strategy emphasising preparedness, resilience, and response over new funding, supported by governance structures, demand modelling, and escalation protocols. It was outlined that a comprehensive winter plan to address urgent and emergency care (UEC) priorities for 2025/26 had been developed. The plan is structured around five locality areas, each led by a Senior Responsible Officer, and aims to ensure system-wide coordination and readiness. The Winter Plan focuses on preparation, resilience, and response to seasonal pressures, with no additional central funding expected. It emphasises learning from previous years, strong governance, and proactive discharge planning, especially around the Christmas and New Year period. Localities developed their own plans using an ICB checklist, with assurance statements to be signed off by locality boards. Gaps remain, particularly around seven-day and Christmas period services, but ongoing development is planned. The plan underwent quality and equality assessment, with the main risk identified as workforce capacity during periods of escalation. The plan itself was not seen as disadvantaging patients, but winter pressures pose inherent risks. Key components of the plan include: • Local Delivery and Assurance: Plans are supported by robust local arrangements and a structured agenda, including locality-level "Check & Challenge" sessions and participation in Exercise Aegis (held on 8 September 2025). • Board Assurance: Completion of the Board Assurance Statement and winter readiness checklists from each locality are central to the submission process. • Strategic Objectives: The plan targets improvements in ambulance response times, A&E performance, mental health delays, and discharge processes. • Funding and Investment: While no additional revenue funding is available, national capital investment will support urgent care infrastructure. • Governance and Compliance: The plan aligns with national guidance and affirms the ICB's commitment to meeting NHS England's requirements. This strategic approach ensures the Board can be confident in the system's preparedness for winter pressures, with a focus on risk mitigation and continuous improvement The plan has been stress-tested, reviewed for assurance, and approved for submission to NHS England, with ongoing development overseen by locality boards and the Quality and Performance Committee. Engagement with voluntary, community, and social enterprise sectors is planned, alongside proactive vaccination efforts as part of the winter readiness strategy. All NHS providers have been asked to sign off their own assurance statements, with no reported refusals,

Agenda Item, Discussion, Outcomes and Action Points
and weekly regional assurance sessions updates to NHS England will continue. While no new funding is included, contingency planning is advised to address potential resource needs. Multi-agency discharge events are scheduled for November and December to ease holiday pressures, and escalation roles are clearly defined using OPAL scores and system-wide triggers. Board members raised the need for: • Stress-testing the plan to ensure it can withstand severe winter scenarios. • Clear modelling of surge capacity, escalation triggers, and the impact of interventions (e.g., stopping electives). • System-wide cost and risk analysis, including for general practice, pharmacy, and the voluntary sector. • Contingency planning for potential extra costs, as escalation often leads to increased expenditure **The ICB Board:** • **approved the assurance statement and endorsed the continuing approach to further develop, test, and assure winter resilience**
ICB/09/25/18 Cheshire and Merseyside Work and Health Strategy and 'Get Britain Working' Plans
Prof. Ian Ashworth presented the item. In summary, it was outlined how the ICB has endorsed a region-wide Work and Health Strategy, developed in response to a national mandate and aligned with the ICB's fourth strategic objective: contributing to social and economic development. The strategy was presented as a nationally mandated requirement, focusing on supporting people with health conditions into employment and addressing barriers such as long-term sickness, mental health, and social isolation. The strategy aims to reduce health-related barriers to employment, focusing on groups such as people with long-term sickness, mental health needs, carers, care leavers, refugees, over-50s, and women. It was developed collaboratively with local authorities, economic partners, and the voluntary sector. The approach involved collaboration with local partners, combined authorities, and economic growth teams, with an emphasis on joint governance and integrated action plans. Board members emphasised the need to prioritise actions from the strategy, clarify the NHS/ICB's specific role, and ensure provider organisations are engaged and accountable, especially regarding employment opportunities for people with learning disabilities and care leavers. There was discussion about leveraging NHS employment opportunities for people with learning disabilities and care leavers, and the importance of incorporating these aims into commissioning intentions and contracts. Key next steps agreed included • Further define and prioritise specific actions for the NHS and ICB. • Strengthen provider engagement and incorporate employment targets into commissioning intentions and contracts • Develop joint governance, aligned with strategic authorities in LCR and C&W and ensuring integration with health and wellbeing boards • Continue to monitor progress and update the Board through the Executive Committee and evolving governance structures. **The Board agreed to:** • **acknowledge the joint working and development of the strategy.** • **Endorse the published Cheshire Merseyside Work and Health Strategy and the two "Get Britain Working" plans.** • **Endorse the proposed governance and oversight approach, with further work needed to**

Agenda Item, Discussion, Outcomes and Action Points
connect with strategic authorities and health and wellbeing boards. • **Recognise the progress made and the need for ongoing prioritisation and implementation planning.**
ICB/09/25/19 Proposed draft NHS Cheshire and Merseyside Board Assurance Framework Strategic Risks for the 2025-2028 period
ICB Assistant Chief Executive presented Cheshire and Merseyside ICB's draft Board Assurance Framework (BAF) for 2025–2028, outlining strategic risks aligned to statutory duties and the ICB's four strategic objectives. The framework reflects the evolving healthcare landscape, including financial pressures, performance challenges, governance reforms, and system-wide transformation. The following was covered briefly due to time constraints: • the draft 2025–2028 Board Assurance Framework (BAF) and its strategic risks were presented for endorsement, with the intent to finalise controls, mitigations, and ambitions by November. • the BAF is designed to cover a three-year period, with the understanding that while risks may remain stable, controls and mitigations could be updated annually. The Board agreed that Clare would bring back the finalised BAF and a formal risk appetite statement to the November 2025 Board, following further work and a board development session. Ruth Hussey suggested rewording a risk from "failure to recover access and performance" to "failing to meet access and performance standards" for clarity and durability. The board noted recent work on risk appetite and agreed that the BAF should be adaptable to changing circumstances, especially given current financial and performance challenges. **The board approved moving forward with the proposed approach and timeline for the BAF and risk appetite work, and agreed to finalise approving the BAF at its November 2025 meeting.**
Meeting Governance
ICB/09/25/20 Minutes of the previous meeting: • July 2025.
The minute of the previous meeting held on July 2025 were accepted and recorded as a true and accurate reflection of the meeting**.**
ICB/09/25/21 Board Action Log
The Action log was taken as read
ICB/09/25/22 Closing Remarks and review of the meeting
Productive and enjoyable meeting, thanks given to all for active participation. The Chair closed the meeting.
CLOSE OF MEETING

CONSENT ITEMS
The Board received and noted the items within the Consent Item section of the September 2025 Board.

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

ICB Board Meeting Action Log

Updated: **20.11.25**

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status	Recommendation to Board
ICB-AC-91	27/03/2025	**Supporting Care Leavers into Employment**	Chief People Officer to develop a delivery plan and budget for the care leavers recruitment initiative and provide a report back to Board.	**Mike Gibney**	Nov-25	*Update included within the November 2025 Cex Report.*	COMPLETED	Board is asked to approve closure of action
ICB-AC-94	28/05/2025	**Report of the Chair of Specialised Commissioning Joint Committee**	Clare to follow up with the Spec Comm leadership team to identify actions to reduce overconsumption of resources of SpecComm, with a report back to Board in three to six months.	**Clare Watson**	Nov-25	*Added to Forward Plan for Board. Update to be provided in January 2026*	ONGOING	

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 November 2025

Report of the Chief Executive

Agenda Item No: ICB/11/25/08

Responsible Director: Liz Bishop
Chief Executive

Report of the Chief Executive (November 2025)

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

Cessation of NHS funded Gluten Free prescribing

3.1 At its May 2025 meeting, the Board agreed to cease NHS-funded prescribing of gluten free foods for both adults and children. It was agreed however that implementation for children and young people under 18 was deferred for six months, until November 2025, to allow further consideration of how Places could mitigate the impact, particularly for children and vulnerable groups. During this period, we have:

- thoroughly explored the option of targeted prescribing for vulnerable groups, but concluded that this approach would be unworkable in clinical practice and could inadvertently create new inequalities in access to care.
- engaged with Place-based teams, who have confirmed that local initiatives are in place to support their populations, including financial advice and assistance.
- continued to advance the All Together Fairer programme, which addresses wider determinants of health through workstreams such as maximising household income (in partnership with DWP and Local Authorities), promoting access to free school meals and the Healthy Start scheme, and delivering poverty awareness training to frontline staff.

3.2 These actions reflect our ongoing commitment to reducing health inequalities and supporting families most at risk.

3.3 In light of the above the ICB is proceeding with the cessation of NHS-funded gluten free prescribing for all age groups following the November Board meeting. Place-based teams will continue to support affected patients through

local networks and resources, and GPs have been engaged to ensure a smooth transition.

Thirlwall Inquiry Update

3.4 The Inquiry has written to Core Participants with an update on the timetable for the final report. Work on the report is ongoing, and publication is scheduled for after Easter 2026. A further update on the timetable will be provided at the end of February 2026. We will keep the Bord updated on any developments and implications for the ICB and system.

NHS Industrial Action

3.5 Resident doctors took strike action from 7am on Friday 14 November 2025 to 7am on Wednesday 19 November 2025, impacting NHS services across the Cheshire and Merseyside region.

3.6 Hospital services – including most planned care - were maintained throughout the period of Industrial Action, with prioritisation of patients with the greatest clinical need. The Cheshire and Merseyside system as a whole performed well throughout the period, with no major disruptions to patient care.

3.7 This is testament to our staff – across the system – whom NHS Cheshire and Merseyside would like to thank for their huge efforts to keep our NHS services running smoothly. Whilst this period of industrial action has come to an end, we are now entering the busy winter period (and the flu season) and this huge effort will continue to be required to maintain high quality services for our patients.

Winter – Flu vaccination

3.8 As the weather gets colder we are continuing to work with our system partners to ensure we are as resilient as we can be ahead of winter. An important action we can take is to get a seasonal Flu and/ or Covid vaccination if you are eligible. The NHS has issued a ‘flu jab SOS’ as a new strain of the seasonal flu virus is leading to a higher number of cases than we would normally see at this time of year.

3.9 At our July Board we had a discussion about the importance of Flu vaccination for our front line Health and Social Care staff to protect the people we care for, each other and our communities. We agreed that in Cheshire and Merseyside, despite Flu vaccination rates declining in health care staff in the last 5 years, we wanted to strive higher than the national ambition of each Provider aiming for a 5% improvement on last year. We agreed that all of our Providers in Cheshire and Merseyside should aim for a minimum of at least 50% uptake. The latest published data for all NHS Provider Trusts can be found here: https://www.england.nhs.uk/statistics/statistical-work-areas/flu-vaccinations/

3.10 To date, none of our Trusts have hit the local 50% ambition target so there is still lot of work to be done. However, Alder Hey, Countess of Chester, Merseycare and Clatterbridge have already exceeded last year’s uptake, with

Clatterbridge only one of 5 Trusts in the country so far to have achieved 5% more than last year. We will continue to work closely with all of our Providers in the weeks ahead.

3.11 NHS Cheshire and Merseyside are urging all eligible groups, especially children and young adults, to come forward for winter vaccinations as latest data suggests flu and COVID-19 is increasing early this year with hospitalisations starting to rise. Current data indicates that flu cases amongst younger adults and school-age children are driving early flu cases alongside increased presentations to general practice and emergency departments

3.12 Across Cheshire and Merseyside there are a wide range of options available for people to access vaccinations, with some GP practices running drop-in clinics and local teams hosting sessions close to home. For further information on how to get your winter vaccines then visit: www.cheshireandmerseyside.nhs.uk/wintervaccines

Adult Social Care (ASC) Nurse Prescribing Pilot

3.13 The Adult Social Care (ASC) Nurse Prescribing Pilot 2025/26 is a pioneering initiative funded by the Department of Health and Social Care and delivered in partnership with NHS England across the three Northwest Integrated Care Boards. This first-of-its-kind pilot enables nurses in adult social care to undertake the V300 Non-Medical Prescribing qualification, empowering them to prescribe independently within GP services.

3.14 The pilot's objectives are closely aligned with national priorities: reducing delays in care through faster prescribing, supporting safe admissions and discharges, improving resident outcomes, and alleviating workforce pressures on GPs and pharmacists. Social care providers are required to ensure IT compatibility, indemnity, and support for study leave, while the system benefits from cross-ICB collaboration, integrated care pathways, and a scalable blueprint for potential national rollout.

3.15 The pilot is expected to deliver significant benefits at multiple levels. For residents, it promises faster access to medicines, improved health outcomes, and enhanced experiences in care settings. For the workforce, it offers increased job satisfaction, professional development, and reduced workload pressures on GPs and pharmacists. System-wide, the initiative supports improved integration between ASC and primary care, reduced hospital admissions, and the generation of robust evidence to inform future workforce and prescribing policy.

3.16 Evaluation is central to the pilot, with both quantitative and qualitative measures informing interim and final reports throughout 2026. If successful, the model will provide a blueprint for national adoption, supporting the NHS Long Term Plan and the transformation of adult social care.

AMR Leadership and Governance Programme – Funding Success

3.17 The NHS England (NHSE) Antimicrobial Resistance (AMR) Board has endorsed the implementation of a funded programme to strengthen leadership and governance, as part of the UK 5-year action plan for antimicrobial resistance (2024–2029). This initiative aims to confront AMR through enhanced strategic coordination.

3.18 We are pleased to share that NHS Cheshire and Merseyside, in collaboration with Mersey and West Lancashire Teaching Hospitals NHS Trust and Wirral University Teaching Hospital NHS Foundation Trust, has successfully secured funding to support two Consultant Antimicrobial Pharmacist posts. These roles will provide strategic leadership for the antimicrobial stewardship (AMS) agenda at a system level, ensuring alignment with both national priorities and local health system objectives. They will work with Directors of Nursing and IPC colleagues to support reducing healthcare associated infection rates.

NHS Prevention Pledge Summit

3.19 The 2025 NHS Prevention Pledge Summit, held in Liverpool on 16 October 2025, brought together all 16 NHS provider trusts from Cheshire and Merseyside, alongside representatives from NHS England, active partnerships, and the Champs Public Health Collaborative. Now in its third year, the summit showcased best practice and innovation through interactive workshops on key prevention themes, including Making Every Contact Count (MECC), smokefree NHS estates, and creating an active workforce. The event highlighted the region's commitment to the NHS Prevention Pledge—a framework of 14 core commitments adopted by all local provider trusts to address prevention of ill health, health inequalities, social value, and staff wellbeing.

3.20 The summit featured expert speakers and practical sessions, including case studies on MECC training, smokefree policy implementation, and workforce physical activity initiatives. Delegates explored barriers, enablers, and pragmatic actions to embed prevention across NHS organisations, with a strong focus on aligning local efforts to the ambitions of the national 10 Year Health Plan. The event reinforced the importance of collaborative action and continuous improvement in population health, with ongoing work to extend the Prevention Pledge into primary care and refresh the region's All Together Active strategy in 2026.

3.21 The Prevention Pledge supports the ICB's role in leading system-wide collaboration, ensuring that prevention is embedded in service delivery, and that anchor institution practices are maximised for community benefit. The summit's outcomes—shared learning, practical tools, and strengthened partnerships—equip the ICB and its partners to deliver more equitable, sustainable, and person-centred care, in line with national policy and local strategic objectives. The Board's continued support for these initiatives will be critical in driving forward the region's prevention agenda and achieving better health for all communities.

Personal health budgets publication

3.22 A new report, Growing Personal Health Budget Take-Up and Impact in Cheshire and Merseyside[1], demonstrates how personal health budgets (PHBs) for continuing healthcare and children's continuing care are improving lives across the region. PHBs provide individuals with NHS funding to manage their health and wellbeing needs, offering greater choice, control, and flexibility in how care is delivered.

3.23 The report, commissioned by NHS England North West and delivered by Community Catalysts CIC, presents compelling evidence that PHBs enhance patient and family experience, support more personalised and sustainable care, and deliver value for money for the NHS. It features local examples and insights from people with PHBs, their families, third sector partners, and health professionals.

3.24 This development is of particular importance to the Board and aligns directly with the ICB's statutory responsibilities to promote personalised care, improve outcomes, and ensure efficient use of resources. With the national 10 Year Health Plan setting ambitious targets to double PHB uptake by 2028/29 and reach one million people by 2030, the insights and recommendations from this report will be instrumental in guiding local strategy and supporting system-wide collaboration. The Board's attention to this agenda will be critical in meeting national expectations, reducing health inequalities, and empowering individuals and families to shape their own care.

Building Attachments and Bonds Service (BABs)

3.25 The Experience story at Novembers Board is on the Building Attachments and Bonds Service (BABs). BABS is recognised regionally and nationally as a best practice, 'health and care' integrated neighbourhood model which supports the most vulnerable parents and babies with the greatest inequalities and disadvantage to build good bonds and break cycles via an easy to engage, strengths-based, attachment and trauma-informed approach.

3.26 The BABS service is very different to other mental health services as it steps outside of the medical and mental health box and offers a psycho-social, safeguarding model to help vulnerable parents with high ACES (adverse childhood experiences) to separate out their past and present issues and struggles from their relationship with their baby, which can impact and pose a risk. We also support the system around families to ensure as a partnership we safeguard families relationships, mental health, and risk.

3.27 BABS services are delivered by Mersey Care NHS Foundation Trust and co-located in council Family Hubs across five of Merseyside's most deprived boroughs (Knowsley, Sefton, St Helens, Halton and Warrington North). BABS is aligned to offering babies the Best Start in Life, during the 1001 critical days, Children Services reforms putting families first for children the Neighbourhood Health mission and Cheshire and Merseyside's commitment to 'All Together Fairer' and reducing inequalities for our most vulnerable families. Most

[1] https://www.cheshireandmerseyside.nhs.uk/your-health/personal-health-budgets/growing-personal-health-budget-take-up-and-impact/

importantly BABS is driven grass roots up by families and their lived experiences and need for accessible, non-judgemental, strength-based parent infant mental health services.

Children and Young People's Neurodevelopmental Profiling tool

3.28 During October we have commenced the training on the Children and Young People's Neurodevelopmental Profiling tool. This training is for professionals working with children, particularly SENDCOs in schools and is the first step in the Neurodevelopment pathway.

3.29 Where a family or the school believes a child may have ADHD or Autism, the professional in their education setting will work with them to complete the 'This Is Me' profiling tool. This helps systematically identify what early support a child might need to maximise their potential and manage any symptoms. The profiling tool can then form part of a referral for Neurodevelopmental assessment, if the early help provided is insufficient to meet the child's needs.

3.30 We will be rolling the 'This Is Me' profiling tool training out to every school in Cheshire and Merseyside, as well as to early help support teams and family practitioners.

Prescription Medication savings

3.31 NHS Cheshire and Merseyside launched the 'Only Order What You Need' medicines waste communications campaign in November 2024, with the aim to reduce wasted prescription medications across our region.

3.32 From November 2024 - March 2025 we saw a total of £5M savings - a reduction of 641,000 medicines items ordered, compared to forecasted numbers for dispensed medicine items. This is approximately 60 tonnes of prescription medicines, which weighs roughly the same as five double decker buses.

3.33 Our communications team have relaunched the campaign this winter, celebrating the huge savings made, and asking patients to support us in making similar savings this year.

Cheshire and Merseyside primary care recognised at regional awards ceremony

3.34 Primary care staff across Cheshire and Merseyside have been recognised for their outstanding dedication and significant contributions to the field of general practice at an awards ceremony earlier this month.

3.35 The Royal College of General Practitioners (RCGP) Mersey Faculty Awards 2025 were held in Liverpool on Friday 7 November, where individuals and teams from across the region were invited to celebrate their achievements, innovations and impact on patient care.

3.36 NHS Cheshire and Merseyside's Dr Jonathan Griffiths and Dr Bryony Kendall won the GP Award for 'When a Child Dies' – an innovative framework which helps practitioners support bereaved families following the death of a child. This

follows their win at the recent Daffodil Standard Awards, which took place earlier this month, with Dr Griffiths and Dr Kendall jointly winning the 'Addressing Inequalities in End of Life' award alongside the Brownlow Health Homeless Palliative Team.

Super Bodies campaign to go global

3.37 The NHS Cheshire and Merseyside 'Super Bodies' campaign, developed and launched last winter by our communications team, has been widely acclaimed by NHS colleagues across the UK and rolled out nationally this year for use by other NHS ICBs.

3.38 Colleagues from the World Health Organisation have now viewed the campaign and have requested permission to use Super Bodies internationally to support the global fight against antimicrobial resistance - first in Romania, followed by more widespread use, with NHS Cheshire and Merseyside credited for development of the communications campaign.

All Together Smiling

3.39 Board members have been briefed previously regarding the All Together Smiling[2] programme that is funded by the ICB and hosted by Beyond, the children and young people's transformation programme.

3.40 The programme delivers a structured supervised toothbrushing intervention within eligible early years settings, primary schools, and childminders, alongside the targeted provision of free oral health packs (containing a toothbrush, fluoride toothpaste, and oral health key message leaflet for families).

3.41 The programme also delivers communication campaigns to help raise awareness of the importance of oral health and share key messages.

3.42 The programme is pleased to report that 217 settings, 41% of those eligible, are now delivering daily supervised toothbrushing programmes supporting 9,395 children. The programme target is a minimum of 262 settings (50%) taking part – this is required to start to see a difference in our children's oral health.

National Care Leavers Month

3.43 November marks National Care Leavers Month, themed "*Rising as Me: overcoming challenges, transforming and finding your identity.*" This extended month of recognition celebrates achievements, raises awareness of barriers, and calls for real change. Throughout the month, there's promoted resources, shared blogs from care-experienced young people, and highlights of the role of corporate parents. It also includes promotion of the new self-identification features in ESR (Employee Staff Records) and in TRAC (our online recruitment system), which will enable care-experienced young people to access tailored support, guaranteed interviews, and greater understanding from hiring managers.

[2] https://www.cheshireandmerseyside.nhs.uk/about/cheshire-and-merseyside-health-and-care-partnership/all-together-smiling/

3.44 Despite financial challenges, this year has seen significant progress in supporting care-experienced young people across Cheshire and Merseyside. We have hired 10 care-experienced young people into roles across the ICS, including the ICB, creating meaningful employment opportunities and embedding inclusion within our workforce.

3.45 The formation of the Regional Corporate Parenting Steering Group has strengthened governance and accountability, chaired by Chris Douglas, Executive Director of Nursing & Care and our Executive Champion for Care-Experienced Young People. This group brings together local authorities, our ICS, and third-sector partners to drive collaboration and systemic change. These activities, combined with our employment initiatives and advocacy for systemic improvements, demonstrate our commitment to creating fair opportunities and improving life chances for care-experienced young people.

4. Decisions taken at the Executive Committee

4.1 At its meetings throughout October and November 2025, the Executive Committee has also considered papers and made decisions on the following areas:

- **Interim Varicose Vein policy:** The Executive Team approved the launch of an interim Varicose Veins Policy for Cheshire and Merseyside, designed to manage referrals and support improvements in Referral to Treatment (RTT) performance while a full policy review is undertaken. The interim policy introduces stricter criteria for referral to secondary care, prioritising urgent cases with the greatest clinical need and supporting GPs to manage less severe symptoms in primary care. The Policy will support the urgent need to address waiting list pressures and will be communicated to all relevant providers. A pilot review of the waiting list will be initiated, with ongoing development of a comprehensive, clinically supported policy
- **IFR:** The Executive Team approved the recommendation for the development of a single North West Individual Funding Request (IFR) and policy development service, hosted by NHS Greater Manchester, to streamline and harmonise IFR processes and clinical policy review across the three regional ICBs. This includes supporting a phased transition to a unified operating model, with shared governance and consistent policies, to improve efficiency, equity, and quality in handling exceptional funding requests and policy development for the region
- **GP IT:** The Executive Committees supported two key recommendations regarding GP IT: first, to decommission non-mandatory GP IT software solutions through a phased approach over two financial years from April 2026, and to fund GP practices for up to 16 SMS fragments per registered patient per year from January 2026, supporting cost-effective patient communication and generating further recurrent savings.
- **Service Change Panel TOR:** the Executive Committee received and approved the updated Service Change Panel Terms of reference

- **National Cyber Funding:** The Executive Committee approved the recommended approach for managing the 2025/26 national cyber security funding across Cheshire and Merseyside. The proposal was to retain the full revenue allocation for delivery of the Board-approved ICS Cyber Security Strategy. This will enable full delivery of cyber security objectives, strengthen system-wide risk management, and ensure compliance with national requirements. The Committee also supported the recommendation that capital funding is distributed to organisations for targeted investments that support compliance and risk reduction. Approval will allow rapid deployment of resources to enhance cyber resilience across the region.
- **General Practice Estates Investment:** The Executive Committee approved several recommendations regarding general practice estates investment and governance. Specifically, the Committee endorsed changes to the decision-making and approval process for estates investment, confirmed the recommended four high-priority schemes as system priorities and that these four schemes would be included in the ICB Commissioning Intentions and 5-Year Commissioning Plan. The next steps outlined involved utilising available capital or Section 106 funds to develop full business cases for each scheme—without committing the ICB to financial liability until formal approval at the business case stage—and ensuring each project is prioritised locally.

4.2 Additionally at its meetings throughout October and November 2025, the Executive Committee has also considered papers on or had verbal updates discussing the following areas:

- Financial recovery and financial position on a monthly basis
- Resourcing priority programmes across the ICB
- Neighbourhood health
- System Delivery meetings
- Winter Planning and responding to Industrial Action
- IVF Policy
- Winter vaccinations
- ADHD referrals
- CHC Fast track discharges proposals
- S117 Panel Process Options
- Area Prescribing Group recommendations.

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

5. Officer contact details for more information

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Chief Executive

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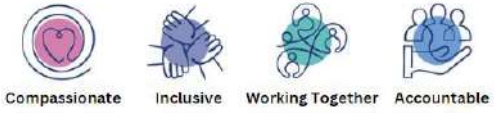
Cheshire and Merseyside



Leading integration through collaboration

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 November 2025

Cheshire and Merseyside System Financial Position – Month 7

Agenda Item No: ICB/11/25/09

Responsible Director: Andrea McGee, Executive Director of Finance

Cheshire and Merseyside System Financial Position – Month 7

1. Purpose of the Report

1.1 This report provides an update to the Board on the financial performance of the Cheshire and Merseyside Integrated Care System ("the ICS") at Month 7 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

2.1 On 27 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 30 April 2025.

2.2 As part of agreeing to the deficit control total a further system stretch of £235m was included in plans (£30m for the ICB and £205m for providers). Of the system stretch £75m was factored into CIP/CRES plans during the planning process (£16m for the ICB and £59m for providers).

2.3 In addition, the ICB at planning also assumed delivery of further non pay savings and efficiencies of £23m, increasing the ICB requirement to £192m.

2.4 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 be released to the system quarterly subject to prospective assurance from NHSE covering areas such as progress with delivery of efficiency plans, and review of expenditure and workforce run rates.

2.5 The system received £44.5m of deficit support funding (DSF) for Quarter One however, due to the level of financial risk in the Cheshire and Merseyside system, the Deficit Support Funding (DSF) for Quarter 2 and Quarter 3 has not been awarded to the ICB. Therefore, the YTD system financial position is adversely affected due to £59.4m of DSF funding relating to Q2 and month 7 being withheld.

2.6 NHS has placed a number of 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.

3. Financial Position as at Month 7

3.1 As of 31 October 2025 (Month 7), the ICS is reporting a YTD deficit of £138m (including Q1 DSF) against a planned YTD deficit of £78.6m resulting in an adverse YTD variance of £59.4m which is all in relation to the withheld DSF.

3.2 Appendix One contains details of the ICB financial position and the overall system position.

3.3 Excluding DSF, the ICS is reporting on plan at month 7, which includes mitigating £6m of Industrial Action costs, which were not planned for.

3.4 It should be noted that the first seven months of the financial year consumes 102% of the annual deficit ICS plan. Significant improvement in the run-rate will be required in order to meet the plan by the end of the year, i.e. a surplus will need to be delivered.

3.5 DSF is being withheld by the region as they want to see a clear and credible plan that describes how the ICS will achieve the improved run-rate and deliver the 2026/27 plan by the end of the year.

3.6 The current Mid-case forecast (Appendix One slide 4) is a £349m deficit, which is £171m off plan with a best-case forecast of £243m (£65m adverse variance to plan).

3.7 The impact on cash positions in NHS Providers is set out in Appendix One, slide 7. The low levels of cash are impacting on Better Payment Practice Code and resulting in applications to NHSE for distress cash funding (£82m approved so far this year).

3.8 NHSE has been working alongside all system partners to work on a consistent underlying position. At Month 7 the underlying position is between the range of £472m and £372m deficit, depending on a risk assessment of CIP deliverability. This excludes DSF and assumes current business rules continue as is. Further work on the underlying position will be undertaken as part of the planning process, taking into account changes to NHS business rules.

3.9 PWC has been deployed alongside NHSE to undertake monthly reviews with High-risk organisations, including the ICB. In addition, they are conducting Grip and Control reviews and Balance Sheet reviews. It is imperative that organisations develop their plans to deliver their control totals at pace, supported by credible delivery actions. These will be reviewed in the next round of financial performance review meetings.

4. Ask of the Board and Recommendations

4.1 The Board is asked to

- **note** the financial position and metrics reported at Month 7 and the risks to delivery of the financial plan.

5. Officer contact details for more information

Andrea McGee
Executive Director of Finance (Interim) Cheshire and Merseyside ICB

6. Appendices

Appendix One: Cheshire and Merseyside ICB / ICS Financial Position Summary Month 7

CM ICB Board Meeting
27 November 2025
Agenda Item: ICB/11/25/09

NHS
Cheshire and Merseyside

Appendix One:
Cheshire & Merseyside ICB
Financial position headlines

Cheshire & Merseyside ICB
M7 25/26 – key data
12th November 2025

Month 7 YTD – C&M ICB Position

ICB Total	C&M ICB TOTAL - Month 7 Position		
	Budget £'m	Actual £'m	Variance £'m
Acute	2,178	2,179	(1)
Community	429	424	5
Mental Health - Contracts	331	342	(11)
Mental Health - Packages of Care	127	125	2
CHC	279	282	(3)
Delegated GP	356	355	1
Delegated Other - DOP	191	182	10
Prescribing	321	334	(13)
Primary Care Other	73	73	0
Other Commissioned Services	9	9	1
Other Programmes	36	35	1
Reserves	5	0	5
Specialised Commissioning	452	448	4
Sub Total - Programme Expenditure	**4,786**	**4,787**	**(1)**
Running Costs	24	24	0
TOTAL EXPENDITURE	**4,810**	**4,811**	**(1)**
Surplus / (Deficit) Plan	*29*	*0*	*29*
Sub Total - Net Surplus / (Deficit) Reported	***4,840***	***4,811***	***28***

ICB Headlines Month 7 – on plan YTD (£28m surplus)

Key overspends continue to be :

- Primary care prescribing (£13m)
- ADHD (£12m)
- Acute sector (£1m)
- AACC (£3m)

Offset by budgetary performance within:

- Delegated POD £10m (includes £6m prior year)
- Community non-NHS £5m
- MH packages of care £2m
- Reserves £5m
- Specialised commissioning £4m

Risks

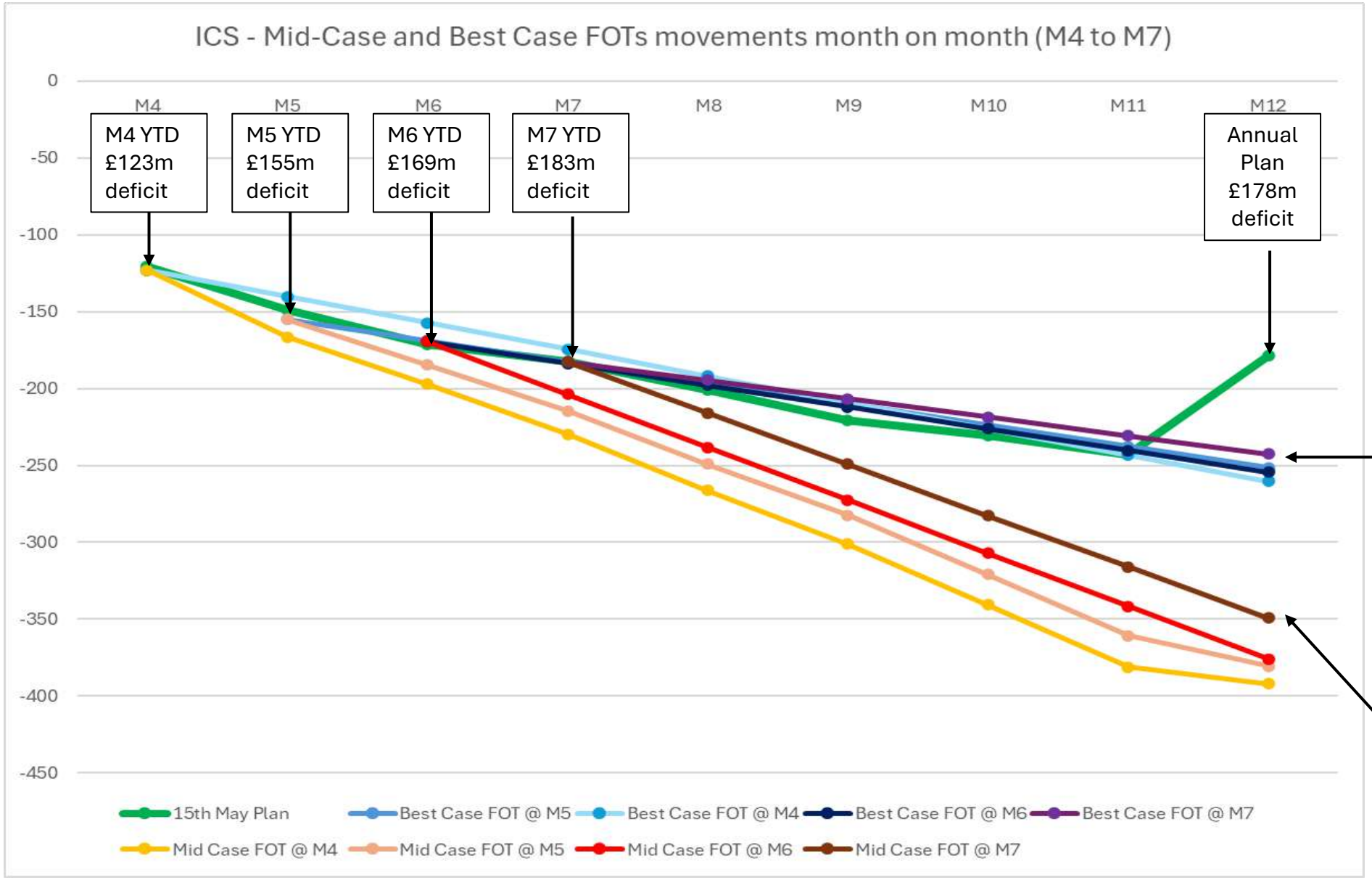
- CRES profile (£49m more in H2)
- c£50m other mitigations to achieve plan

Month 7 – C&M ICS YTD I&E

Org	Month 7 YTD (including DSF)			DSF YTD			Month 7 YTD (excluding DSF)			Full Year Plan	M7 YTD as a % of Plan	Mid Case M7 FOT comparsion	
	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance			SW M7 YTD Forecast reported in Sept (M6)	M7 YTD actual variance to SW FOT (mid case)
	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	%	£,000	£,000
Alder Hey Children's	118	96	(22)	0	0	0	118	96	(22)	7,160	1%	(1,226)	1,322
Bridgewater Community	(2,610)	(2,609)	1	0	0	0	(2,610)	(2,609)	1	(1,530)	171%	(2,678)	69
Cheshire & Wirral Partnership	(2,876)	(1,744)	1,132	0	0	0	(2,876)	(1,744)	1,132	3,985	-44%	(1,733)	(11)
Countess of Chester Hospitals	(13,146)	(19,693)	(6,547)	(11,449)	(4,908)	(6,541)	(24,595)	(24,601)	(6)	(34,040)	72%	(25,270)	669
East Cheshire Trust	(8,418)	(11,865)	(3,447)	(6,027)	(2,583)	(3,444)	(14,445)	(14,448)	(3)	(17,934)	81%	(14,473)	25
Liverpool Heart & Chest	5,182	5,180	(2)	0	0	0	5,182	5,180	(2)	9,552	54%	5,255	(75)
Liverpool University Hospitals	(24,581)	(39,290)	(14,709)	(25,954)	(11,122)	(14,832)	(50,535)	(50,412)	123	(56,609)	89%	(53,993)	3,581
Liverpool Women's	(9,797)	(14,246)	(4,449)	(8,929)	(3,828)	(5,101)	(18,726)	(18,074)	652	(31,024)	58%	(18,106)	32
Mersey Care	1,701	3,002	1,301	0	0	0	1,701	3,002	1,301	14,305	21%	2,680	322
Mid Cheshire Hospitals	(14,827)	(22,047)	(7,220)	(13,441)	(5,761)	(7,680)	(28,268)	(27,808)	460	(39,379)	71%	(29,010)	1,202
Mersey & West Lancs	(25,190)	(30,687)	(5,497)	(17,632)	(7,556)	(10,076)	(42,822)	(38,243)	4,579	(40,950)	93%	(39,086)	843
The Clatterbridge Centre	159	165	6	0	0	0	159	165	6	890	19%	142	23
The Walton Centre	3,775	3,902	127	0	0	0	3,775	3,902	127	6,900	57%	4,104	(202)
Warrington & Halton Hospitals	(13,907)	(20,005)	(6,098)	(10,689)	(4,582)	(6,107)	(24,596)	(24,587)	9	(28,726)	86%	(24,920)	333
Wirral Community	(332)	1,000	1,332	0	0	0	(332)	1,000	1,332	900	111%	400	600
Wirral University Hospitals	(3,207)	(17,533)	(14,326)	(9,863)	(4,229)	(5,634)	(13,070)	(21,762)	(8,692)	(22,140)	98%	(19,834)	(1,928)
TOTAL Providers	**(107,956)**	**(166,374)**	**(58,418)**	**(103,984)**	**(44,568)**	**(59,415)**	**(211,940)**	**(210,943)**	**997**	**(228,640)**	**92%**	**(217,747)**	**6,804**
C&M ICB	29,381	28,396	(985)	0	0	0	29,381	28,396	(985)	50,367	56%	20,710	7,686
TOTAL ICS System	**(78,575)**	**(137,978)**	**(59,403)**	**(103,984)**	**(44,568)**	**(59,415)**	**(182,559)**	**(182,547)**	**12**	**(178,273)**	**102%**	**(197,037)**	**14,490**

- Aggregate ICS Position £138.0m deficit YTD (including Q1 deficit support) – £59.4m adverse from plan, of which £59.4m relates to withhold of M4-7 deficit funding support
- Aggregate ICS position £182.5m deficit YTD (excluding deficit support) – £12k favourable to plan, the position includes £6m of M4 industrial action impact
- The first 7 months of the financial year consumes 102% of the annual deficit ICS plan – effectively meaning a breakeven requirement for every month for remainder of year to achieve plan.

Month 7 – C&M ICS Forecast Risk Range – movements month 4 to month 7



The chart shows the aggregated provider and ICB forecast trajectories and how they have moved over the last 4 months

M7 Best-Case FOT of £243m deficit, improved by £18m between M4 to M7 – but remain £65m adverse to plan

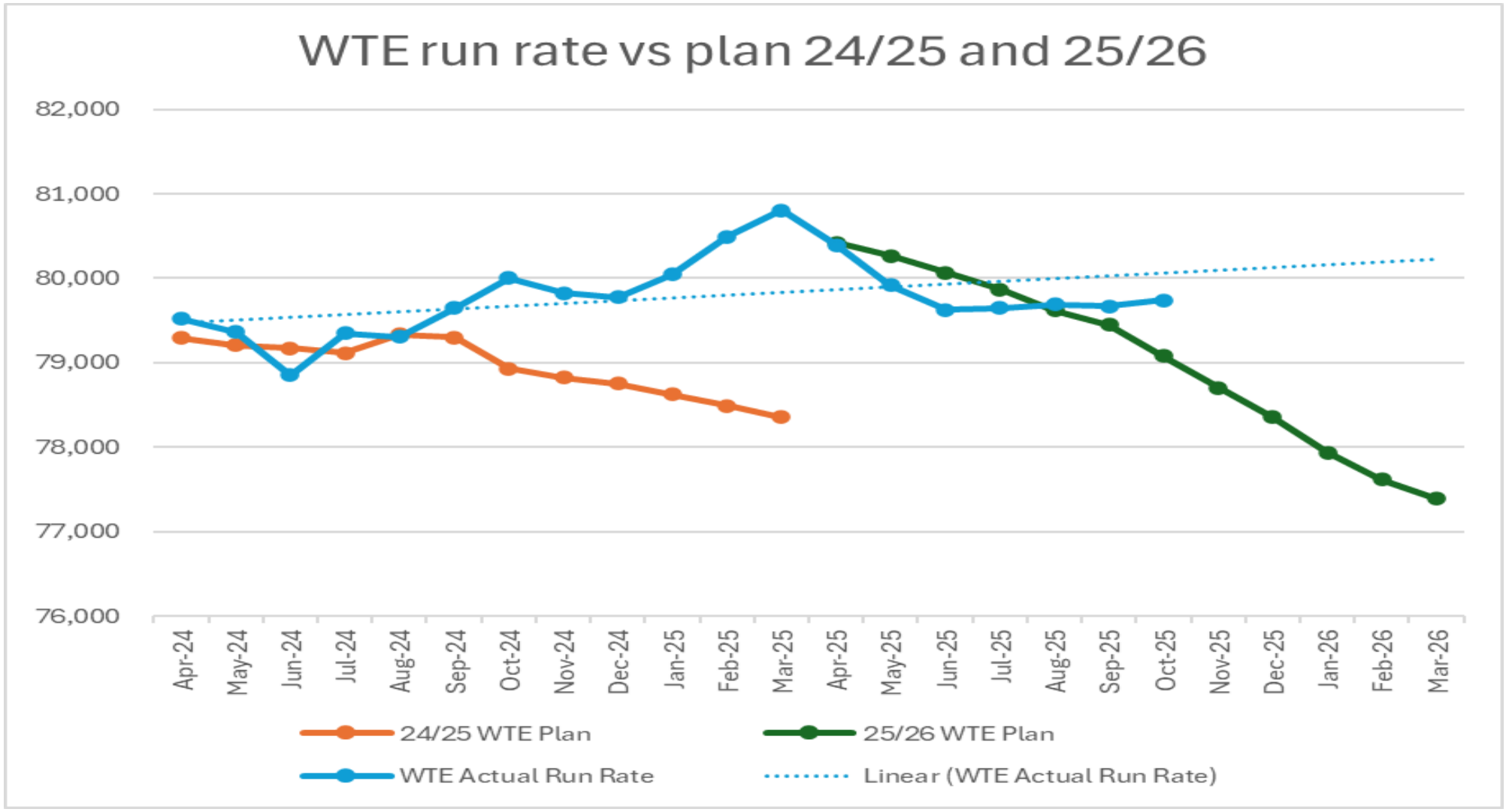
M7 Mid-Case FOT of £349m deficit, improved by £43m between M4 to M7 – but remain £171m adverse to plan

2025/26 Month 7 CIP delivery and recurrent YTD position (providers only)

Org	CIP delivery (Month 7 YTD)					CIP Recurrent / Non Recurent YTD			Full year CIP				CIP Metrics	
	M7 YTD Plan £,000	M7 YTD Actual £,000	M7 YTD Variance £,000	M7 YTD % Variance %	M7 YTD CIP as a % of CIP FOT %	M7 YTD Actual Recurrent £,000	M7 YTD Actual Non Recurrent £,000	M7 Actual Recurrent as a % of YTD plan %	Full year CIP £,000	FOT £,000	Variance to plan £,000	M6 YTD CIP as a % of CIP FOT £,000	M7 CIP delivery as a % of Op Ex %	CIP FOT as % of Op Ex %
Alder Hey Children's	12,321	11,232	(1,089)	-9%	49%	4,876	6,356	40%	22,746	22,746	(0)	49%	4.2%	5.0%
Bridgewater Community	2,983	3,010	28	1%	55%	2,874	136	96%	5,475	5,475	(0)	55%	4.7%	5.1%
Cheshire & Wirral Partnership	7,423	8,154	731	10%	55%	3,777	4,377	51%	14,856	14,856	(0)	55%	4.4%	4.7%
Countess of Chester Hospitals	13,113	6,840	(6,273)	-48%	25%	6,840	-	52%	27,703	27,703	0	25%	2.3%	5.9%
East Cheshire Trust	6,665	6,666	1	0%	55%	3,009	3,657	45%	12,175	12,175	0	55%	4.6%	5.0%
Liverpool Heart & Chest	6,595	5,889	(706)	-11%	44%	3,477	2,412	53%	13,499	13,499	(0)	44%	3.8%	5.0%
Liverpool University Hospitals	50,514	56,260	5,746	11%	48%	30,400	25,860	60%	117,185	117,185	(0)	48%	6.5%	8.1%
Liverpool Women's	6,014	6,832	818	14%	52%	3,675	3,157	61%	12,680	13,178	498	52%	5.9%	6.5%
Mersey Care	20,835	20,557	(278)	-1%	51%	15,454	5,103	74%	40,696	40,037	(659)	51%	4.4%	4.6%
Mid Cheshire Hospitals	16,990	17,363	373	2%	52%	12,764	4,599	75%	31,668	33,443	1,775	52%	5.9%	6.7%
Mersey & West Lancs	26,678	28,534	1,856	7%	57%	17,600	10,934	66%	48,200	49,700	1,500	57%	4.8%	5.0%
The Clatterbridge Centre	7,586	7,586	(0)	0%	50%	5,172	2,414	68%	14,790	15,124	334	50%	3.6%	4.7%
The Walton Centre	6,910	6,910	(0)	0%	56%	6,283	627	91%	12,247	12,247	(0)	56%	5.3%	5.5%
Warrington & Halton Hospitals	10,813	10,822	9	0%	50%	5,189	5,633	48%	21,477	21,486	8	50%	4.3%	5.1%
Wirral Community	3,118	3,045	(73)	-2%	44%	3,045	-	98%	5,702	6,940	1,238	44%	4.8%	6.3%
Wirral University Hospitals	18,678	18,676	(2)	0%	58%	11,229	7,447	60%	32,020	32,020	0	58%	5.7%	5.8%
TOTAL Providers	**217,235**	**218,375**	**1,140**	**0.5%**	**50%**	**135,665**	**82,711**	**62%**	**433,118**	**437,813**	**4,695**	**50%**		

- £1.140m favourable CIP to plan, largely driven by LUFT and MWL, with x3 organisations with material YTD CIP shortfall COCH, Alder Hey and Liv H&C
- Of £218.4m delivered £82.7m is non recurrent (38% of plan) – impact on underlying position
- A number of organisations have increased their CIP forecast vs Plan (£15.3m in aggregate) to reflect a combination of stretch and mitigations schemes

2025/26 Month 7 – WTE run rates at system level



2025/26 Month 7 – Cash

£82.6m distressed cash YTD
£59m DSF withheld
(cash shortage > DSF)

£50m requested Nov & Dec

Org	Cash Bala			Operating Days Cash Actual and Forecast*											Trend (Actuals) M1-7	DHSC External Cash Support - Revenue		BPPC % of bills paid in target	
				25/26 M2 Actual	25/26 M3 Actual	25/26 M4 Actual	25/26 M5 Actual	25/26 M6 Actual	25/26 M7 Actual	25/26 M8 For	25/26 M9 For	25/26 M10 For		M7 YTD	FOT	2024/25 M7 By number	2024/25 M7 By Value
				Days	Days	Days	Days	Days	Days	Days	Days	Days		£m	£m	%	%
Alder Hey Children's				35	30	27	29	25	23	25	25	28		0.0	0.0	91.6%	90.9%
Bridgewater Community				28	21	31	37	30	21	21	20	18	16	0.0	0.0	99.1%	99.0%
Cheshire & Wirral Partnership				32	31	29	31	33	29	29	29	30	30	0.0	0.0	97.1%	94.4%
Countess of Chester Hospitals	28.2			29	17	16	14	19	17	16	12	16	10	4	1	8.4	12.0	88.8%	92.6%
East Cheshire Trust	14.0	9.3	(4.7)	20	32	15	17	18	19	20	21	10	15	8	3	2	0.0	0.0	88.3%	90.7%
Liverpool Heart & Chest	49.4	46.7	(2.7)	62	66	58	71	76	69	68	72	62	68	68	72	74	0.0	0.0	98.2%	99.5%
Liverpool University Hospitals	30.4	12.6	(17.8)	2	8	6	4	8	4	10	7	1	3	1	1	1	13.8	13.8	77.8%	90.5%
Liverpool Women's	3.8	4.1	0.2	15	13	6	14	11	9	11	4	7	8	2	(4)	(10)	6.3	11.8	88.7%	94.3%
Mersey Care	53.8	43.2	(10.5)	29	27	17	28	24	23	25	27	24	22	19	21	25	0.0	0.0	95.3%	96.0%
Mid Cheshire Hospitals	36.3	35.7	(0.6)	34	41	21	22	30	38	28	33	27	30	20	16	13	0.0	0.0	95.2%	90.1%
Mersey & West Lancs	10.2	1.7	(8.5)	1	3	3	1	1	4	1	1	1	1	(2)	(5)	(3)	21.9	21.9	95.3%	95.3%
The Clatterbridge Centre	73.2	67.2	(6.0)	85	82	63	80	79	76	70	84	71	72	84	88	92	0.0	0.0	97.0%	97.6%
The Walton Centre	62.4	46.8	(15.7)	111	103	83	129	99	78	76	87	73	78	93	100	103	0.0	0.0	88.3%	87.9%
Warrington & Halton Hospitals	16.3	11.9	(4.4)	14	11	11	18	12	13	16	11	9	11	2	(5)	(10)	8.6	15.3	53.0%	55.1%
Wirral Community	7.8	11.5	3.7	37	37	19	33	39	39	49	25	25	52	45	49	51	0.0	0.0	89.1%	93.8%
Wirral University Hospitals	0.1	0.3	0.2	3	3	0	5	3	1	0	0	0	0	(3)	(6)	(6)	23.5	23.5	43.7%	50.5%
TOTAL Providers	**476.2**	**364.2**	**(112.0)**														**82.6**	**98.4**	**87.1%**	**88.8%**

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

** the M8-10 Forecast does not include revenue Deficit Support Funding via ICB - with Q2 also remaining on hold

- £112.0m reduction in cash at M7 compared to M12 (24/25)
- With Q2 DSF on hold - c£59m of Deficit Support Funding has not been distributed over M4-M7 adding to cash pressure
- £82.6m of distressed external NHSE cash support has been provided YTD across COCH, LUFT, LWH, MWL, W&H and WUFT.
- Nov & Dec– c£50m distressed cash applications – COCH (£4m), LWH (£3m), MWL (£18m), W&H (£8m), WUFT (£7m), LUFT (£15m)

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 November 2025

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

Agenda Item No:

Report approved by: Sue Lorimer, ICB Non-Executive Member

NHS
Cheshire and Merseyside

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

Committee Chair	Mike Burrows (Oct 2025)
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Meeting date	21 October 2025

Introduction

The Finance, Investment and Resources Committee convened on 21 October 2025 and 18 November 2025 to review the financial position of the Cheshire and Merseyside Integrated Care System (ICS) and Integrated Care Board (ICB), assess key risks, and make decisions on procurement and governance matters. The meetings were well-attended by senior finance and operational leaders across the system, with active participation and robust discussion throughout.

Key escalation and discussion points from the Committee meeting

Alert

Key Items Discussed

Financial Position – ICS and ICB

- The system is currently facing a significant financial challenge, with a forecast deficit of £203m against plan. While month 6 performance showed a £2m favourable variance YTD (excluding DSF), the overall trajectory remains concerning.
- The ICB reported a £1m adverse variance against its £25m surplus plan, with key pressures in prescribing, independent sector activity, and all-age continuing care.
- The Committee acknowledged the progress made in CIP delivery and system collaboration but noted that even the best-case forecast still falls £11m short of the required £50m surplus.
- Winter pressures and redundancy costs are not yet factored into forecasts across the ICS, representing additional unquantified risks.

Key Risks Identified

- **Financial Recovery Gap**: Even under best-case assumptions, the system remains £11m short of its required surplus.
- **Winter Pressures**: No funding currently allocated; urgent system-wide planning required.
- **Prescribing Volatility**: Drug price fluctuations and prescriber compliance remain high-risk areas. Additionally delays in availability of data result in time lag in understanding impact of CIP measures
- **Governance Complexity**: Need for clearer financial accountability and streamlined decision-making.

Recommendations and Next Steps

- Escalate key financial risks and governance issues to the ICB Board.
- Support the implementation of the financial governance review.
- Ensure alignment between Trust and ICB contractual forecasts between each other.
- Continue to monitor and challenge delivery of CIPs and stretch targets.
- Prepare for difficult decisions regarding discretionary spend and service prioritisation.

Advise

. **Financial Governance Review**

- A financial governance review has been commissioned internally to clarify decision-making responsibilities across the ICB and place levels.
- The review aims to streamline oversight, align with the Well-Led Framework, and ensure clarity on financial accountability. Committee members welcomed the initiative and will be engaged in the process.

Procurement and Contracting Decisions
The Committee approved the following:

- **All-Age Continuing Care Case Management System**: Consolidation of contracts into a single solution, expected to deliver savings of over £400k annually.
- **Referral Management System**: Contract award approved.
- **Out-of-Hours Contract**: Approved as part of ongoing service continuity and value assurance.

Assure

Risk and Escalation

- The Committee discussed the need for greater transparency and alignment across providers, particularly regarding income forecasts and CIP maturity.
- Concerns were raised about the lack of winter funding and the potential need to reallocate existing resources, including Better Care Fund usage, to address immediate pressures.
- The Committee noted that several providers are now under formal enforcement or undertakings due to financial performance.

Committee Effectiveness and Role

A critical reflection was raised regarding the Committee's role—whether it is purely advisory or has directive authority. The Chair acknowledged this and committed to ensuring that the Committee's outputs influence ICB Board decisions and system-wide actions

Committee risk management

.

Achievement of the ICB Annual Delivery Plan

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

Service Programme / Focus Area	Key actions/discussion undertaken
Deliver of financial savings through productivity and reducing Waste	FCOG update
Delivery of the financial position	Month 6 report
Development and delivery of the Capital Plans.	Month 6 report

Service Programme / Focus Area	Key actions/discussion undertaken
Development of System Estates Plans to deliver a programme to review and rationalise our corporate estates.	Future Committee meetings

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 November 2025

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

Agenda Item No: ICB/11/25/10

Committee Chair: Sue Lorimer, Non-Executive Member

NHS
Cheshire and Merseyside

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

Committee Chair	Sue Lorimer
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Meeting date(s)	18 November 2025

Introduction

The Finance, Investment and Resources Committee convened on 18th November 2025 to review the financial position of the Cheshire and Merseyside Integrated Care System (ICS) and Integrated Care Board (ICB), assess key risks, and make decisions on procurement and governance matters. The meeting was well-attended by senior finance and operational leaders across the system, with active participation and robust discussion throughout.

Key escalation and discussion points from the Committee meeting

Alert

Key Items

1. Financial position YTD
   - The ICB is reporting a £1m variance against a £28m surplus plan. Key pressures reported in Primary Care Prescribing, ADHD, All Age Continuing Care and Acute overperformance (IS and NHS Drugs and Devices overperformance offset by underperformance in NHS activity).
   - The ICS is off plan by £59.4m overall, which wholly relates to the withdrawal of Deficit Support Funding.
   - Excluding DSF, the ICS is reporting a balanced position overall of a total deficit of £182.6m. Within this a number of Providers are reporting above plan – Mersey and West Lancs, Cheshire &Wirral Partnership, Mersey Care and Wirral Community, while Wirral University Teaching Hospitals and Cheshire and Merseyside ICB are off plan.
   - Staffing numbers were not available at the time of the committee but will be updated in time for the Board meeting.

2. Financial Position – Forecast
   NB: The updated forecasts for M7 were not available at the time of the committee. The M6 forecast was reviewed.
   The current mid case forecast shows the potential for the ICS to be £198m worse than plan by the year end. However, the actual position at M7 is £15m better than the mid case and the committee discussed whether the current forecast is too pessimistic. The ICB element of the forecast is a negative variance of £62m.

   A credible recovery plan for the system is required in order to secure deficit support funding of £178m. The ICB has a high-level plan to make significant inroads to its own variance and the detail will be developed for the next meeting of the committee. The Board will have some challenging decisions to make over the forthcoming weeks.

3. System alignment update
   The committee approved the approach to resolving cross-system financial misalignment issues with the following outcomes
   - Letters to Providers to be sent regarding resolution of funding disputes.
   - A solution regarding Southport CDC has been agreed with NHS England and approved at ICB Executive Committee.
   - The Provider Collaborative is reviewing NHS 25/26 elective performance alongside Place Assistant Directors of Finance to identify achievable and realistic forecasts for NHS Providers in terms of contract performance.

4. West Midlands Ambulance Service dispute
   The committee noted an issue which has been highlighted in the press. Whilst discussion on resolution has continued between the ICB and provider, the issue has not been escalated by WMAS via the formal contractual dispute process. The escalation process will be instigated and a resolution to be sought as soon as possible.

Advise

1. The committee asked that PWC attend the December FIRC to present an update on their work and findings so far.

2. With regard to capital the committee noted the remaining risk reserve of £10.1m is to be allocated prior to M8 reporting. The team have been in regular contact with providers regarding their capital spend and requirements. An update paper is expected at December FIRC

3. Provider representatives reported significant pressures from multiple sources – FPRMs, CQC, Performance and Planning requirements. The committee agreed that this is a continuing challenge, particularly in some providers.

4. Procurement and Contracting Decisions
Approved the corporate level PSR procurement route recommendations for contract awards for 2026/27
Endorsed the consideration of long-term contracts (up to 3 years) for services awarded under Direct A or Direct B procurement decisions.
Noted
- update to 25/26 procurement decision plans for Health and non-health goods and services
- the intention to implement a High Cost Drugs gain share with local NHS Providers
- the position on NHS and IS contracts and the work to manage activity in year. (see also Alert on system alignment issues).

Assure

1. Planning paper was postponed due to timing of NHSE updates/release– update to be provided to Board and December FIRC.

2. Update on ISFE 2 – new ledger implementation. Ongoing challenges and risks recognised. MIAA to review ledger implementation as part of the internal audit programme.
   Committee Chair recorded thanks and appreciation to the Finance team for their

hard work in implementing the new ledger.

3. Terms of Reference of FIRC to be reviewed alongside review of governance. Committee will use the scheme of delegation to deploy the powers available and work collaboratively with Providers for the benefit of the overall system.

Committee risk management

Committee discussed the risk paper and acknowledged that further changes to risk governance were likely, particularly in the light of changes to the roles and responsibilities of the ICB.

New BAF Risk P13 – Inability to achieve financial sustainability and productivity- was reviewed in the light of the above report and supported for approval by Board.

Existing Committee risks:
F5 – Procurement capacity
F7 – allocation of operational capital budget
Both risks were reviewed and supported for continued review by FIRC

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
Delivery of financial savings through productivity and reducing Waste	FCOG update
Delivery of the financial position	Month 7 report
Development and delivery of the Capital Plans.	Capital paper
Development of System Estates Plans to deliver a programme to review and rationalise our corporate estates.	Future Committee meetings

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 November 2025

Integrated Performance Report

Agenda Item No: ICB/11/25/11

Responsible Director: Anthony Middleton: Director of Performance and Planning

Integrated Performance Report

1. Purpose of the Report

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

2. Executive Summary

2.1 The integrated performance report for November 2025, 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 Anthony Middleton, Director of Performance and Planning. Actions will be shared with, and followed up by, relevant teams. Feedback will support future reporting to the Q&P committee.

15. Officer contact details for more information

15.1 Andy Thomas: Associate Director of Planning:
andy.thomas@cheshireandmerseyside.nhs.uk

16. Appendices

Appendix One: Integrated Quality and Performance report

NHS
Cheshire and Merseyside

Integrated Performance Report

27th November 2025

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Integrated Quality & Performance Report – Guidance:

NHS Cheshire and Merseyside

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

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

C&M National Ranking against the 22 Cancer Alliances

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

Notes on interpreting the data

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

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

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

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

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

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

Integrated Quality & Performance Report – Interpreting SPC Charts:

NHS Cheshire and Merseyside

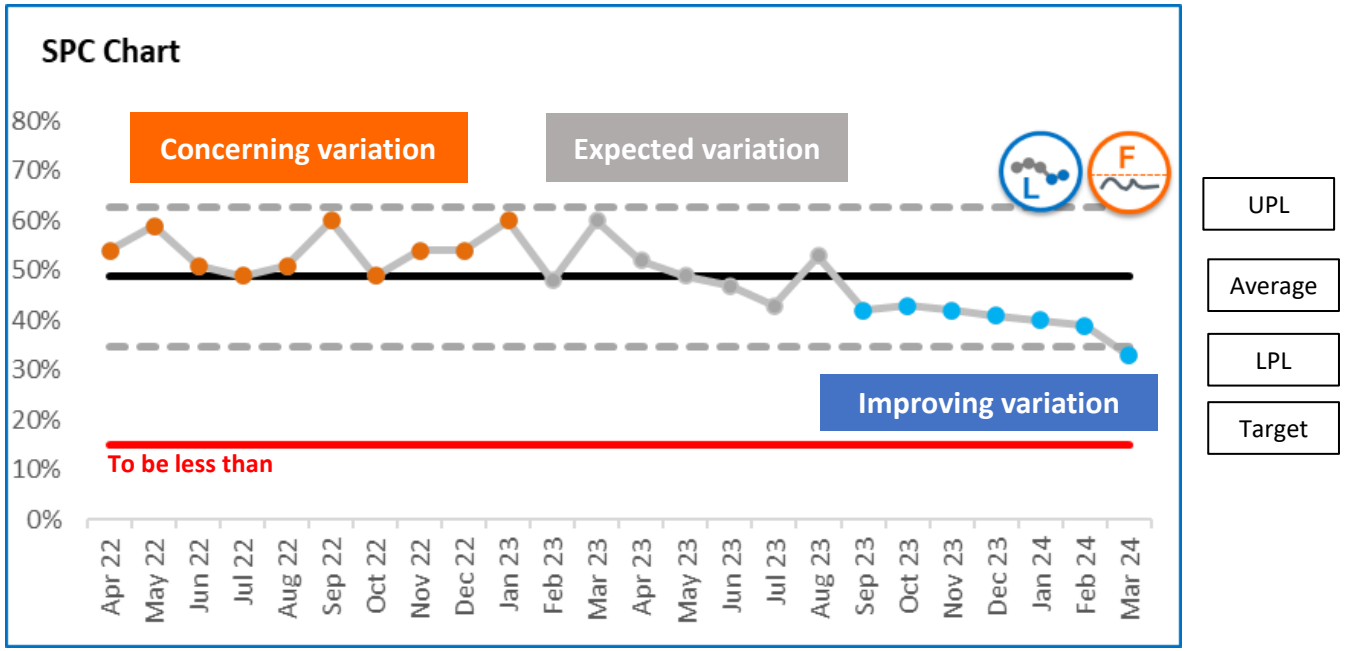
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

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

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

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

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



UPL

Average

LPL

Target

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

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

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

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

Integrated Quality & Performance Report – Interpreting summary icons:

NHS Cheshire and Merseyside

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

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

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

1. ICB Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Local Trajectory	National Target	Region value	National value	Latest Rank
Urgent care	4-hour A&E waiting time (% waiting less than 4 hours)	Oct-25	72.3%	72.4%	71.4%	72.9%	73.1%	72.6%	72.7%	73.7%	73.0%	71.9%	72.8%	72.5%	71.9%	75.2%	78% by Year end	71.7%	74.1%	30/42
	Ambulance category 2 mean response time	Oct-25	00:56:23	00:52:34	01:06:45	00:52:51	00:38:28	00:32:43	00:27:58	00:26:44	00:30:22	00:32:05	00:27:24	00:28:44	00:32:51	-	00:30:00	00:27:37	00:32:56	22/42
	Mean Ambulance Handover time (ED and Non ED)	Oct-25	00:52:35	00:50:58	00:55:51	00:47:53	00:39:09	00:34:32	00:34:23	00:31:57	00:32:58	00:31:04	00:25:02	00:27:41	00:31:48	00:35:36	00:15:00	00:26:15	00:31:03	25/42
	A&E 12 hour waits from arrival (Type 1 & 2)	Oct-25	17.0%	15.7%	18.3%	18.3%	17.4%	16.2%	15.9%	16.6%	16.8%	17.0%	16.3%	17.6%	17.2%	16.0%	-	14.2%	10.8%	41/42
	Adult G&A bed occupancy (all acutes)	Oct-25	96.3%	96.5%	96.0%	97.4%	97.2%	95.9%	96.4%	96.5%	95.8%	95.6%	94.9%	96.1%	95.7%	94.1%*	92.0%	95.0%	95.2%	19/42
	Percentage of beds occupied by patients no longer meeting the criteria to reside (NEW - rolling 7-day average last week of month)	Oct-25	20.4%	21.7%	19.5%	22.7%	21.6%	22.9%	21.2%	20.0%	20.3%	20.0%	20.7%	19.7%	19.1%	18.6%	-	n/a	n/a	-
	Discharges - Average delay (exclude zero delay)	Sep-25	9.2	9.0	8.8	9.5	9.0	10.1	9.8	8.8	8.6	8.4	7.9	8.6		8.9		6.8	6.3	35/42
	Percentage of patients discharged on discharge ready date	Sep-25	89.0%	87.8%	89.1%	88.2%	89.0%	89.0%	88.3%	88.3%	88.4%	88.5%	88.5%	89.1%		85.7%		87.3%	85.7%	9/42
Planned care	Total incomplete Referral to Treatment (RTT) pathways	Sep-25	367,350	366,053	361,746	358,637	356,570	360,184	354,386	350,979	355,722	362,412	366,066	367,700		353,903	-	1,042,807	7,298,187	-
	The % of people waiting less than 18 weeks on the waiting list (RTT)	Sep-25	56.9%	57.4%	56.7%	56.5%	57.3%	58.0%	58.0%	59.1%	59.0%	58.7%	58.4%	59.2%		59.6%	92.0%	58.9%	61.8%	33/42
	The % of people waiting more than 52 weeks on the waiting list (RTT)	Sep-25	3.5%	3.4%	3.3%	3.4%	3.3%	3.0%	3.5%	3.7%	3.9%	3.9%	3.9%	3.6%		2.5%		3.1%	2.4%	40/42
	Number of 52+ week RTT waits, of which children under 18 years.	Sep-25	1,063	886	902	922	919	750	972	983	1,031	1,098	1,114	899		754	-	n/a	n/a	-
	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Sep-25	1,091	1,093	1,282	1,167	1,091	659	990	1,443	1,325	1,242	941	677		-	0 by Sept 2024	1,063	12,782	
	Patients waiting more than 6 weeks for a diagnostic test	Sep-25	7.2%	6.9%	10.3%	11.2%	5.9%	6.7%	10.1%	12.0%	11.4%	11.2%	14.2%	12.4%		5.0%	5.0%	16.0%	22.5%	4/42
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	Sep-25	73.8%	75.9%	74.9%	71.6%	74.7%	76.4%	76.1%	75.0%	73.8%	75.4%	76.2%	72.7%		73.9%	85.0%	69.9%	67.9%	12/42
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Sep-25	94.6%	94.2%	95.5%	92.8%	95.8%	95.3%	94.7%	95.5%	95.5%	95.2%	95.1%	93.7%		96.0%	96.0%	94.0%	91.2%	14/42
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Sep-25	73.3%	75.4%	75.5%	66.8%	76.6%	76.3%	75.4%	71.8%	73.6%	71.7%	70.5%	70.6%		78.5%	77% by Year end	72.5%	73.9%	32/42
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028. (Rolling 12 months)	Jul-25	58.5%	58.6%	58.9%	58.8%	59.0%	59.2%	59.3%	59.4%	59.2%	58.6%				70.0%	75% by 2028	58.5%	59.4%	24/42
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Sep-25	86%	83%	85%	84%	83%	85%	86%	86%	86%	87%	87%	88%		70.0%	70.0%	89.0%	85.0%	16/42
	Virtual Wards Utilisation	Oct-25	93.2%	75.2%	69.2%	94.7%	73.5%	83.1%	75.3%	74.7%	63.7%	78.9%	72.0%	72.9%	72.0%		80.0%	79.7%	79.8%	28/42
	Community Services Waiting List (Adults)	Sep-25	48,815	48,663	50,574	50,937	41,919	43,198	42,897	41,462	54,290	66,869	72,441	68,623				120,862	850,196	-
	Community services Waiting List (CYP)	Sep-25	21,747	22,890	22,834	23,164	20,184	20,110	20,519	21,794	24,606	25,457	19,198	19,103				41,958	304,716	-
	Community Services – Adults waiting over 52 weeks	Sep-25	435	411	234	164	94	118	95	71	237	424	613	449		0		951	10,144	-
Note/s	* from BIP sentinel metric run report																			

1. ICB Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	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	Sep-25	75.0%	76.0%	78.0%	79.0%	79.0%	83.0%	77.0%	76.0%	69.0%	79.0%	80.0%	84%		60.0%	60.0%	76.0%	67.8%	18/42
	People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months	To Jun 2025		52.0%			62.0%			56.0%						-	60.0%	58.0%	60.0%	32/42
	Dementia Diagnosis Rate	Sep-25	67.6%	67.4%	67.3%	67.2%	67.4%	67.6%	67.6%	67.6%	67.8%	68.0%	68.2%	68.1%		66.7%	66.7%	70.7%	66.3%	14/42
	CYP Eating Disorders Routine	Sep-25	84.0%	87.0%	89.0%	88.0%	87.0%	86.0%	92.0%	93.0%	93.0%	93.0%	94.0%	93.0%		95.0%	95.0%	87.0%	80.4%	5/42
	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact	Sep-25	34,730	35,000	34,550	34,710	34,550	34,625	35,450	35,185	35,485	35,090	35,105	35,220		37246	-	123310	848750	-
	Number of people accessing specialist Community PMH and MMHS services	Sep-25	3,480	3,505	3,555	3,530	3,555	3,625	3,620	3,600	3,645	3,635	3,655	3,675		3420	-	8980	66468	-
	Talking Therapies 1st to 2nd Treatment >90 days (NEW)	Sep-25	30%	31%	31%	32%	32%	31%	36%	31%	30%	19%	15%	17%		-	10%	28%	23.2%	16/42
	Talking Therapies completing a course of treatment - % of plan achieved	Sep-25	95.0%	94.0%	92.0%	92.0%	92.0%	91.0%	102.0%	97.0%	104.0%	98.0%	95.0%	97.0%		100.0%	100.0%	99.0%	98.0%	24/42
	Talking Therapies Reliable Recovery	Sep-25	48.0%	48.0%	45.0%	47.0%	47.0%	49.0%	48.0%	48.0%	48.0%	47.0%	47.0%	44.0%		48.0%	48.0%	43.0%	47.3%	24/42
	Talking Therapies Reliable Improvement	Sep-25	66.0%	66.0%	65.0%	66.0%	68.0%	68.0%	67.0%	68.0%	68.0%	67.0%	66.0%	64.0%		67.0%	67.0%	65.0%	67.7%	26/42
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Sep-25	85	85	85	80	80	80	80	75	75	75	75	75		48	-	220	1,790	18/42
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Sep 25 YTD	37.6%	45.7%	52.7%	63.0%	73.3%	85.5%	3.1%	7.5%	12.7%	18.5%	23.4%	31.1%		22.9%	75% by Year end	32.6%	31.3%	17/42
Primary Care	Units of dental activity delivered as a proportion of all units of dental activity contracted	Sep-25	86.0%	88.0%	78.0%	82.0%	94.0%	95.0%	82.0%	81.0%	80.0%	79.0%	76.0%	77.0%		80.0%	100.0%	83.0%	83.0%	32/44
	Number of unique patients seen by an NHS Dentist – Adults (24 month)	Sep-25	932,009	932,314	933,534	934,964	936,873	937,773	940,716	941,167	941,865	944,188	944,222	944,793		943,484		2,658,093	18,160,956	-
	Number of unique patients seen by an NHS Dentist – Children (12 month)	Sep-25	329,456	330,255	331,503	332,275	332,480	333,475	333,796	333,871	334,907	335,719	336,135	336,563		334,384		1,032,960	7,223,394	-
	Appointments in General Practice & Primary Care networks	Sep-25	1,649,116	1,319,968	1,191,861	1,401,109	1,258,627	1,342,136	1,237,198	1,220,981	1,272,114	1,377,472	1,167,168	1,364,319		1,266,474		-	-	-
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care. (rolling 12 months)	Jul-25	6.94%	6.94%	6.94%	6.98%	7.02%	7.09%	7.14%	7.18%	7.22%	7.28%				10.0%	10.0%	-	7.62% (Dec 24)	-
	Total volume of antibiotic prescribing in primary care	Jul-25	1.02	1.01	1.01	0.99	0.98	0.97	0.95	0.94	0.94	0.93				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)	Jul-25	260	240	238	216	220	239	229	232	235	191				-	-	-	174.5	-
	Percentage of people who are discharged from acute hospital to their usual place of residence (New data source)	Jul-25	81.3%	81.5%	80.5%	78.9%	80.4%	80.5%	82.3%	82.3%	83.5%	83.0%				-	-	-	81.8%	-
	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)	Jun-25	162	154	163	133	116	127	145	140	109					-	-	-	124.9	-
Note/s																				

1. ICB Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Local Trajectory	National Target	Region value	National value	Latest Rank
Specialised Commissioning	Cardiac Treatment waiting list (LH&CH) ^	Sep-25	414	390	401	389	386	376	363	383	403	402	402	398		410				-
	Neurosurgery waiting list (TWC) ^	Sep-25	876	929	914	927	921	967	974	950	993	1,006	1,021	989		885				-
	Specialised Paediatrics waiting list (AHCH) ^	Sep-25	312	265	261	256	269	248	238	221	203	180	180	207		287				-
	Vascular waiting list (LUFT) ^	Sep-25	145	163	153	166	167	180	160	183	182	213	214	197		145				-
Health Inequalities & Improvement	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q1 25/26	65.50%			69.07%			67.34%							77.0%	80.0%	68.51%	68.3%	27/42
	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) (NEW)	Q1 25/26	44.8%			46.0%			45.6%								50.0%	47.1%	47.61%	28/42
	Smoking at Time of Delivery V2	Q1 25/26	6.1%			5.9%			5.4%							-	6.0%	5.4%	4.70%	30/42
	Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems.(Aged 15+) ~	Oct-25	13.6%	13.6%	13.5%	13.5%	13.4%				14.0%	14.0%	14.0%	13.9%	13.8%	12.0%	12.0%	-	12.7%^	-
Continuing Healthcare	Standard Referrals completed within 28 days	Q1 25/26	73.10%			76%			71.70%							80.0%	>80%	80.9%	75.6%	26/42
	Number eligible for Fast Track CHC per 50,000 population (snapshot at end of quarter)	Q1 25/26	27.18			27.04			23.78							18.00		20.53	16.54	35/42
	Number eligible for standard CHC per 50,000 population (snapshot at end of quarter)	Q1 25/26	53.85			54.67			54.27							34.00		46.42	32.47	40/42
Maternity	HIE (Hypoxic ischemic encephalopathy) grade 2 or 3 per 1,000 live births (>=37 weeks)	Q1 25/26	0.9			0.5			0.7							2.5	2.5	1.3		
	Still birth per 1,000 (rolling 12 months) (GP Reg MSDS)	Jul-25	2.42	2.13	2.34	2.44	2.54	2.49	2.41	2.43	2.49	2.44				-	2.6*	-	3.1	-
Quality & Safety	Healthcare Acquired Infections: Clostridium Difficile - Place aggregation (All cases)	12 months to Sep-25	1156	1176	1205	1198	1210	1191	1155	1143	1133	1134	1129	1108		843		3125	17838	
	Healthcare Acquired Infections: E.Coli Place aggregation (All cases)	12 months to Sep-25	2359	2357	2367	2352	2333	2330	2330	2326	2330	2297	2325	2334		2001		5975	44669	
	Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation #	May-25	0.989	0.984	0.986	0.997	0.988	0.986	0.989	0.996						0.887 to 1.127 *		-	1.000	-
	Never Events	Oct-25	0	3	0	6	1	2	0	5	3	2	0	3	1	0	0	-	-	-
Workforce / HR (ICS total)	Staff in post	Sep-25	73,910	74,068	74,101	74,208	74,450	74,600	74,524	74,471	74,457	74,345	74,362	74,427		74,098	-			
	Bank	Sep-25	5,084	4,868	4,848	5,000	5,289	5,459	5,214	4,851	4,564	4,778	4,816	4,756		4,656	-			
	Agency	Sep-25	1,009	886	824	838	775	749	639	621	604	554	511	487		691.7	-			
	Turnover	Jul-25	10.9%	10.8%	10.7%			10.4%	10.1%	10.0%	9.9%	9.8%				11.3%	-			
	Sickness##	Jul-25	5.6%	5.6%	5.6%	6.2%	5.7%	6.1%	6.1%	6.1%	6.1%	6.1%				5.9%	-			
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

NHS Cheshire and Merseyside

ICB Overall Financial Position:

Category	Metric	Latest period	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Plan (£m)	Dir. Of Travel	FOT (£m) Plan	FOT (£m) Current	FOT (£m) Variance
Finance	Financial position £m (ICS) ACTUAL	Sep-25	-108.5	-112.9	-129.5	-129.7	-109.7	-89.7	-45.9	-	-37.4	-51.7	-78.4	-110.4	-124.8	-82.2	↘	0.0	0.0	0.0
	Financial position £ms (ICS) VARIANCE	Aug-25	-48.8	-51.4	-67.4	-61.2	-47.3	-33.2	-45.9	-	0.2	1.4	-17.3	-35.6	-42.6		↘			
	Efficiencies £ms (ICS) ACTUAL	Aug-25	156.4	192.9	235.3	276.6	321.3	362.7	417.1	-	61.0	98.1	147.8	180.7	226.1	223.9	↗	572.5	587.8	15.3
	Efficiencies £ms (ICS) VARIANCE	Aug-25	-25.0	-26.7	-22.5	-20.7	-23.4	-29.4	-22.8	-	-1.9	1.0	9.3	0.0	2.2		↗			
	Capital £ms (ICS) ACTUAL	Sep-25	97.1	121.7	145.0	170.0	204.1	241.0	327.0	-	-	-				-	-	246.5	246.5	0.0
	Capital £ms (ICS) VARIANCE		26.8	28.3	28.2	32.1	24.6	10.9	-16.7	-	-	-				-	-	N/A	N/A	

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

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

3. Provider / Trust Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Providers																	
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts				Net OOA/ Other/ ICB	ICB *
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP		
NHS SOF	Segment (NEW)@	25/26 Q1	④	③	③	④	④	④	③	①	①	③	①	①	③	①	②	④		
Urgent care	4-hour A&E waiting time % waiting less than 4 hours	Oct-25	64.6%	48.6%	61.0%	70.1%	67.5%	70.8%	78.0%	91.4%		83.3%	-	-	-	-	-	-	-	71.9%
	Mean Ambulance Handover time (ED and Non ED)	Oct-25	00:25:59	00:27:50	00:18:19	00:24:57	00:27:49	00:42:45	00:34:18	00:21:13										00:31:48
	A&E 12 hour waits from arrival	Oct-25	18.6%	15.6%	17.2%	23.2%	23.0%	16.9%	19.0%	#	-	0.0%	-	-	-	-	-	-	-	17.2%
	Adult G&A bed occupancy	Oct-25	98.2%	97.5%	96.3%	94.0%	97.2%	95.7%	98.4%	-	85.1%	53.8%	90.7%	87.2%					-	95.7%
	Percentage of beds occupied by patients no longer meeting the criteria to reside (NEW - rolling 7-day average last week of month)	Oct-25	22.4%	11.3%	18.8%	13.3%	23.0%	19.4%	21.5%										-	19.1%
	Discharges - Average delay (exclude zero delay)	Sep-25	12.5	**	**	**	9.8	6.7	10.6	0.0	9.5	1.5	1.5	0.0						8.6
	Percentage of patients discharged on discharge ready date	Sep-25	83.8%	**	**	**	82.1%	83.8%	96.5%	100.0%	97.7%	89.4%	97.4%	100.0%						89.1%
Planned care	Total incomplete Referral to Treatment (RTT) pathways	Sep-25	34,103	19,328	43,704	48,195	32,461	65,581	76,984	17,469	4,876	17,035	940	14,533			44	-	-	367,700
	The % of people waiting less than 18 weeks on the waiting list (RTT)	Sep-25	51.4%	56.5%	54.8%	61.7%	59.4%	56.0%	64.2%	62.0%	77.5%	46.7%	95.6%	63.4%			100.0%			59.2%
	The % of people waiting more than 52 weeks on the waiting list (RTT)	Sep-25	7.6%	3.2%	4.2%	2.4%	4.0%	3.2%	2.3%	1.4%	0.8%	9.7%	0.0%	0.7%			0.0%			3.6%
	Number of 52+ week RTT waits, of which children under 18 years.	Sep-25	154	29	161	109	74	61	68	241	0	2	0	0						899
	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Sep-25	145	25	304	4	31	95	55	5	0	0	0	1			0	-		677
	Patients waiting more than 6 weeks for a diagnostic test	Sep-25	23.5%	18.1%	15.2%	12.6%	3.8%	10.7%	9.3%	4.4%	0.3%	15.8%	0.4%	0.9%	24.0%	0.0%	-	-	-	12.4%
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	Sep-25	76.1%	60.0%	64.0%	75.2%	77.3%	70.6%	76.0%	100.0%	83.6%	36.5%	85.6%	100.0%	80.0%				-	72.7%
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Sep-25	92.0%	94.0%	83.2%	91.3%	98.9%	87.2%	91.0%	100.0%	100.0%	83.8%	99.3%	100.0%	23.1%				-	93.7%
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Sep-25	70.6%	75.9%	70.2%	62.9%	74.3%	75.9%	65.8%	100.0%	76.2%	66.0%	78.9%	100.0%	65.1%				-	70.6%
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028 (calendar YTD)	Jun-25	59.2%	65.9%	63.8%	60.3%	47.9%	57.5%	54.6%	50.0%	51.6%	75.2%	75.8%	-	100.0%	-				59.2%
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6, 7 and 8 for the ICB's latest position on the above metrics ** Indicates that provider did not meet to DQ criteria and is excluded from the analysis # Value supressed due to small numbers @ 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)																			

3. Provider / Trust Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Providers																	
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts				Net OOA/ Other/ ICB	ICB *
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP		
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Sep-25	85.0%	94.0%	90%	Community Service Providers only									95.0%	89.0%	82.0%	79%	-	88.0%
	Virtual Wards Utilisation ~	Oct-25	86.7%	80.6%	81.7%	0.0%	73.3%	76.2%	71.4%	100.0%										72.0%
	Community Services Waiting List (Adults)	Sep-25	0	4,227	6,382		-	-	299	0	166	-	-	-	3,883	5,359	20,217	5,359	22731	68,623
	Community services Waiting List (CYP)	Sep-25	1,483	471	2,665		-	-	655	5,289	0	-	-	-	4,625	260	831	260	2564	19,103
	Community Services – Adults waiting over 52 weeks	Sep-25	0	2	1		-	-	2	0	0	-	-	-	92	0	0	0	352	449
Mental Health	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Sep-25			Mental Health service providers only												82.0%	84.0%	-	84%
	CYP Eating Disorders Routine	Sep-25								91%							87.0%	100.0%		93.0%
	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact	Sep-25				1675				5095					1690		8780	8290	9690	35,220
	Number of people accessing specialist Community PMH and MMHS services	Sep-25															2425	1310		3675
	Talking Therapies completing a course of treatment - % of LTP trajectory	Sep-25	Just number available/ no target																	97.0%
	Talking Therapies Reliable Recovery	Sep-25															47.0%			44.0%
	Talking Therapies Reliable Improvement	Sep-25															66.0%			64.0%
Learing Disabilities	Inpatients with a learning disability and/or autism (rounded to nearest 5)	Sep-25								#							50	25		75
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 supressed 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

NHS Cheshire and Merseyside

Category	Metric	Latest period	Providers																	
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts				Net OOA/ Other/ ICB	ICB/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 Q1	0.0	0.0	1.5	1.4	3.5		0.0			0.0								0.7
	Still birth per 1,000 (rolling 12 months)	Jul-25	2.71	0.97	4.14	3.14	2.88	-	2.56	-	-	4.13	-	-						2.44
Quality & Safety	Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation (Healthcare Associated)	12 months to Sep 25	68	24	40	154	78	192	125	21	4	2	17	10						735
	Healthcare Acquired Infections: E.Coli (Healthcare associated)	12 months to Sep 25	46	26	53	99	79	259	155	12	7	4	29	10						779
	Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation** #	May-25	0.9116	1.2410	0.9533	1.0242	1.0548	0.9688	0.9929											0.996
	Never Events (rolling 12 month total)	12 Months to Oct 25	3	0	2	4	2	2	6	3	1	1	0	1	0	0	0	1		26
Workforce / HR (Trust Figures)	Staff in post	Sep-25	4,522	2,418	5,128	5,933	4,246	14,125	9,634	4,219	1,911	1,707	1,896	1,516	1,333	1,443	10,523	3,873	-	74,427
	Bank	Sep-25	327	184	363	311	368	926	744	94	61	82	13	71	18	44	933	217	-	4,756
	Agency	Sep-25	9	45	77	17	44	100	92	3	5	5	5	4	1	2	55	24	-	487
	Turnover	Jul-25	11.5%	11.5%	9.0%	10.3%	9.1%	9.7%	8.6%	10.7%	8.9%	10.0%	9.2%	12.5%	10.1%	10.6%	9.9%	8.9%	-	9.8%
	Sickness (via Ops Plan Monitoring Dashboard)	Jul-25	5.6%	5.3%	5.3%	6.0%	5.9%	6.0%	6.2%	5.8%	4.9%	6.0%	4.2%	5.5%	6.7%	6.5%	7.6%	6.1%	-	6.1%
Finance	Overall Financial position - YTD Surplus / (Deficit) (£m) (NEW) (including deficit support funding)	Sep-25	-17.37	-10.63	-21.58	-12.62	-17.47	-32.37	-29.53	-1.02	4.20	-11.92	0.14	3.17	-2.31	0.70	1.67	-2.00	24.10	-124.84
	Overall Financial position - YTD Surplus / (Deficit) (£m) (NEW) (excluding deficit support funding)	Sep-25	-22.28	-13.21	-27.34	-16.85	-22.05	-43.50	-37.09	-1.02	4.20	-15.75	0.14	3.17	-2.31	0.70	1.67	-2.00	24.10	-169.41
	Overall Financial position - YTD Variance from plan (£m) (NEW) (including deficit support funding)	Sep-25	-0.20	0.00	0.82	-5.16	0.00	0.02	3.69	-0.00	-0.00	0.46	0.01	0.02	0.00	1.10	1.20	1.10	-1.00	2.04
	Efficiencies - YTD Variance from plan (£m)	Sep-25	-5.25	0.00	0.21	-0.00	0.00	7.58	1.86	0.11	-0.61	0.74	-0.00	-0.00	0.02	-0.03	0.18	0.84	-3.40	2.25
	Capital - YTD Variance from plan £m	Sep-25	0.18	2.35	1.77	2.46	2.30	3.33	8.82	1.12	1.68	0.38	-0.69	1.36	0.50	0.73	-3.69	0.97	0.00	23.56
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6, 7 and 8 for the ICB's latest position on the above metrics ** The SHMI banding gives an indication for each non-specialist trust on whether the observed number of deaths in hospital, or within 30 days of discharge from hospital, was as expected when compared to the national baseline, as the UCL and LCL vary from trusts to trust. This "banding" is different to the "rate" used for the ICB on slide 5, therefore a comparison cannot be drawn between the two. # Banding changed Aug 23 to reflect SOF rating by NHSE. 'As expected' rating is RAG rated Green, 'Higher than expected' is RAG rated Red.																			

4. Place Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Sub ICB Place										ICB *	Local Trajectory	National Target
			Cheshire & Wirral				Merseyside								
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton				
			East **	West **							South Sefton	S/port & Formby			
Urgent Care	4-hour A&E waiting time % waiting less than 4 hours	Oct-25	56.2%	63.2%	27.5%	57.0%	72.2%	70.5%	78.4%	73.2%	69.6%		71.9%	75.2%	78% by Year end
	Ambulance category 2 mean response time	Sep-25	00:30:17		00:30:08	00:28:45	00:27:06	00:28:01	00:28:16	00:30:54	00:28:18		00:28:44		00:30:00
	A&E 12 hour waits from arrival	Oct-25	16.6%		21.4%	21.6%	13.3%	23.5%	15.1%	23.8%	17.6%		17.2%	16.0%	-
	Discharges - Average delay (exclude zero delay)	Sep-25	6.8	9.7	4.1	9.9	6.7	12.4	8.1	8.9	6.0		8.6	8.9	
	Percentage of patients discharged on discharge ready date	Sep-25	90.8%	86.2%	96.6%	84.0%	85.1%	94.7%	93.3%	93.1%	89.3%		89.1%	86%	
Planned Care	Total incomplete Referral to Treatment (RTT) pathways	Sep-25	117,715		52,984	27,525	58,630	28,983	22,933	20,572	38,358		367,700	353,903	-
	The % of people waiting less than 18 weeks on the waiting list (RTT)	Sep-25	56.1%		61.9%	62.4%	57.0%	63.0%	61.1%	60.7%	56.7%	67.1%	59.2%	59.6%	
	The % of people waiting more than 52 weeks on the waiting list (RTT)	Sep-25	4.4%		2.7%	3.6%	3.9%	2.3%	3.1%	3.5%	3.1%		3.6%	2.5%	
	Patients waiting more than 6 weeks for a diagnostic test	Sep-25	17.6%		10.4%	4.7%	9.2%	10.8%	9.6%	10.8%	9.7%		12.4%	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	Sep-25	62.4%	72.1%	76.7%	74.8%	72.8%	85.4%	75.3%	79.4%	66.0%		72.7%	73.9%	85.0%
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Sep-25	87.9%	89.6%	93.8%	94.6%	93.7%	96.7%	95.3%	95.9%	92.3%		93.7%	96.0%	96.0%
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Sep-25	72.2%	70.5%	62.9%	71.7%	75.4%	72.9%	73.9%	74.8%	65.7%		70.6%	78.5%	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) (NEW)	Jul 25 YTD	61.7%		59.8%	56.0%	56.6%	57.3%	56.7%	53.1%	57.4%	55.1%	59.2%	70.0%	75% by 2028
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Aug-25	86.3%	83.1%	90.9%	95.6%	79.3%	81.3%	88.2%	98.0%	82.2%		87.0%	70.0%	70.0%
	Virtual Wards Utilisation Number only	Oct-25	65	73	45	28	76	38	12	10	19		366		
	Community Services Waiting List (Adults) - data only available at ICB/Provider level												68,623		
	Community services Waiting List (CYP) - data only available at ICB/Provider level												19,103		
	Community Services – Adults waiting over 52 weeks - data only available at ICB/Provider level												449		
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.														

4. Place Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Sub ICB Place										ICB *	Local Trajectory	National Target
			Cheshire & Wirral				Merseyside								
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton				
			East **	West **							South Sefton	S/port & Formby			
Mental Health	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Sep-25	90.0%		60.0%	70.0%	84.0%	92.0%	83.0%	83.0%	85.0%	75.0%	84.0%	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 Jun 2025	54.0%		56.0%	62.0%	55.0%	49.0%	59.0%	67.0%	47.0%	63.0%	56.0%	-	60.0%
	Dementia Diagnosis Rate	Sep-25	67.4%		66.3%	73.6%	68.8%	67.1%	67.4%	67.0%	68.60%		68.1%	66.7%	66.7%
	CYP Eating Disorders Routine	Sep-25	100.0%		100.0%	100.0%	83.0%	95.0%	89.0%	100.0%	94.0%	100.0%	93.0%	95.0%	95.0%
	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact	Sep-25	6065		4615	3785	8605	4000	2605	1675	2435	1630	35220	37246	-
	Number of people accessing specialist Community PMH and MMHS services	Sep-25	1030		390	320	710	315	295	205	260	155	3675	3420	-
	Talking Therapies 1st to 2nd Treatment >90 days (NEW)	Sep-25	19%		*	53%	3%	7%	15%	17%	50%	46%	17%		<=10%
	Talking Therapies completing a course of treatment	Sep-25	4830		1510	1155	3350	1425	990	595	860	645	97.0%	100.0%	100.0%
	Talking Therapies Reliable Recovery	Sep-25	50.0%		12%	56.0%	47.0%	44.0%	48.0%	48.0%	43.0%	50.0%	44.0%	48.0%	48.0%
	Talking Therapies Reliable Improvement	Sep-25	71.0%		33.0%	72.0%	65.0%	68.0%	64.0%	70.0%	66.0%	69.0%	64.0%	67.0%	67.0%
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Sep-25	25		5	5	15	5	10	5	5		75	48	-
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Sep 25 YTD	30.2%		31.4%	27.4%	31.1%	27.8%	33.5%	33.5%	34.7%		31.1%	22.9%	75% by Year end
Primary Care	Appointments in General Practice & Primary Care networks @	Sep-25	206,295	183,868	221,865	116,708	268,710	87,810	85,720	61,061	132,282		1,364,319	1,266,474	
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care. (rolling 12 months)	Jul-25	6.13%	7.41%	9.31%	6.28%	7.47%	6.25%	6.74%	6.47%	7.82%		7.28%	10.0%	10.0%
	Total volume of antibiotic prescribing in primary care	Jul-25	0.78	0.87	1.02	0.83	0.93	1.11	1.11	0.97	0.96		0.93	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

NHS Cheshire and Merseyside

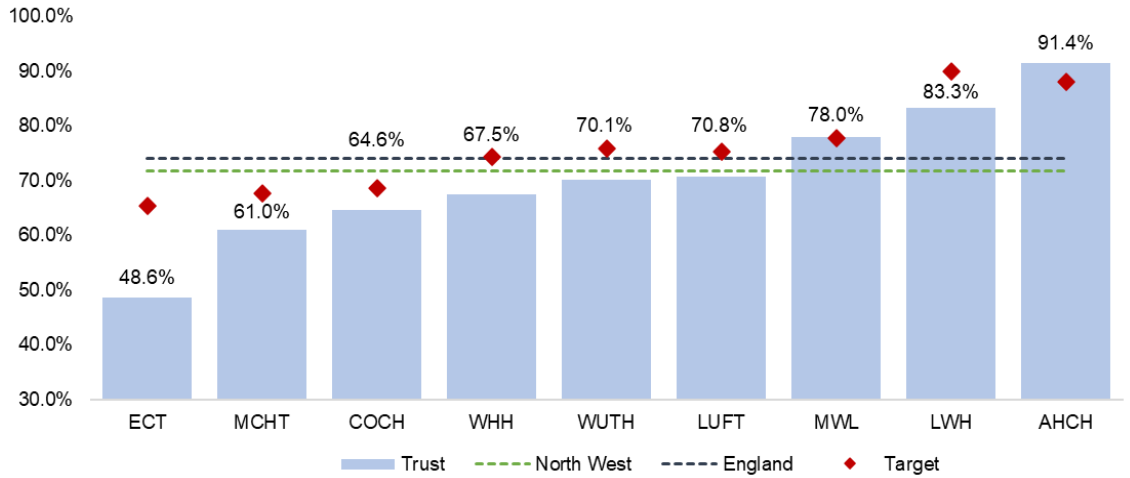
Category	Metric	Latest period	Sub ICB Place										ICB *	Local Trajectory	National Target
			Cheshire & Wirral				Merseyside								
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton				
			East **	West **							South Sefton	S/port & Formby			
Integrated care - BCF metrics ***	Unplanned hospitalisation for chronic ambulatory care sensitive conditions Per 100,000 (New data source)	Jul-25	73.8	199.3	188.9	256.0	262.7	154.6	195.3	216.7	184.2		191.3	-	-
	Percentage of people who are discharged from acute hospital to their usual place of residence (New data source)	Jul-25	75.8%	76.4%	85.3%	89.2%	85.1%	81.1%	82.6%	87.4%	84.3%		83.0%	-	-
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 (New data source)	Jun-25	58.0	87.2	141.7	93.7	173.0	77.3	124.3	78.8	147.4		109.0	-	-
Health Inequalities & Improvement	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q1 25/26	68.1%		66.1%	67.5%	67.5%	67.4%	68.4%	69.3%	64.9%		67.3%	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) (NEW)	Q1 25/26	46.2%		48.0%	44.1%	45.9%	43.5%	47.8%	45.3%	42.9%		45.6%		50%
	Smoking at Time of Delivery	Q1 25/26	4.5%		5.4%	2.6%	6.7%	8.0%	5.9%	6.1%	6.9%		5.4%		<6%
	Smoking prevalence (aged 15+) - As reported on CIPHA from GP Systems	Oct-25	11.50%		13.40%	12.50%	16.70%	14.00%	16.70%	15.10%	15.00%	11.80%	13.8%	12%	12%
Continuing Healthcare	Standard Referrals completed within 28 days	Q1 25/26	70.0%		68.5%	89.7%	56.0%	100.0%	92.3%	81.8%	60.5%	65.0%	71.70%	>80%	>80%
	Number eligible for Fast Track CHC per 50,000 population (snapshot at end of quarter)	Q1 25/26	20.95		33.25	22.38	20.83	5.77	6.94	22.86	45.03	56.98	23.78	18.00	
	Number eligible for standard CHC per 50,000 population (snapshot at end of quarter)	Q1 25/26	64.4		72.8	40.2	47.3	25.2	30.3	44.4	55.0	83.6	54.27	34	
Quality & Safety	Still birth per 1,000 - (rolling 12 mths) (GP Reg MSDS)	Jul-25	2.50	1.88	2.67	1.13	4.41	1.92	0.68	0.00	2.40		2.44		
	Healthcare Acquired Infections: Clostridium Difficile - (All cases)	12 months to Sep-25	232		212	102	214	69	82	70	127		1108	843	-
	Healthcare Acquired Infections: E.Coli - (All cases)	12 months to Sep-25	643		292	177	483	188	183	104	264		2334	2001	
Finance	Overall Financial position Variance (£m)	Sep-25	-4.0	-1.6	-2.4	-0.1	-6.0	-0.4	-1.6	-1.8	2.1		14.8	0.0	0.0
	Efficiencies (Variance)	Sep-25	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	0.0	0.0
	Mental Health Investment Standard met/not met (MHIS)	Sep-25	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Yes	Yes
	BCF achievement (Places achieving expenditure target)	Sep-25	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	9/9	9/9
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6,7 and 8 for the ICB's latest position on the above metrics ** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT. *** Local trajectories set by Place as part of their BCF submissions to NHSE, therefore RAG rating will vary for Places with lower/higher trajectories														

5. Exception Report – Urgent Care

NHS Cheshire and Merseyside

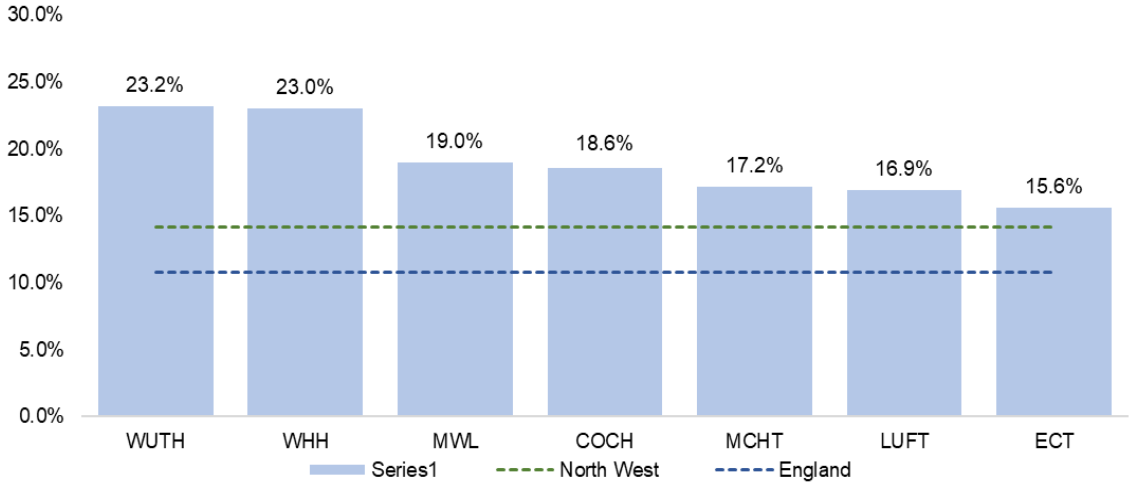
A&E 4 hour waits from arrival

Latest ICB Performance (Oct-25)	71.9%	National Ranking	30/42
Provider Breakdown (Oct-25)			Deteriorated



A&E 12 hour waits from arrival

Latest ICB Performance (Oct-25)	17.2%	National Ranking	41/42
Provider Breakdown (Oct-25)			Improved



Issue

- A&E 4-hour performance across Cheshire and Merseyside has fallen to 71.9% in October, placing the ICB 30th out of 42 nationally and remaining below the 78% national ambition. This is driven by sustained attendances, high occupancy, and discharge delays.
- A&E 12-hour waits from arrival have improved marginally to 17.2%, with the ICB now 41st nationally. However, this remains significantly above acceptable levels and highlights ongoing system-wide pressures around flow, long-stay patients, and discharge pathways.

Action

- **Mid Mersey (MWL):** 4-hour performance 78.0%; 12-hour waits 18.1%. Continued focus on ECIST criteria for admission/discharge, NC2R, strengthening Fit-to-Sit and escalation processes.
- **East Cheshire (ECT):** 4-hour performance 48.6%. Front-door GP and Fit-to-Sit models are being strengthened to improve triage, reduce mental health escalation, and increase alternative pathways.
- **Mid Cheshire (MCHT):** 4-hour performance 61.0%; 12-hour waits 16.7%. Continued emphasis on triage, rapid streaming, and reducing prolonged stays with GIRFT support.
- **Countess of Chester (COCH):** 4-hour performance 64.6%; 12-hour waits 25.3%. Front-door streaming, SDEC optimisation, and review of long-wait cohorts remain key priorities under GIRFT guidance.
- **Wirral (WUTH):** 4-hour performance 70.8%; 12-hour waits 23.2%. SDEC expansion and frailty optimisation continue with on-site GIRFT support.
- **Liverpool (LUFT):** 4-hour performance 70.1%; 12-hour waits 15.4%. Continued focus on specialty-in-reach and community capacity to reduce ED delays.
- **Warrington (WHH):** 4-hour performance 67.5%; 12-hour waits 23.0%. Continued implementation of ECIST recommendations on triage and workforce models.
- **Liverpool Women's (LWH):** 4-hour performance 83.3% with no material 12-hour waits.
- **Alder Hey (AHCH):** 4-hour performance 91.4%, the highest across the system, with no reported 12-hour breaches.

Delivery

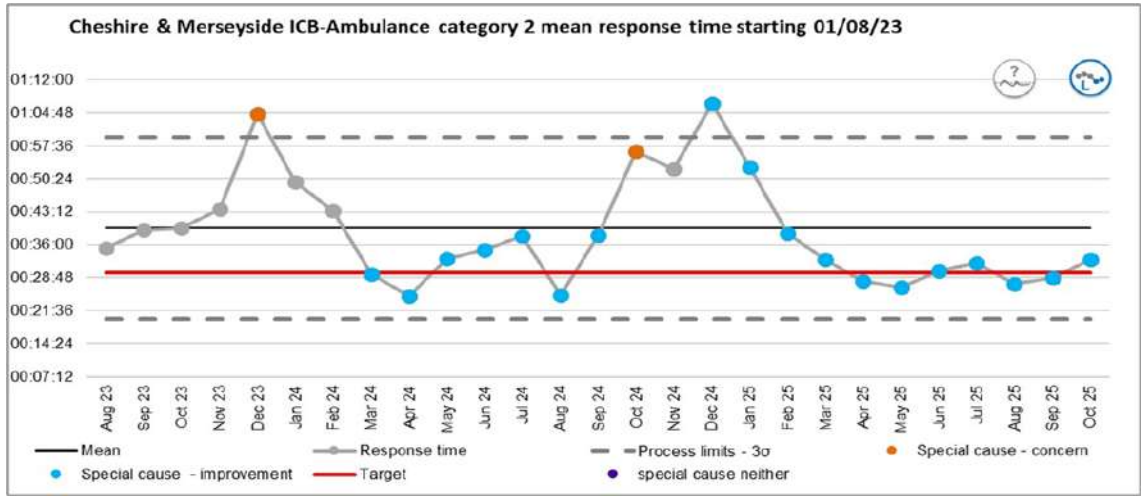
- Trust-level improvement plans are being delivered through targeted tests of change, workforce redesign, frailty and specialty pathway optimisation, and strengthened community response.
- System-wide recovery remains under daily oversight through SCC governance, aligned to the 2025/26 UEC Improvement Plan and NHSE Winter Assurance Framework.

5. Exception Report – Urgent Care

NHS Cheshire and Merseyside

Ambulance category 2 mean response time

Latest ICB Performance (Oct-25)	00:32:51	National Ranking	22/42
ICB Trend (Sep-25)			Deteriorated



Issue

- C&M's latest Cat 2 mean response time (Oct-25) is 00:32:51, placing the system 22nd out of 42 ICBs nationally and representing a slight deterioration from the previous month. Performance remains above the national 30-minute standard, with notable unwarranted variation across localities (ranging from 00:31:23 in Wirral to 00:35:03 in Halton.

Action

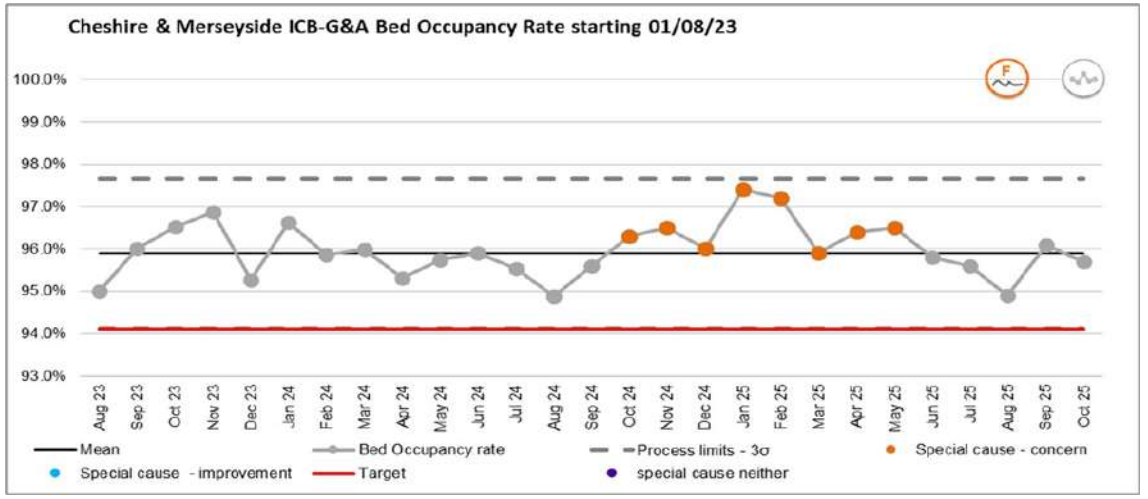
- Targeted H045 actions progressed across all acute sites, with additional focus on Liverpool, Warrington and Cheshire due to the highest C2 volumes and slowest responses.
- Locality-level joint improvement plans agreed between NWAS and acute trusts addressing management of crews approaching 45-minutes, enhanced front-door streaming and early senior review to reduce conveyance.
- NWAS and localities implementing Cat 2 stack management escalation procedures, ensuring senior clinical oversight of long waits and improved prioritisation.

Delivery

- The H045 programme continues to drive gradual but variable improvement, with further reliability work underway through SCC local and regional escalation routes. SCC daily calls now include real-time ambulance monitoring for long Cat 2 waits by locality, enabling quicker corrective actions across acute and community.
- Locality UEC SROs are embedding daily flow reviews to mitigate predictable surges and better align hospital flow with ambulance demand.
- Additional ED and flow improvements across acutes—such as enhanced board rounds, discharge acceleration and expanded EDD tracking—are expected to support handover performance and therefore improve Cat 2 response

Adult G&A bed occupancy

Latest ICB Performance (Oct-25)	95.7%	National Ranking	19/42
ICB Trend (Oct-25)			Improved



Issue

- Adult G&A occupancy for October is 96.1%, placing the ICB 19th out of 42 nationally. Occupancy remains materially above the optimal 92–93% threshold, continuing to constrain patient flow, impede timely ED admissions and contribute to extended ambulance handover delays.
- Several sites report persistent pressure at the front door, limited early discharge activity, and variable delivery of internal flow processes, resulting in day-to-day instability and reduced capacity to respond to winter surges.

Action

- All sites have set a trajectory to achieve 92% occupancy by the festive period with the exception of CoCH.
- **Warrington (WHH)** MADE events planned in November with additional work to maximise flow across 7 days
- **Wirral (WUTH):** Implementation of new 21 day CTR review with support from GIRFT
- **Liverpool (LUFT):** Overnight GP streaming introduced and relaunch of continuous flow model
- **East Cheshire (ECT):** Implementation of clinical criteria for discharge and MADE events planned for November
- **Mid Mersey (MWL):** EDD and Pathway 0 tracking embedded. Ward and board rounds now rolled out to additional wards.
- **Mid Cheshire (MCHT):** MADE events during November and focus on board rounds.

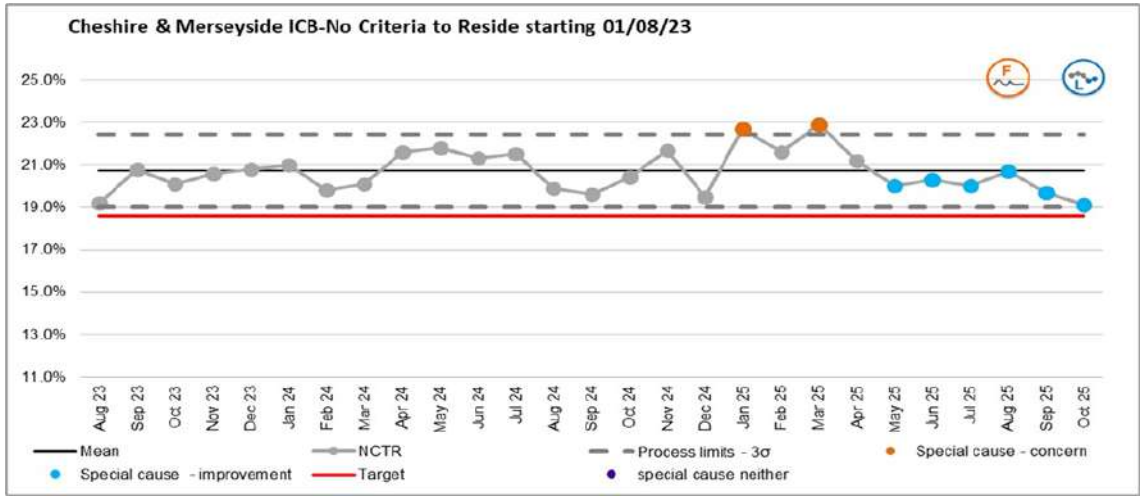
Delivery

- The system remains focused on driving occupancy down towards 92%, with strengthened leadership oversight via SCC morning calls. Daily scrutiny of discharge and flow interventions are aligned to winter planning requirements, with active monitoring of surge capacity arrangements and improved internal processes anticipated to stabilise occupancy through December and into January.

5. Exception Report – Urgent Care

NHS Cheshire and Merseyside

Percentage of beds occupied by patients no longer meeting the criteria to reside			
Latest ICB Performance (Oct-25)	19.1%	National Ranking	n/a
ICB Trend (Oct-25)			Improved



Issue

- NCTR patients account for 19.1% of occupied beds in October, an improvement from September and now below the upper process limit. Despite improvement, levels remain well above the 12% ambition, with sustained delays for patients medically optimised but awaiting onward care.
- Analysis shows that 70% of all NCTR delays are driven by a small number of root causes, primarily:
  - Pathway 3 (150 cases) – awaiting complex bed-based rehabilitation or long-term care.
  - Pathway 1 (118 cases) – requiring supported discharge packages at home.
  - Waiting for confirmation or referral to the Care Transfer Hub (105 + 57 cases).
  - Awaiting therapy decision or review (53 cases).

Action

- Daily NCTR escalation calls continue to focus on the highest-volume delay categories with targeted work up on Pathway 1 and Pathway 3 delays at each acute site.
- Local authority and community partners engaged through weekly discharge cells to accelerate allocation of homecare and bed-based capacity, with senior oversight.
- Acute providers enhancing therapy prioritisation and increasing early therapy review capacity
- Care Transfer Hubs strengthening referral triage, daily oversight and turnaround times to reduce delays. Roll-out of Trusted Assessor and Discharge to Assess models to streamline assessments and reduce duplication for the highest-volume delay categories.

Delivery

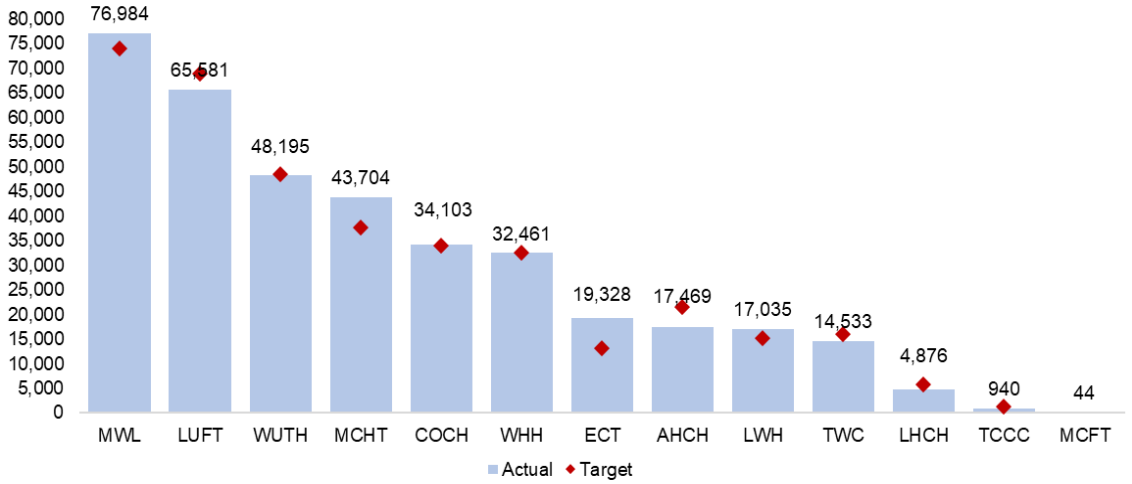
- Month-on-month improvement suggests interventions are taking effect, with the system positioned to drive NCTR down further into November and December as winter plans and community capacity uplifts embed.

5. Exception Report – Planned Care

NHS Cheshire and Merseyside

Total incomplete Referral to Treatment (RTT) pathways

Latest ICB Performance (Sep-25)	367,700	National Ranking	n/a
Provider Breakdown (Sep-25)			Deteriorated



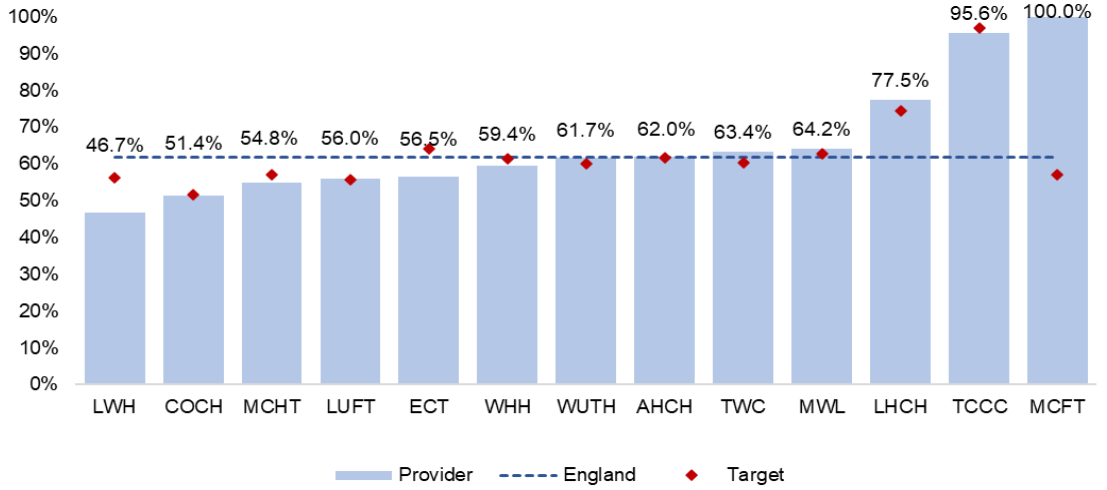
Issue
- The total wait list size in September was 367,700. This is 9,787 less than a revised trajectory of 377,487 (following revision of Sep, Oct & Nov trajectories requested by NHSE (not shown above).
- There is a risk that waiting list numbers will exceed planned trajectories from December onwards. This is largely driven by waiting list growth at Mid Cheshire and East Cheshire Hospitals following implementation of their Digital Clinical System. Data Quality issues account for approx. 60% of growth, with reduced levels of activity accounting for approx. 40% of growth.

Action
- 5 'high risk' providers have been asked to produce recovery plans that achieve a return to plan by the end of March 26 at the latest.
- A C&M H2 Elective Recovery Programme is being mobilised with additional NHSE funding to support increased clinical triage of patients waiting >27wks for ENT, Gynae and Dermatology (approx. 19k patients) – achieving between 20 to 30% removals. Mobilisation in early December.
- As part of the programme, 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 COO Group and Delivery Board

The % of people waiting less than 18 weeks on the waiting list

Latest ICB Performance (Sep-25)	59.2%	National Ranking	33/42
Provider Breakdown (Sep-25)			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 are deploying new trust-wide EPR systems, both providers are experiencing challenges due to DCS implementation.

Action
- 5 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 call with all providers to review performance and to provide support for any escalated actions.
- All providers are participating in the national Q3 validation sprint to help manage demand and improve performance.
- 90 Improvement programmes have been delivered for T&O, ENT and Gynaecology and are now being evaluated to inform scaling and sustaining of changes.
- The H2 Elective Recovery Plan is designed to help manage demand and increase capacity to improve performance. In addition, there are productivity improvements schemes for ENT, Gynae & T&O to increase clinic and theatre utilisation.

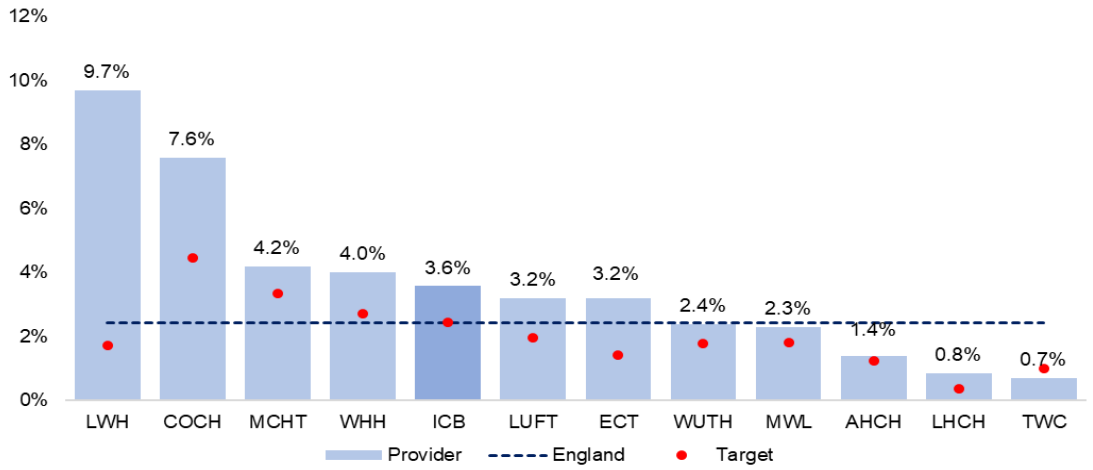
Delivery
- This will be delivered via a C&M Clinical Operational Group and Theatres Improvement Group and monitored via the CMPC COO Group and Delivery Board.

5. Exception Report – Planned Care

NHS Cheshire and Merseyside

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

Latest ICB Performance (Sep-25)	3.6%	National Ranking	40/42
Provider Breakdown (Sep-25)			Improved



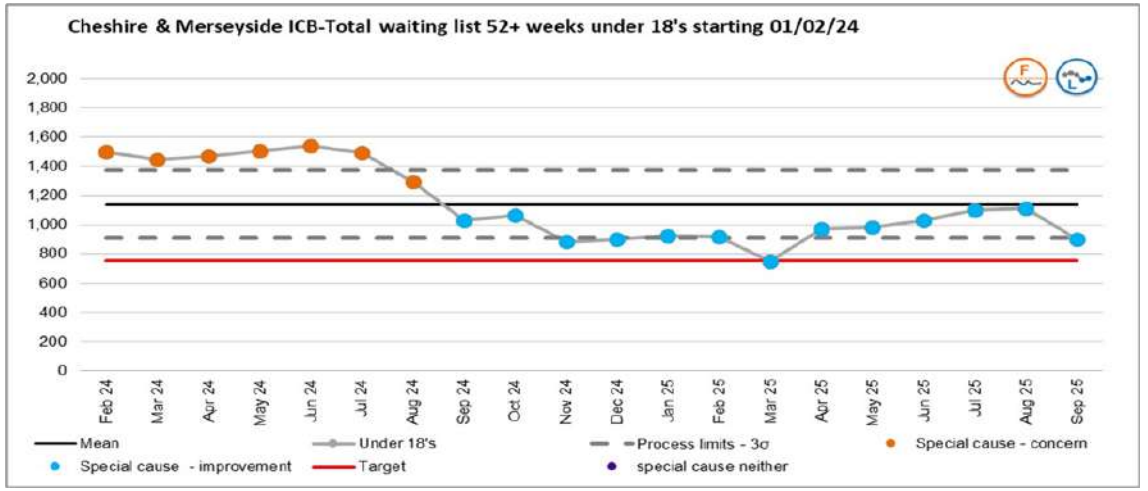
Issue
- While the current performance is behind plan, there is an improving trend (3.1% as of 9th Nov). In Sept 25, there were 11,391 patients waiting over 52 weeks.
- Liverpool Womens is furthest off plan (+8%) due to cessation of insourcing earlier in the year.
- Mid Cheshire & East Cheshire Trusts are deploying new trust-wide EPR systems, both providers are experiencing challenges due to DCS implementation.

Action
- 5 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.
- A C&M H2 Elective Recovery Programme is being mobilised in December with additional NHSE funding to support increased clinical triage of patients waiting >27wks for ENT, Gynae and Dermatology (approx. 19k patients) – achieving between 20 to 30% removals.
- As part of the programme, a System Capacity Management Process is being implemented to increase utilisation of elective hubs and inter-organisational support. Funding will be used to provide increased capacity across the system to help reduce long waiters (and reduce waiting list size).
- A C&M Elective Hub Improvement Group has been established, and all hubs have an agreed improvement plan and trajectory to achieve 85% by end of March 26.

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 (Sep-25)	899	National Ranking	n/a
ICB Trend (Sep-25)			Improved



Issue
- Several organisations are off plan in relation to their 52 week-long waits position. There are 1,008 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.
- The H2 Elective Recovery Plan described opposite is inclusive of CYP and will include specific actions for CYP long waiters in ENT and dental.

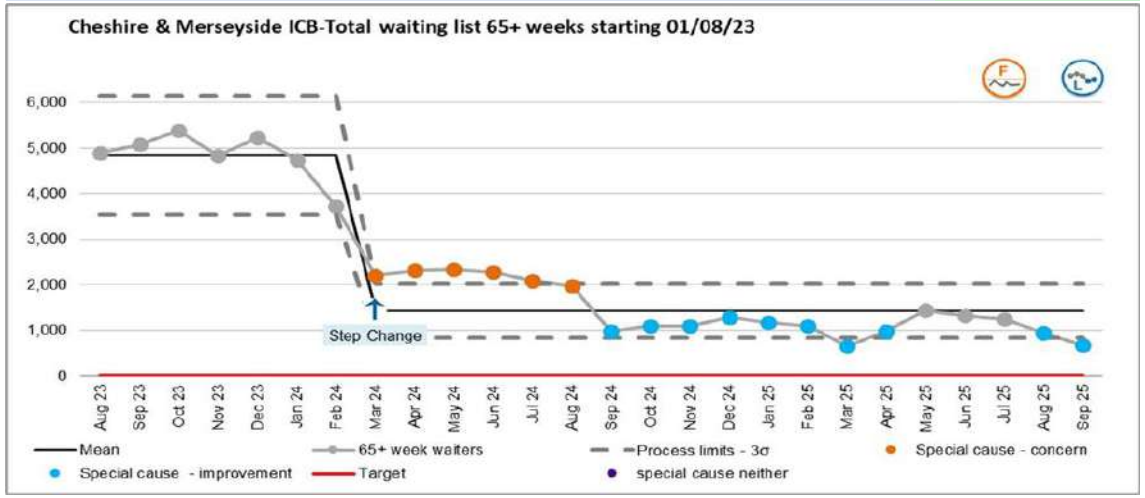
Delivery
- This will be delivered via a C&M Clinical Operational Group and monitored via the CMPC COO Group and Delivery Board

5. Exception Report – Planned Care

Cheshire and Merseyside

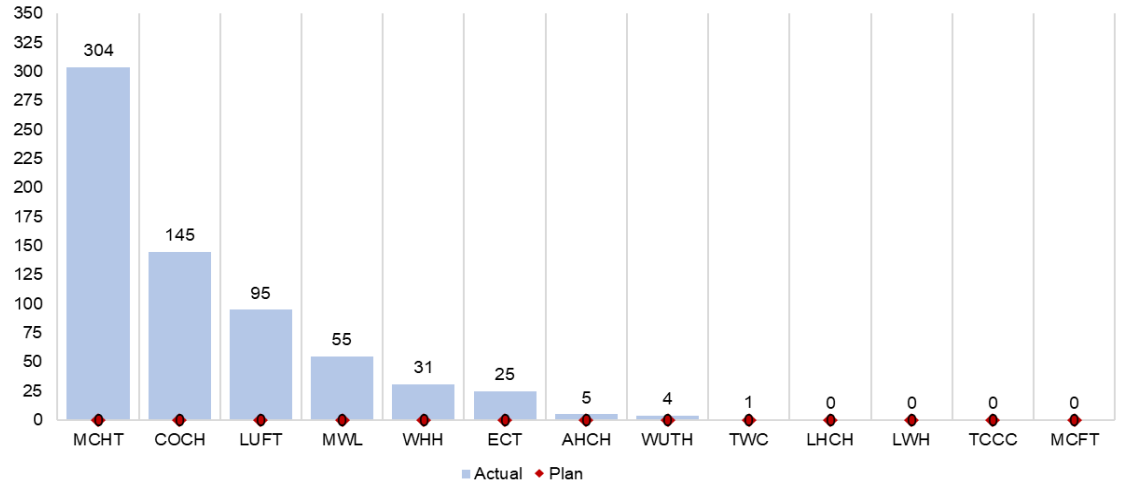
ICB incomplete RTT pathways of 65 weeks or more

Latest ICB Performance (Sep-25)	677	National Ranking	n/a
ICB Trend (Sep-25)			Improved



Trust incomplete RTT pathways of 65 weeks or more

Latest ICB Performance (Sep-25)	677	National Ranking	n/a
Provider Breakdown (Sep-25)			Improved



Issue

- There were 677 patients waiting 65wks+ as of September 25.
- The largest proportion of 65wks is at Mid-Cheshire Trust (304). The implementation of a new Digital Clinical System and cessation of insourcing/outsourcing earlier in the year has caused significant challenges.
- Data quality and accurate forecasting to underpin improvement work has been a challenge. Significant improvements have been made across all providers (there are currently 746 patients waiting 65wks+ against a trajectory of 898. Mid-Cheshire are currently at 225 against a trajectory of 358).The majority of providers are forecasting zero 65-week waits by end of Oct, with COCH and MCHT clearing 65ww patients by 21st December (national deadline).

Action

- A weekly 65wk Performance & Delivery meeting is in place 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 the last two months.
- 5 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. Active mutual aid is being supported for Mid Cheshire in relation to Ophthalmology, Paediatric ENT, T&O.
- CMPC continues to prioritise validation activity with current performance reporting at 12-weeks 64.74%, 26-weeks 73.44% (6 providers reporting above national ambition of 90%) and 52-weeks 84.05%, (with 8 providers reporting above the national ambition of 90%) (no submission from ECHT & MCHT due to implementation of new EPR system).
- The implementation of the C&M H2 Elective Recovery Plan will support further improvements in 65wk performance and mitigate future risks for further 65wk breaches.

Delivery

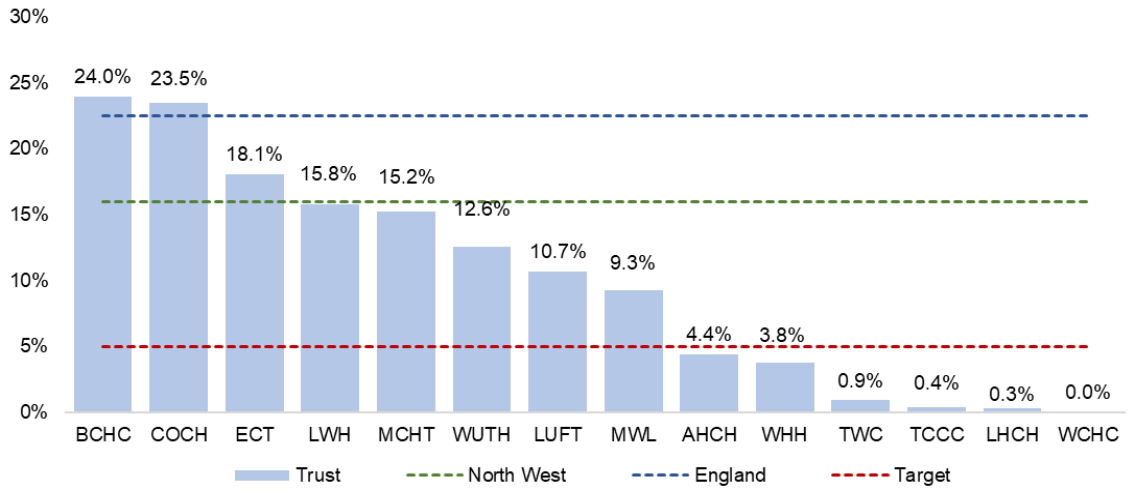
- There is a continued focus on eradicating 65 week waits and to model the delivery of 52 and 18 weeks for future planning.
- This will be monitored via the CMPC COO Group and Delivery Board
- CMPC continues to report into region on current performance and plans for immediate recovery.

5. Exception Report –Diagnostics & Cancer

NHS Cheshire and Merseyside

Patients waiting more than 6 weeks for a diagnostic test

Latest ICB Performance (Sep-25)	12.4%	National Ranking	4/42
Provider Breakdown (Sep-25)			Improved



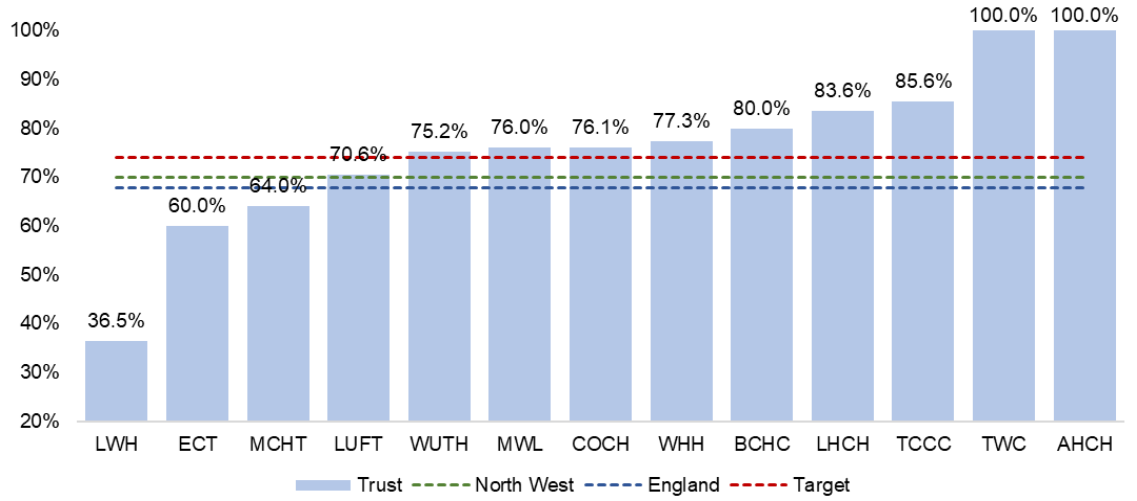
Issue
- C&M performance has deteriorated since March, for various reasons including financial constraints reducing any waiting list initiatives and other premium rate activity alongside significant workforce challenges in some tests. C&M remain in the top 5 ICB areas nationally for diagnostic performance.
- NOUS capacity across C&M is challenged with most Trusts facing Sonographer staffing shortages.

Action
- Mutual Aid Process – refreshed support for the process with Trust COOs and SOP review with additions scheduled for November for sign off and further implementation.
- System capacity continues to be maximised through Community Diagnostics Centres (CDCs) and the Mutual Aid Process, 4 Trusts are currently being supported by neighbouring CDCs and Provider Trusts to reduce NOUS backlogs.
- NOUS demand and activity scoping has been completed by CAMRIN and a deep-dive into NOUS optimisation in CDCs has been completed with next steps and actions TBC.
- Halton Endoscopy Hub – Agreement from Trust COO's in September for endoscopy surveillance patients to be sent to the hub via an opt out process. MWL, as the pilot Trust have begun to operationalise this.

Delivery
- No national diagnostic performance target set by NHSE for 25/26. However, the NHS constitutional standard remains at 99% and timely access to diagnostics is a key enabler for the achievement of RTT and cancer treatment targets.

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 (Sep-25)	72.7%	National Ranking	12/42
Provider Breakdown (Sep-25)			Deteriorated



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 72.7% is 8th amongst Cancer Alliances and 12th amongst ICBs. It should be noted that this figure is 4.8% points ahead of England and represents good performance for C&M in relative terms.

Action
- October forecasts show recovery back above trajectory
- 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.

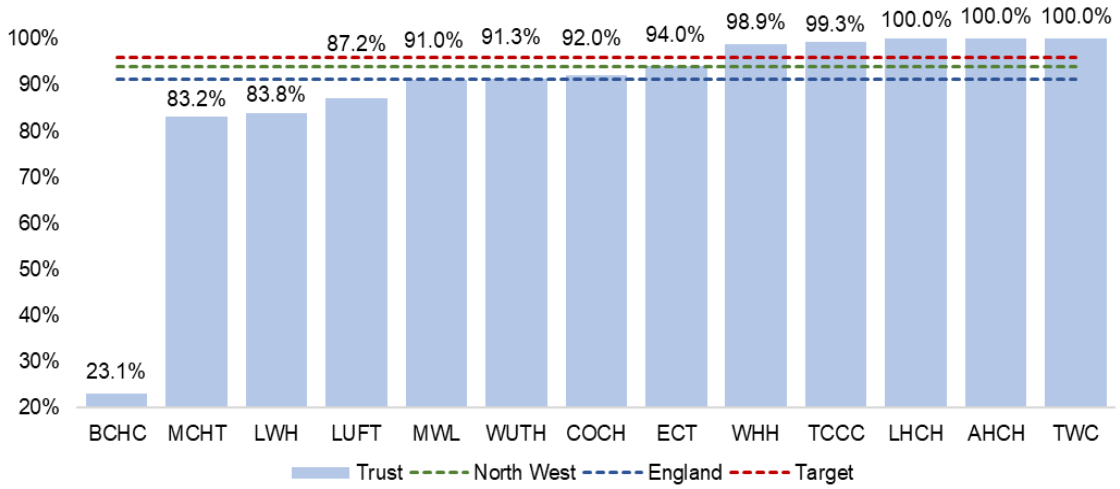
Delivery
- C&M expects to meet the 75% and 85% ahead of England as a whole. There is almost no risk to the end of year trajectory position for 62d.

5. Exception Report – Cancer

NHS Cheshire and Merseyside

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

Latest ICB Performance (Sep-25)	93.7%	National Ranking	14/42
Provider Breakdown (Sep-25)			Deteriorated



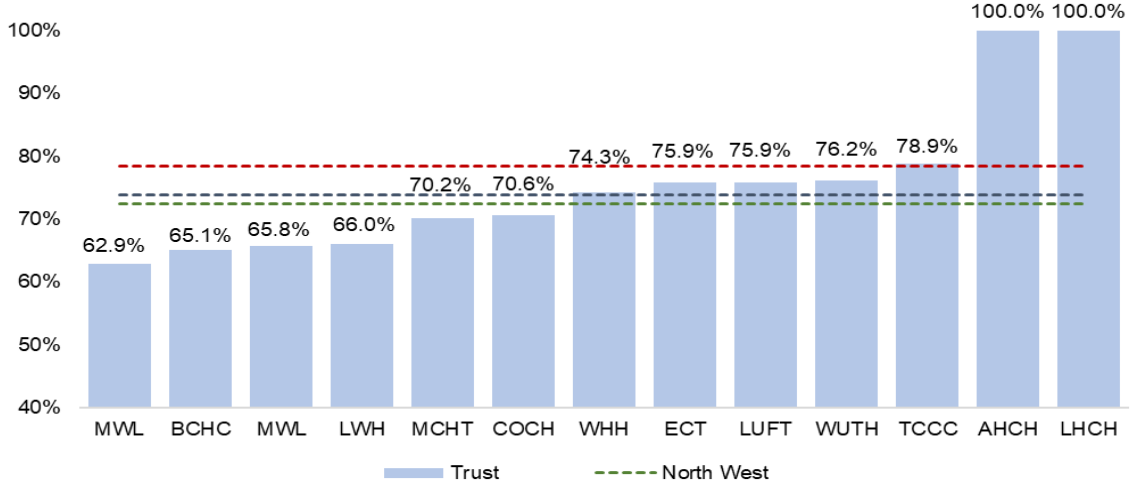
Issue
- C&M not yet achieving the 96% 31-day combined standard required. However, the figure of 93.7% is 6th amongst Cancer Alliances and 14th amongst ICBs. It should be noted that this figure is 2.5% points ahead of England and represents good performance for C&M in relative terms.

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

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

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

Latest ICB Performance (Sep-25)	70.6%	National Ranking	32/42
Provider Breakdown (Sep-25)			Improved



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

Action
- CMCA has produced bespoke improvement trajectories for each provider which are linked to improvement plans managed via the CMCA performance forum.
- The Pathways Improvement Programme continues to work across the nationally mandated priority tumour sites, implementing 'in depth reviews' to assess underlying performance drivers for cancer pathways (LGI, Breast, Skin, Gynae, Urology).
- A range of cross-cutting initiatives are underway such as an MDT bank, CDC optimisation group and single-queue diagnostic work.
- Skin has affected the FDS position seasonally and disproportionately due to system finance controls in part. MWL is exiting a recovery programme led by the alliance over 12 weeks which has recovered FDS performance. We expect a return to trajectory for the alliance in Q4.

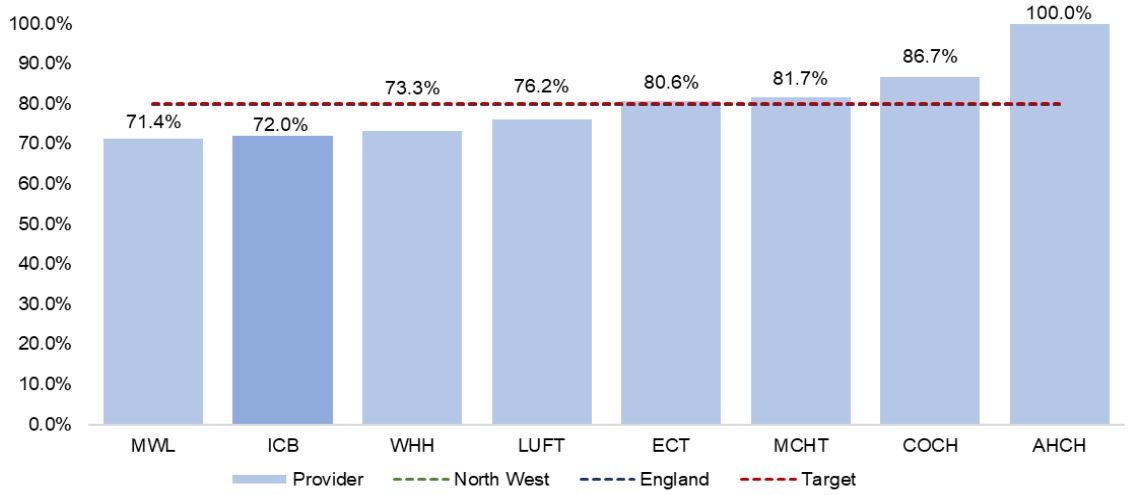
Delivery
- C&M is still expecting to meet the 80% ambition by the end of the financial year 25/26.

5. Exception Report – Community

Virtual Wards Utilisation

Latest ICB Performance (Oct-25)	72.0%	National Ranking	28/42

Provider breakdown (Oct-25)



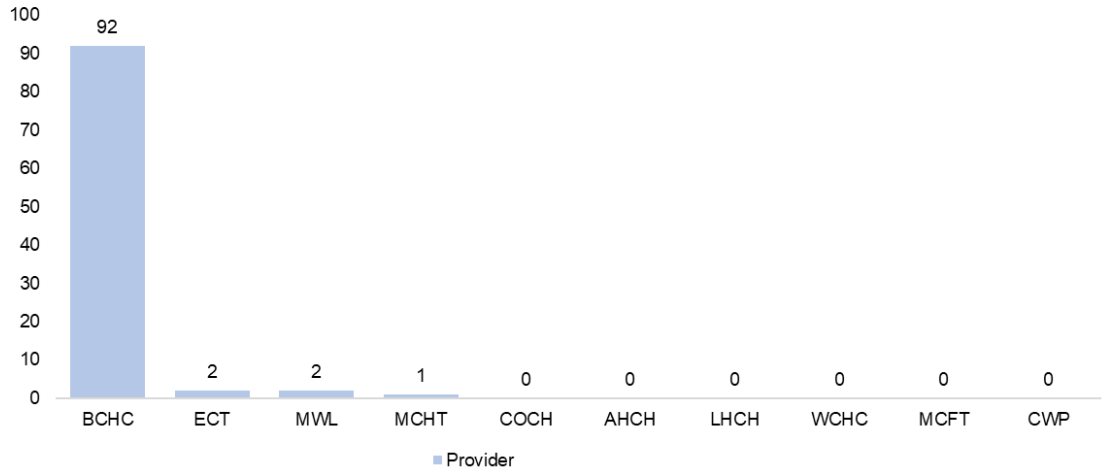
Issue
- The September 2025 Quality and Performance Report shows a discrepancy in utilisation data as was the case for July and August.
- There is variation between the national and local data due to recognised issues related to the timing of the data collection and the reported bed capacity across ICB footprints.
- Local verified data confirms that the actual rate for September was a mean utilisation **of 81.2%.**

Actions
- UHLG intend to open a palliative care pathway in September that will increase the VW opportunity.
- WHHFT have started to report the 10 Palliative Care beds from St Rocco's and this will show in October data.
- A discrepancy remains for MWL in relation to VW beds provided for L&SC reported in the C&M national data. This is being addressed.

Community Services – Adults waiting over 52 weeks

Latest ICB Performance (Sep-25)	449 *	National Ranking	n/a

Provider breakdown (Sep-25)



Issue
- BCHC waits are primarily within the adult podiatry service and a capacity and demand review is in progress to address this issue.

Action
- Capacity and demand review of podiatry service at BCHC.

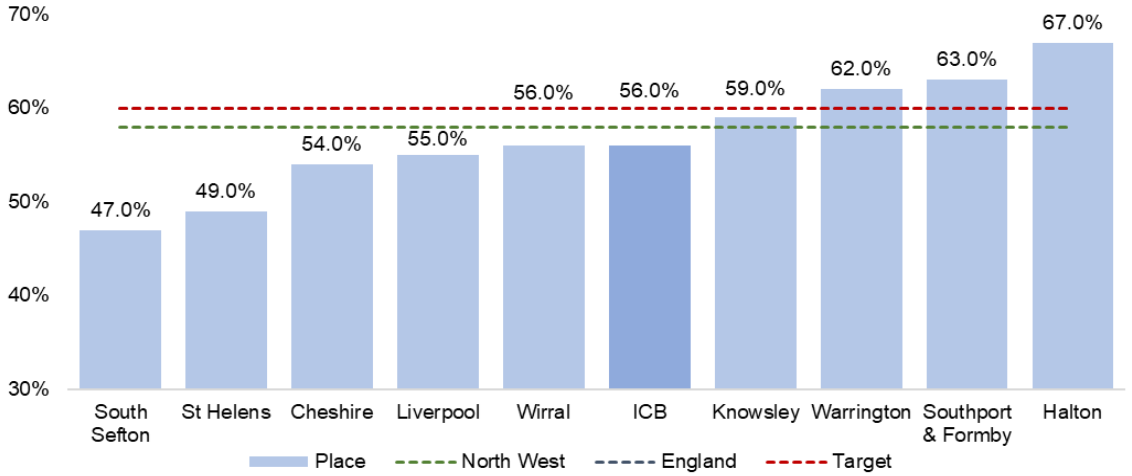
*ICB figure includes the provider HCRG who deliver services outside of C&M

5. Exception Report – Mental Health

NHS Cheshire and Merseyside

People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months

Latest ICB Performance (Q2-25/26)	56.0%	National Ranking	32/42
Place Breakdown (Q2-25/26)			Deteriorated



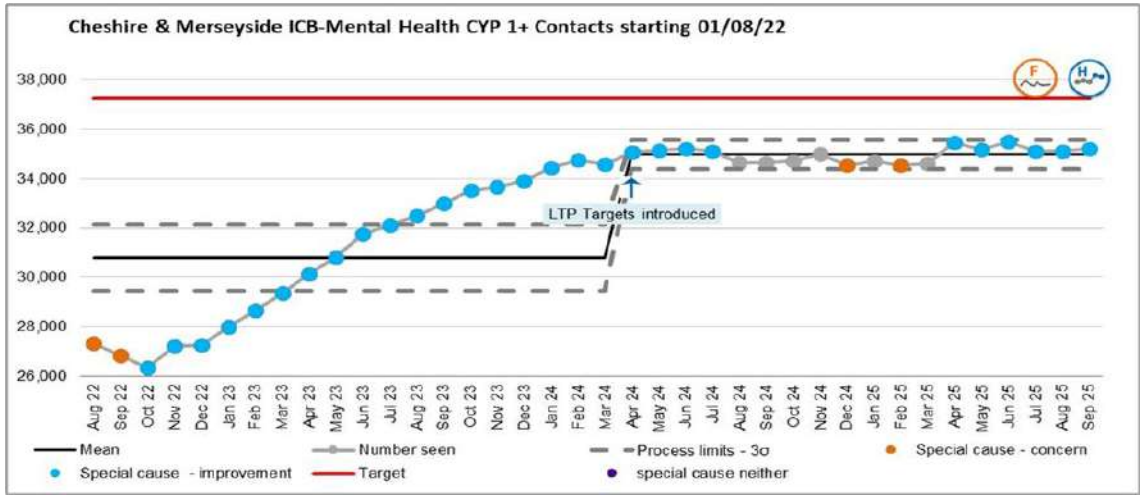
Issue
- ICB performance has fallen below the minimum 60% target. National ambition is to work towards 75% of people with SMI receiving all 6 physical health checks.
- Metric has been removed from MH operational planning metrics for 2025/26 and QOF incentive for GP practices has also been removed for completion of all 6 health checks in the new GP contract. These changes will limit the ability to actively influence a further increase in performance.

Action
- Places to consider continuation of existing outreach schemes which promote and encourage uptake of physical health checks and note the risk of further 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
- 6 of 9 places met the minimum 60% target in Q4 of 2024/25 but this has reduced to 3 places this quarter.
- Historic trends generally indicate below plan performance in the first 2 quarters of the year.

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

Latest ICB Performance (Sep-25)	35,220	National Ranking	n/a
ICB Trend (Sep-25)			Improved



Issue
- There has been a marginal improvement in access, however rates remain circa 2,000 below target at 94% 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
- A deep dive into activity undertaken by existing MH Support Teams in schools is progressing with a view to increasing access reported.
- 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.

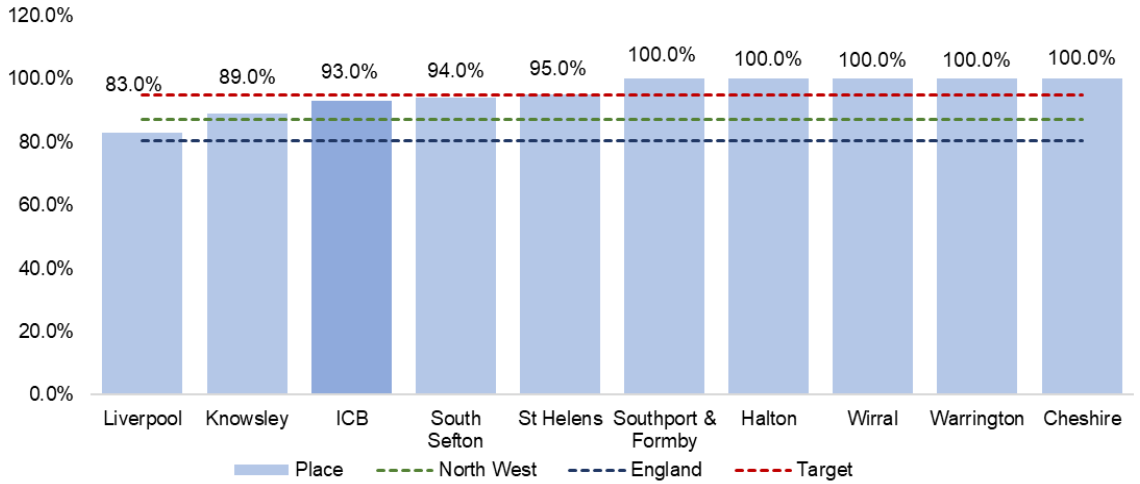
Delivery
- There has been no significant change in overall C&M access rates since 2024, however there is more significant variance in place level trends.

5. Exception Report – Mental Health

NHS Cheshire and Merseyside

CYP Eating Disorders Routine

Latest ICB Performance (Sep-25)	93.0%	National Ranking	5/42
Place Breakdown (Sep-25)			Deteriorated



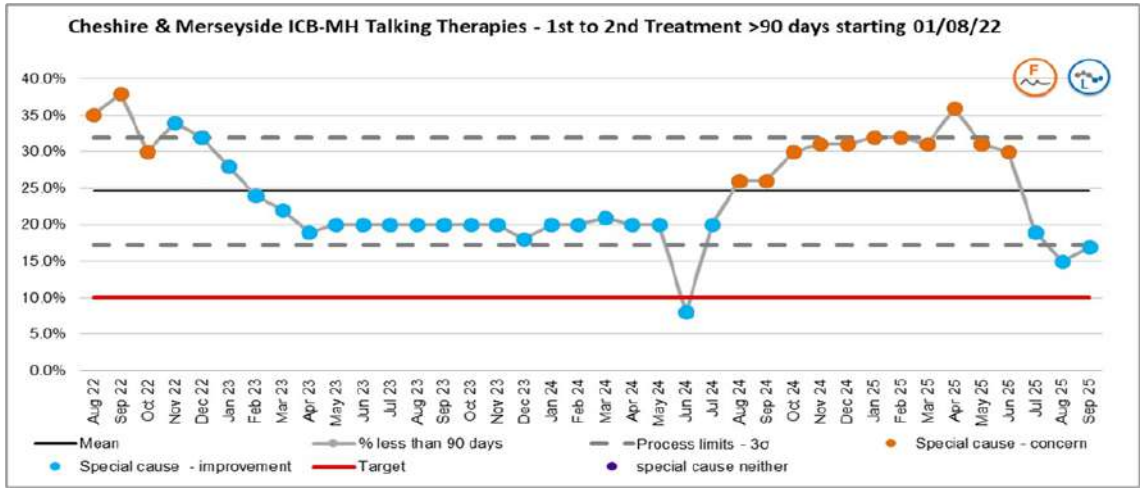
Issue
- National data indicates a 1% deterioration in performance between Aug 25 and Sep 25 based on nationally published data. However, local data indicates that 95% of CYP are being seen within 4 weeks for routine appointments.
- Mersey Care data quality issue has impacted on the overall ICB position; however, local data indicates that the target is being achieved by the trust and the ICB.

Action
- MCFT have developed local 'live' reports to track the MHSDS data set as national reporting does not appear to be reflective of the local data.
- Work is underway to review how pathways can be improved across community eating disorder teams to provide more effective and efficient care.

Delivery
- Alder Hey nationally reported data indicates that 91% of CYP are being seen within 4 weeks.
- CWP continues to achieve 100% of patients seen within 4 weeks.
- Mersey Care nationally reported data indicates 87% of CYP are seen within 4 weeks, however local data reports 100% achievement.

Talking Therapies 1st to 2nd Treatment >90 days

Latest ICB Performance (Sep-25)	17.0%	National Ranking	16/42
ICB Trend (Sep-25)			Improved



Issue
- The proportion of people who wait more than 90 days between 1st and 2nd treatment should not exceed 10%. Current ICB performance exceeds this at 17%.
- Although Sep data is 2% higher than Aug, this represents a significant reduction from 30% in Jun 25, albeit the Wirral Talking Therapy provider, Everyturn MH, has not submitted data following a system migration.

Action
- Wirral data submissions have recommenced, however, waiting times are not currently included
- Group or e-therapy first model being implemented – with staggered starts to groups to create less wait time for a course to start
- Updated service spec embedded which helps providers be clearer on their offer
- Review of waiting lists and reduction in waiting times
- Greater engagement with data which supports providers with insights into areas for improvement within their services

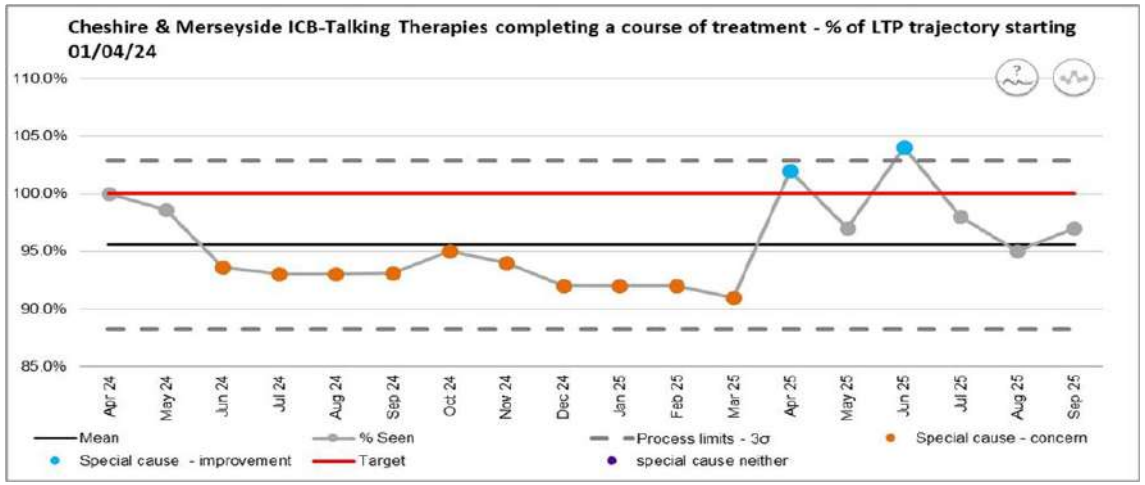
Delivery
- The percentage of people waiting >90 days between treatment varies between 53% and 6% across Cheshire and Merseyside's 5 local providers
- At place level this translates to variances of between 53% in Warrington and 3% in Liverpool

5. Exception Report – Mental Health

NHS Cheshire and Merseyside

Talking Therapies completing a course of treatment - % of plan achieved

Latest ICB Performance (Sep-25)	97.0%	National Ranking	24/42
ICB trend (Sep-25)	Improved		



Issue

- National reporting indicates that the number of people completing a course of treatment has increased since the previous month and the ICB is now achieving 97% of plan.

Action

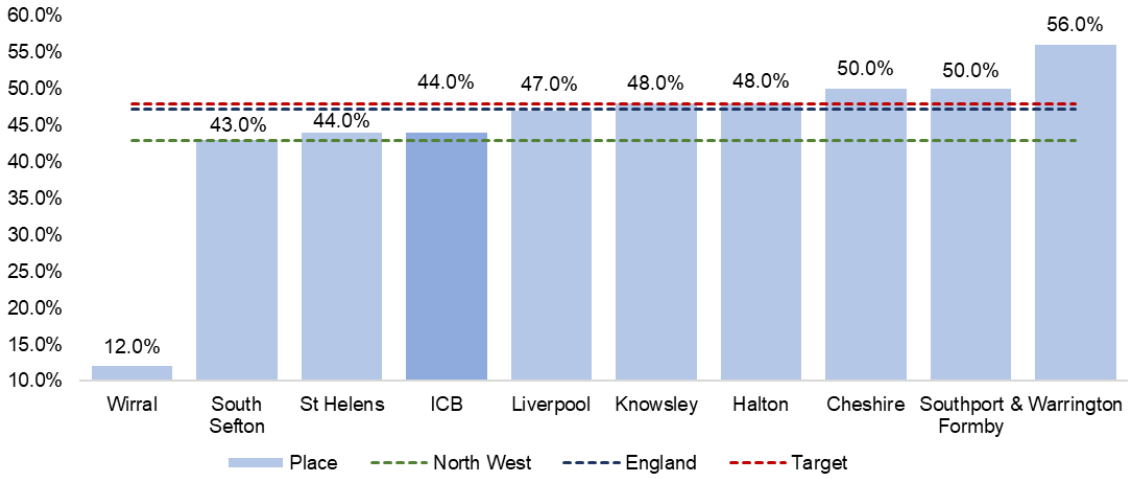
- Workforce expansion is underway aligned with additional funding committed for a 5-year period.
- Additional trainee therapists have started in post and attraction and recruitment of additional qualified therapists from outside of Talking Therapy services is progressing.
- A “readiness for therapy” video has been developed to minimise the number of people not completing their course of treatment.
- Work continues to interrogate Talking Therapies data and look at areas that impact on productivity such as DNA rates, contact hours etc to inform service improvement plans.

Delivery

- Trajectories have been set at place level and shared with each of C&M’s five talking therapy providers and activity will be monitored at this level.

Talking Therapies Reliable Recovery

Latest ICB Performance (Sep-25)	44.0%	National Ranking	24/42
Place breakdown (Sep-25)	Deteriorated		



Issue

- Nationally reported data indicates that reliable recovery rates have reduced from 47% to 44% this month. However, Wirral Talking Therapy provider, Everyturn MH, has recently migrated to a new system and did not submit data in July and Aug. September reliable recovery reported for Wirral is 12% and this is impacting on the overall ICB rates

Action

- Wirral data submissions have resumed following system migration.
- National workforce modelling tool is expected to be published by the end of November.
- 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

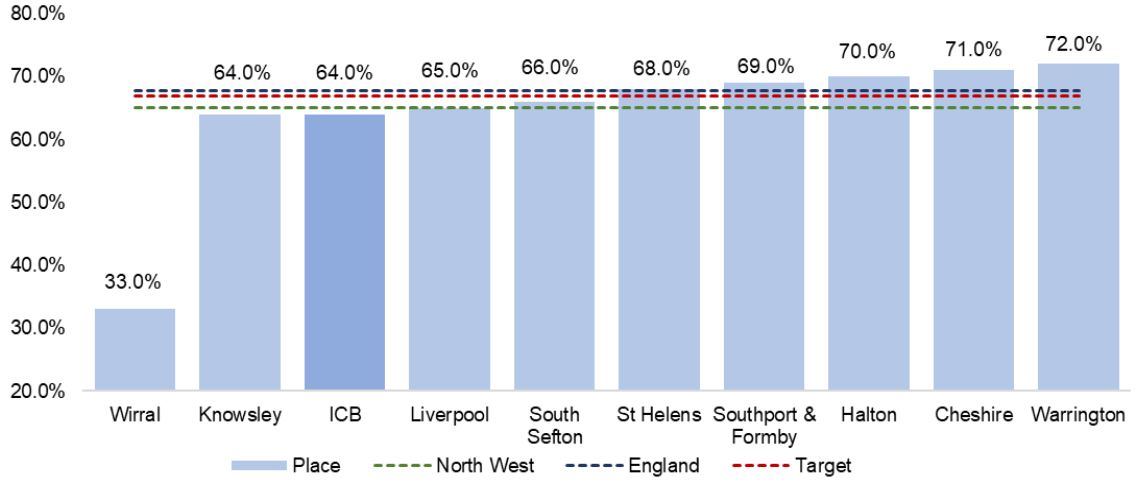
- Cheshire, Halton, Knowsley, and Warrington places have all achieved reliable recovery targets for Sep 25.
- Liverpool rate has remained broadly static and only achieved reliable recovery rates in April 25 following a data refresh by Mersey Care.
- St Helen’s reliable recovery has reduced from 46% to 44% this month.

5. Exception Report – Mental Health & Learning Disabilities

NHS Cheshire and Merseyside

Talking Therapies Reliable Improvement

Latest ICB Performance (Sep-25)	64.0%	National Ranking	26/42
Place Breakdown (Sep-25)			Deteriorated



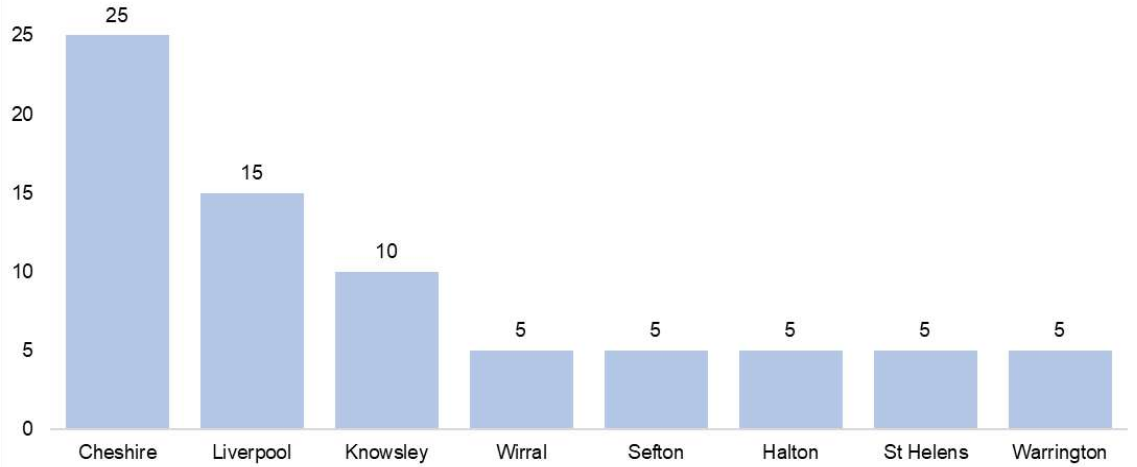
Issue
- Nationally reported data indicates that reliable improvement rates have reduced from 66% to 64% this month; 4% below plan. However, Wirral Talking Therapy provider, Everyturn MH, has recently migrated to a new system and did not submit data in July and Aug. Sep reliable improvement reported for Wirral is 33% and this is impacting on the overall ICB rates

Action
- Wirral data submissions have resumed following system migration
- National workforce modelling tool is expected to be published by the end of November
- 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
- Reliable improvement rates have been achieved by 3 out of 5 talking therapy providers for Sep
- Mersey Care achieved 66% and Wirral 33% following system migration.

Adult inpatients with a learning disability and/or autism

Latest ICB Performance (Sep-25)	75 *	National Ranking	18/42
Place Breakdown * (Sep-25)			No change



Issue
- There were 73 adult inpatients, of which 46 are Specialised Commissioning (Spec Comm) commissioned by NHSE, and 27 ICB commissioned. The target identified for C&M (ICB and Spec Comm) is 46 LD/A or fewer by the end of Q4 2026 and 28 Autism only.

Action
- The Transforming Care Partnership (TCP) has scrutinised those clinically ready for discharge. Of those 73 adults, 11 individuals are currently on Section 17 Leave. It is expected that some of the existing section 17 leave individuals will be discharged in Q3 pending MOJ Clearance and transition progress. We have discharged 22 people 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 Lead 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.

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.
- 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.

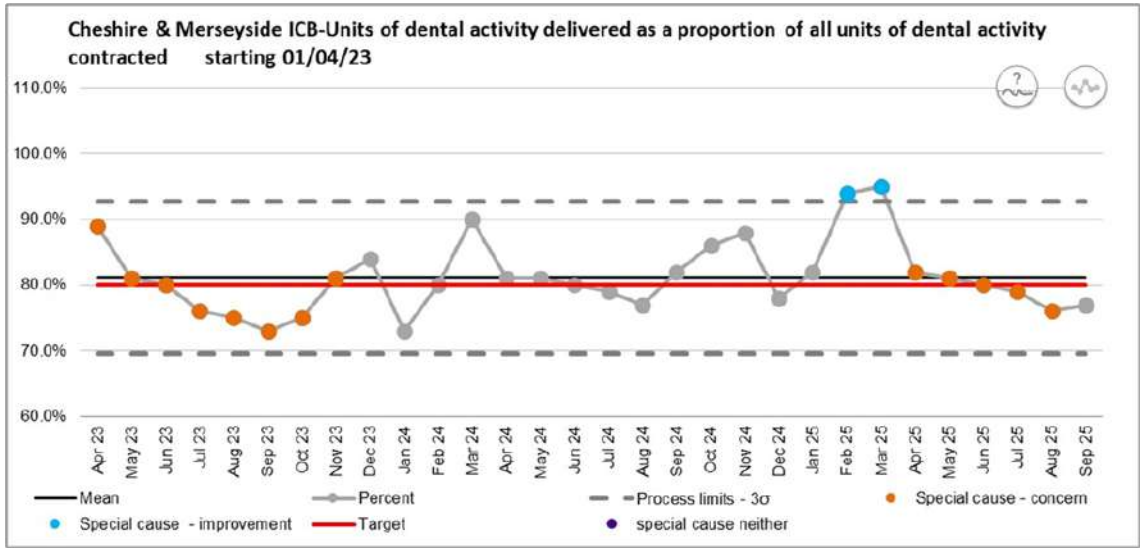
** Data rounded up/down to nearest 5: therefore, Place subtotals may not add up to the ICB total*

5. Exception Report – Primary Care

NHS Cheshire and Merseyside

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

Latest ICB Performance (Sep-25)	77.0%	National Ranking	32/42
ICB Trend (Sep-25)			Improved



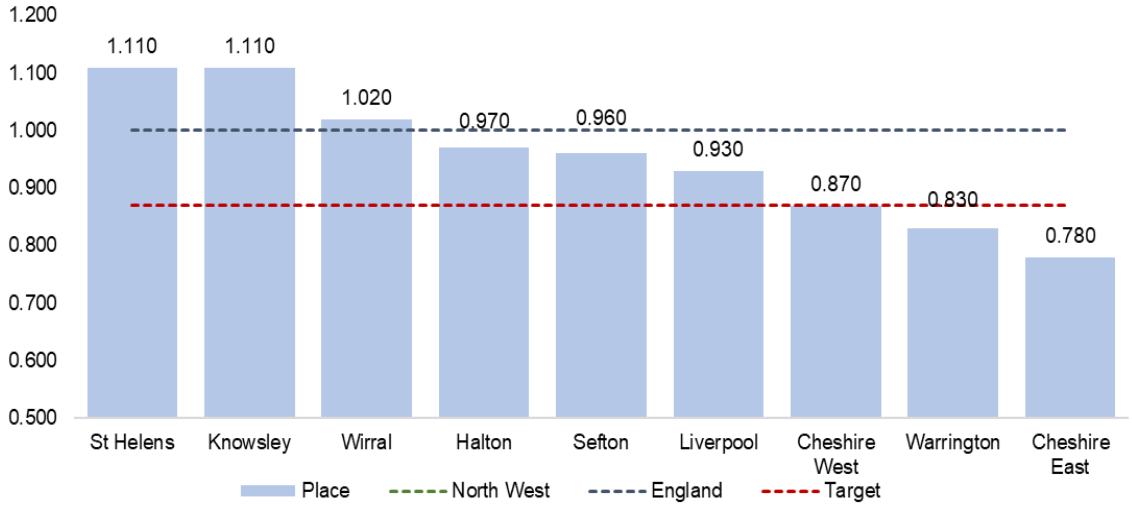
Issue
- C&M does not currently meet the 80% target.

Action
- Local Dental Improvement Plan 25/26 implementation focusing on access and includes actions being taken to increase activity relating to routine access and urgent care linked to national urgent care scheme and C&M share (46k) of the national 700k appts target.

Delivery
- Fluctuations in delivery of target are expected throughout the year such is the nature of national contract.

Total volume of antibiotic prescribing in primary care

Latest ICB Performance (July-25)	0.93	National Ranking	n/a
Place breakdown (July-25)			Improved



Issue
- C&M does not currently meet the target set for the volume of prescribing of antibiotics although we continue to improve in this measure.

Action
- All Places continue the cascade of education, public communication work, reviewing prescribing data and decisions in relation to antibiotic prescribing.
- Bid submitted to NHS England for ICB Leadership and Governance of AMR Funding was successful await next steps of agreeing new posts to be hosted by MWL and WUTH.
- Standardised communication for WAAW 2025 to be agreed and shared across all Places. The theme for World AMR Awareness Week (WAAW) 2025 is “Act Now: Protect Our Present, Secure Our Future”.
- The Pharmacy First service continues to be utilised across NHS C&M with the latest figures on antibiotics issued via Pharmacy First or via primary care reducing in number, giving confidence that we aren’t causing increases in antibiotic exposure across the board.

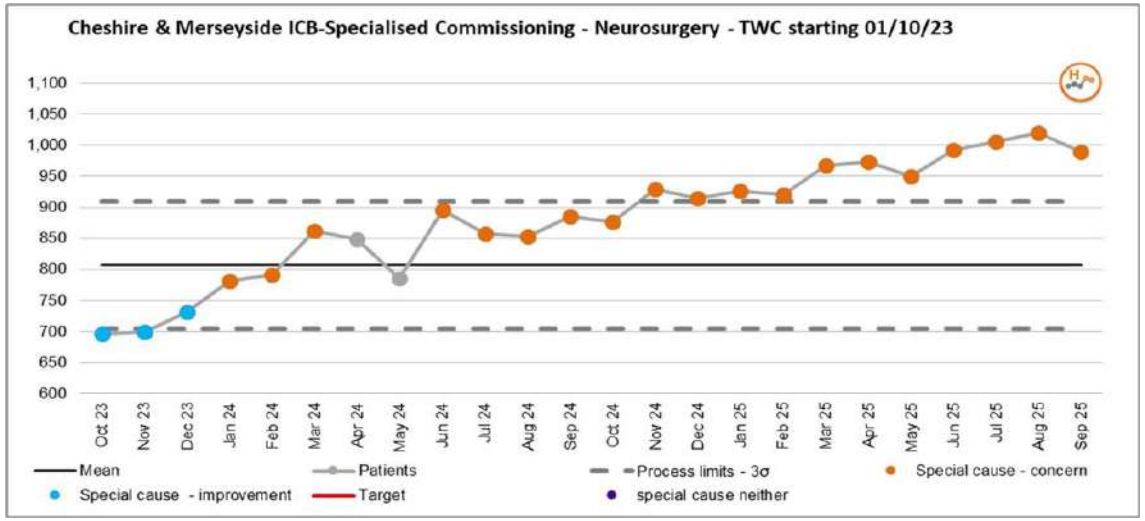
Delivery
- Analysis to continue with Q2 2025/26 data at Place and ICB level to inform areas to focus on at Place and C&M level.

5. Exception Report – Specialised Commissioning

NHS Cheshire and Merseyside

Neurosurgery waiting list (TWC)

Latest ICB Performance (Sep-25)	989	National Ranking	n/a
ICB Trend (Sep-25)			Improved



Issue

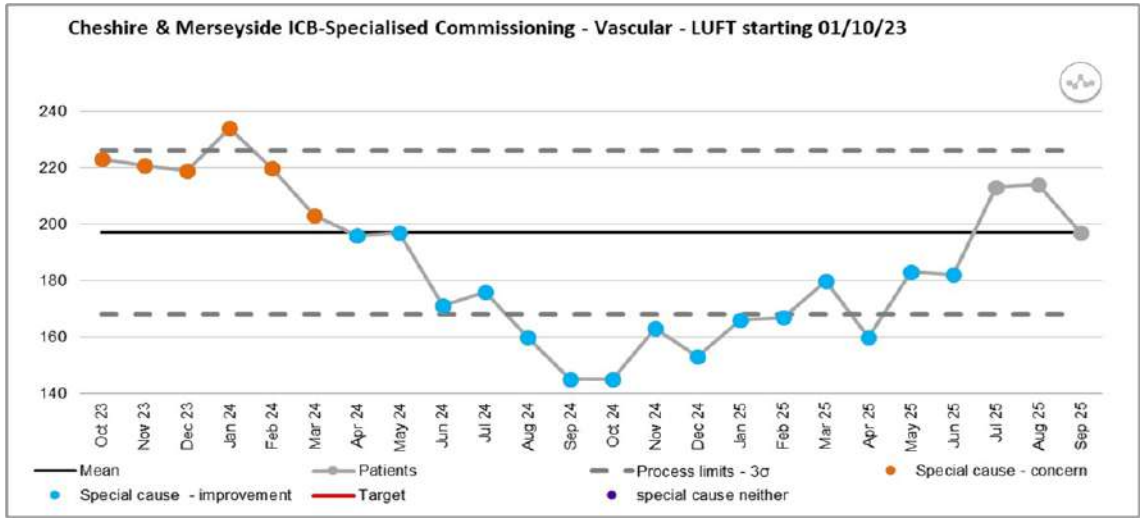
- The waiting list for Neurosurgery at The Walton Centre has been steadily increasing and the current number is greater than the same period last year.

Action

- The Trust have been undertaking a programme of theatre refurbishment works for a large part of this year which means that their theatre capacity has been reduced by 15%. Works are expected to be completed in January.
- Referral rates have increased significantly so work has commenced to strengthen the community MCAT service through virtual MDTs as it is believed that a lot of referrals are reaching the tertiary provider unnecessarily.
- Walton continue to be affected by the ICB cap on bank rates and this has resulted in some cancellations through impact upon critical care workforce capacity. The Trust are actively trying to fill these vacancies and hope to be fully established by the end of March.

Vascular waiting list (LUFT)

Latest ICB Performance (Sep-25)	197	National Ranking	n/a
ICB Trend (Sep-25)			Improved



Issue

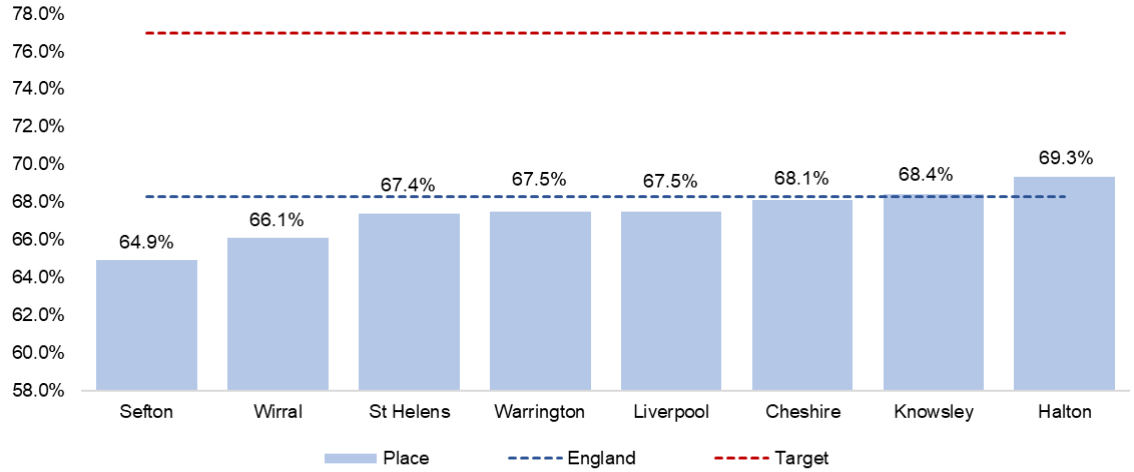
- Upon further investigation, the vast majority of these waits are incorrectly coded, and are actually awaiting varicose vein treatment which is ICB funded.
- Historically, vascular coded activity funded by Spec Comm is very minor. This will be investigated further.

5. Exception Report – Health Inequalities & Improvement

NHS Cheshire and Merseyside

% of patients (18+), with GP recorded hypertension, BP below appropriate treatment threshold

Latest ICB Performance (Q1-25/26)	67.34%	National Ranking	27/42
Place Breakdown (Q1-25/26)			Deteriorated



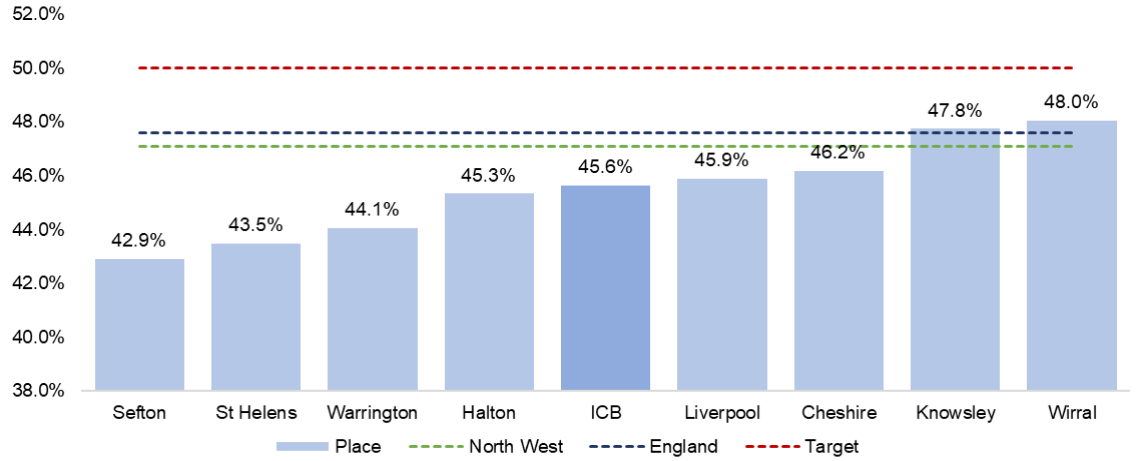
Issue
- There is deterioration this quarter (mirrored by the England trend) and there remains considerable variation between Places. C&M does not currently meet the national target ambition

Action
- The hypertension case finding in optometry pilot continues with 60 opticians and representation from each Place. Over 1000 readings taken with 500 more planned before the project is complete and evaluation can begin. The national evaluation is due to be shared before the end of Q3
- Cycle 2 of the CLEAR programme almost complete. Work to start with the last Cycle in Q3, with a further 6 PCNs adopting a new model of care re: CVDP which may include hypertension.
- Health Inequalities BP optimisation project complete and evaluation shared widely; additional Clinical Pharmacist time secured to lead on development and dissemination of recommendations.
- There has been a successful Know Your Numbers BP awareness Campaign co-ordinated across multiple organisations incl. opportunistic BP testing pop ups in community settings.
- 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 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.

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 (Q1-25/26)	45.6%	National Ranking	28/42
Place Breakdown (Q1-25/26)			Improved



Issue
- **This is a new metric reported this quarter, that aligns with the planning guidance to target established CVD cholesterol management**. Considerable variation exists between Places and between ICBs. There isn't currently a national target ambition for this metric.

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.
- Continued development of a suite of user-friendly resources and educational opportunities for primary care colleagues to better support Lipid management. The second in a series of webinars is planned for November, and the patient toolkit is due to be reviewed by the Clinical Effectiveness Group before launching in Q3.
- Cycle 2 of the CLEAR programme is nearing completion. Work will start with the last Cycle in Q3, with a further 6 PCNs to adopt a new model of care around their chosen aspect of CVD prevention which may include Lipid management.

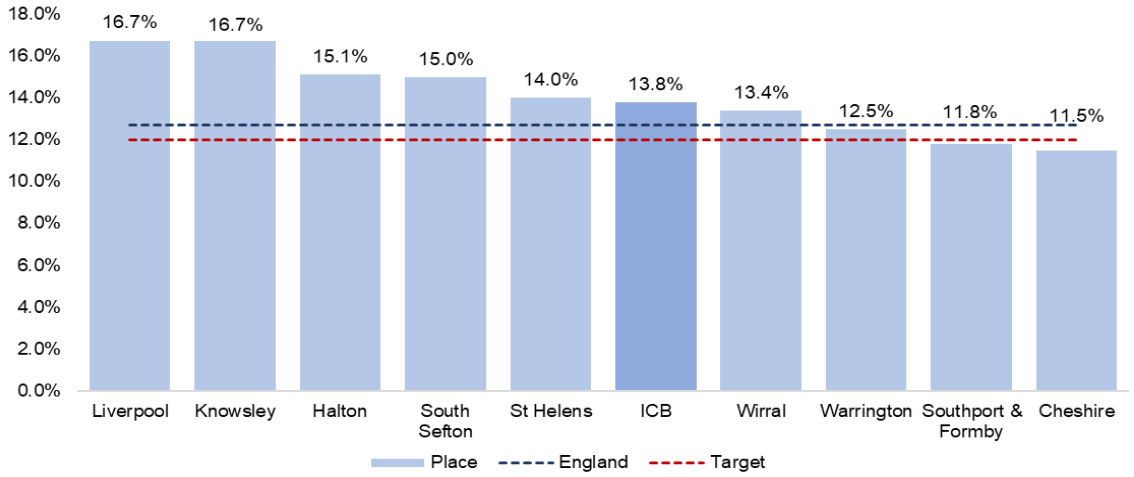
Delivery
- CVDP SRO, Programme lead, CVDP Commissioner (fixed term) and CVD Prevention Board is the vehicle to coordinate C&M wide NHS activity alongside local Place CVD Prevention plans.
- The role of primary care in achieving this ambition is key.

5. Exception Report – Health Inequalities & Improvement

NHS Cheshire and Merseyside

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

Latest ICB Performance (Oct-25)	13.8% *	National Ranking	n/a
Place Breakdown (Oct-25)			Improved



Issue

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

Action

- Segmentation of smokers across C&M has taken place to understand how we effectively communicate to different types of smokers to motivate them to quit.
- The NHS smokefree toolkit has been launched to support NHS Trusts to keep their sites smokefree and support patients, staff and visitors to access smoking cessation support.
- A review of the smoking cessation system in C&M has commenced to ensure we are optimised service capacity to support smokers to quit.

Delivery

- 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.

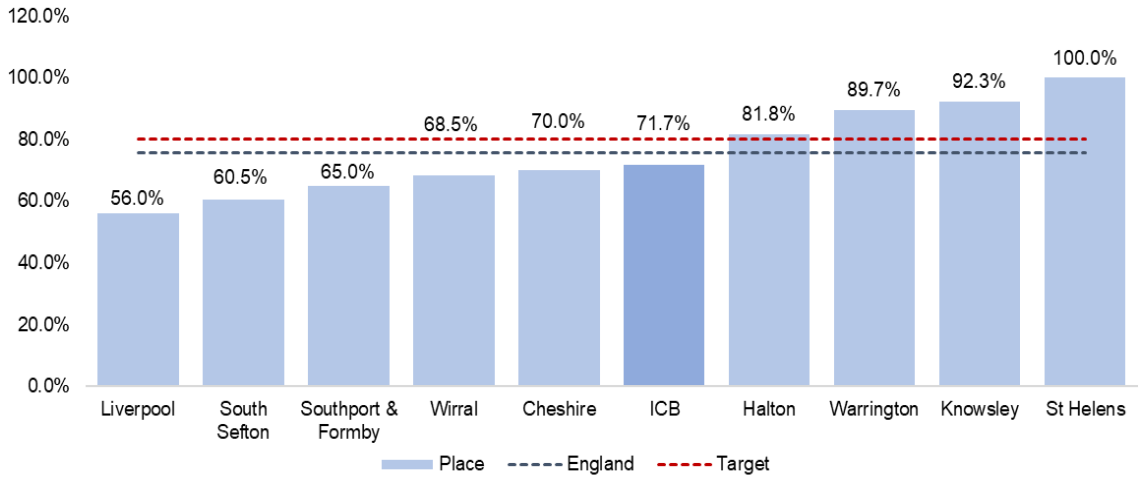
*The methodology for calculating smoking prevalence has changed from April 2025 we are now using the registered population aged 15+ as the denominator

5. Exception Report – Continuing Healthcare

NHS Cheshire and Merseyside

Standard Referrals completed within 28 days

Latest ICB Performance (Q1-25/26)	71.70%	National Ranking	26/42
Place Breakdown (Q1-25/26)			Deteriorated



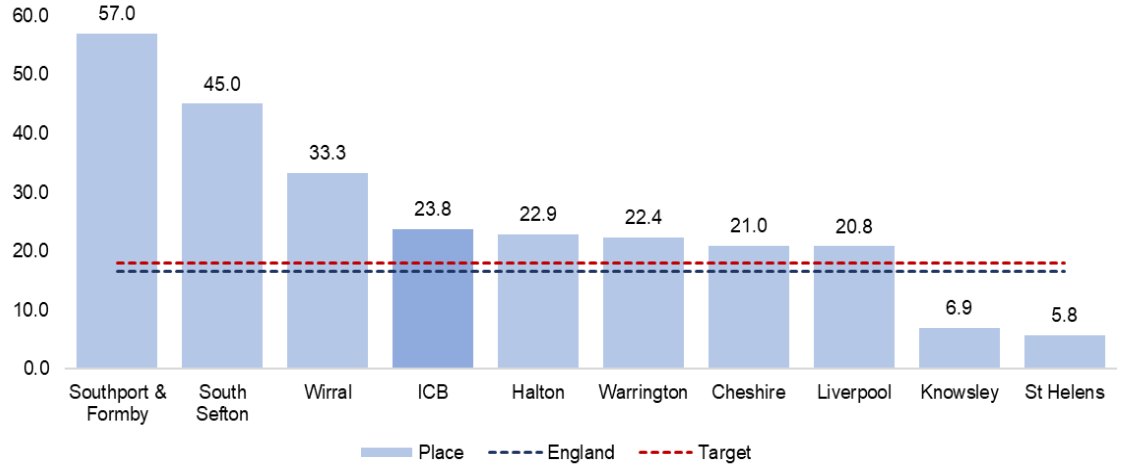
Issue
- Cheshire and Merseyside ICB is not currently meeting the NHS England KPI for Standard CHC referrals to be completed within 28 days. The target is 80%.

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

Delivery
- The ICB delivery was within the quarterly trajectory agreed with NHS England for Q1. The projection was ≥70% to 74.9%.

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

Latest ICB Performance (Q1-25/26)	23.78	National Ranking	35/42
Place Breakdown (Q1-25/26)			Improved



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

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

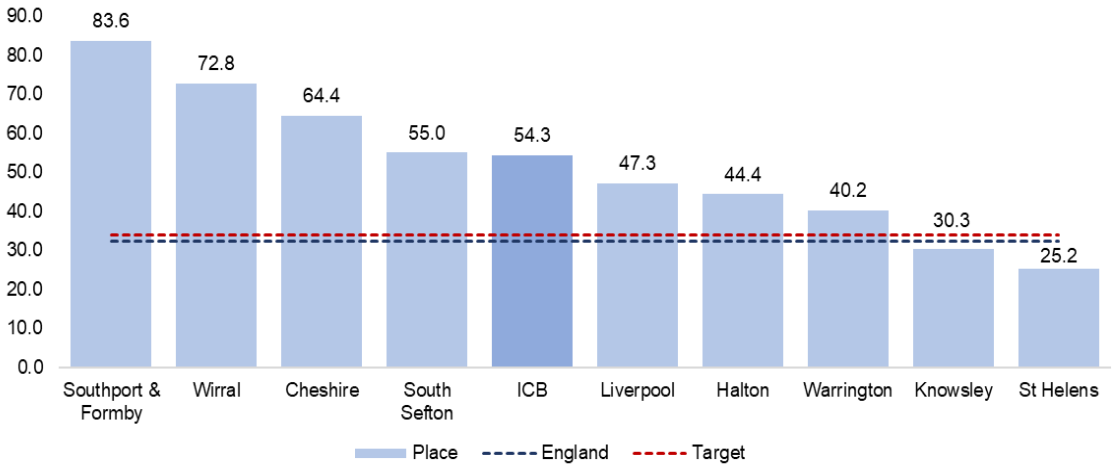
Delivery
- A focused piece of work in Liverpool and Sefton through outsourcing of Fast Track reviews as well as the implementation of the revised structure should ensure that only those individuals who are eligible for Fast Track are in receipt of the funding.
- There is an overall improved position for this metric within C&M.

**snapshot at end of quarter*

5. Exception Report – Continuing Healthcare

NHS Cheshire and Merseyside

Number eligible for standard CHC per 50,000 population *			
Latest ICB Performance (Q1-25/26)	54.27	National Ranking	40/42
Place Breakdown (Q1-25/26)			Deteriorated



Issue

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

Action

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

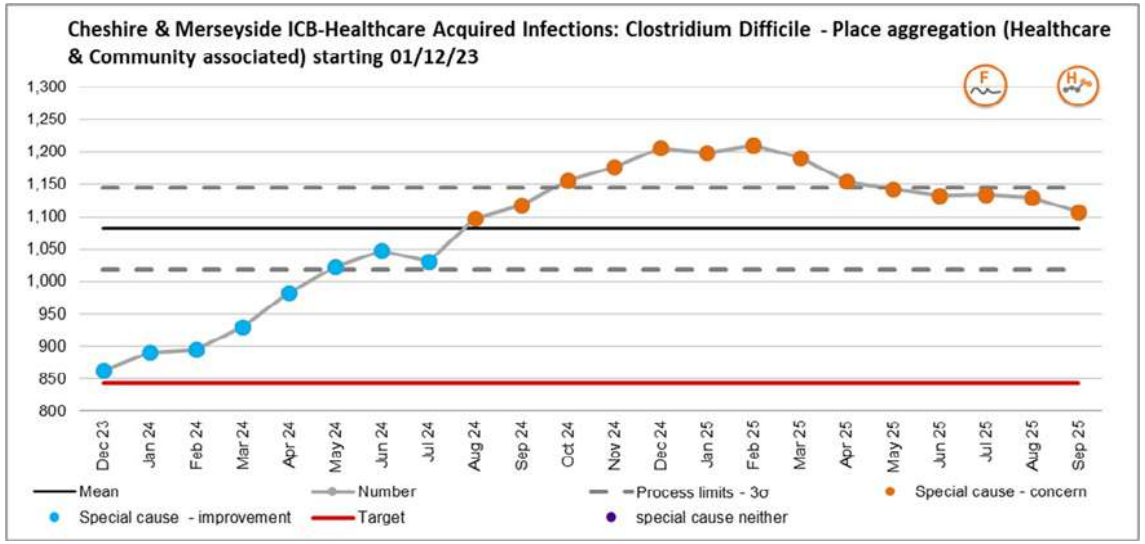
Delivery

- Delivery is anticipated 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.)

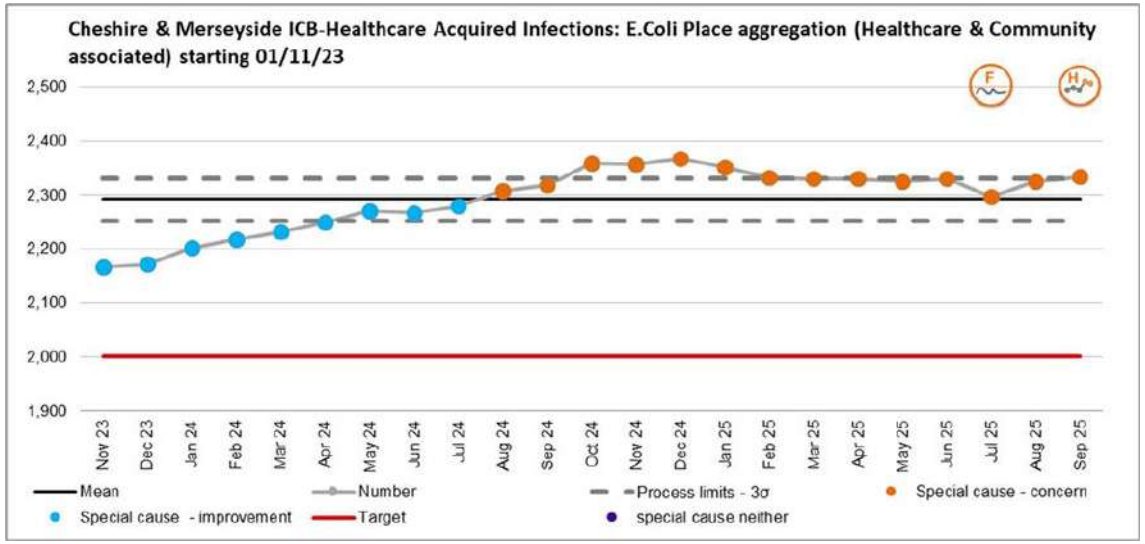
**snapshot at end of quarter*

5. Exception Report – Quality

HCAI: Clostridium Difficile - Place aggregation (Healthcare & Community associated)			
Latest ICB Performance (12 months to Sep-25)	1,108	National Ranking	n/a
ICB Trend (rolling 12 months to Sep-25)	Improved		



HCAI: E.Coli Place aggregation (Healthcare & Community associated)			
Latest ICB Performance (12 months to Sep-25)	2,334	National Ranking	n/a
ICB Trend (rolling 12 months to Sep-25)	Deteriorated		



Issue

- The C&M rate of CDI has continued to show an improvement. There continues to be a high outlier alert for WUTH based on Q2 data and for both WUTH and COCH based on 12-month data. The overall Q2 position for both providers observes a reducing rate. Whilst not an outlier AHCH has seen an increasing rate of infection and has prompted further review due to the nature of services.
- The C&M rate of E. Coli has deteriorated in September. LUFT remains a high outlier in both Q2 and 12 month data with minimal change in rate, the C&M position has been supported by significant reductions in rates at COCH, who are now noted as a low outlier, and MWL. In addition to LUFT, CCC has a high rate of infection and is noted as a high outlier in the 12-month data.

Action

- The implementation and monitoring of the CDI tool kit continues to be a priority, alongside the improvement plans at WUTH and COCH. The emerging concerns at AHCH will be followed up by a meeting between the provider, ICB, NHSE and UKHSA to discuss any action required.
- The progress of the improvement plan at LUFT continues to be a focus at quality contract discussions.

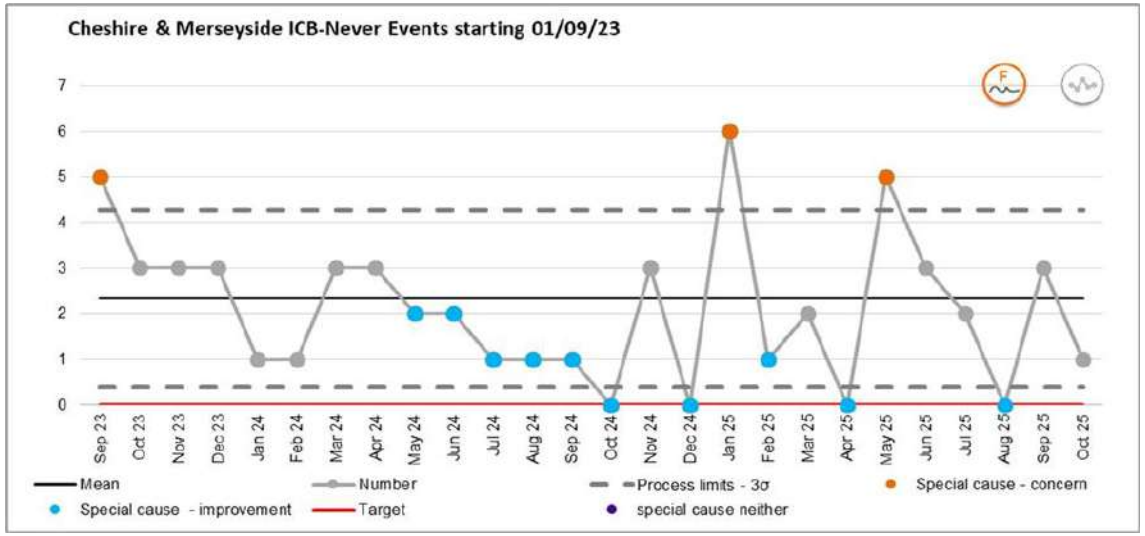
Delivery

- The ICB tolerance for both CDI and E. Coli remains at risk with Q2 rates exceeding 50% of annual tolerance. CDI tolerances have breached annual tolerance at month 6 at AHCH, ECT and LWH. E. Coli tolerances have breached at the Walton Centre.

5. Exception Report – Quality

NHS Cheshire and Merseyside

Never Events			
Latest ICB Performance (Oct-25)	1	National Ranking	n/a
ICB Trend (Oct-25)			Improved



Issue

- C&M continues to see Never Events across the system with 3 reported in September and 1 in October. The rolling 12 month position has increased from 23 to 26 over the past 2 months.
- All of the Never Events within the last 2 months have been surgical ; 2 retained foreign objects at AHCH, a wrong site surgery at WHH and a wrong site surgery at MWL.

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

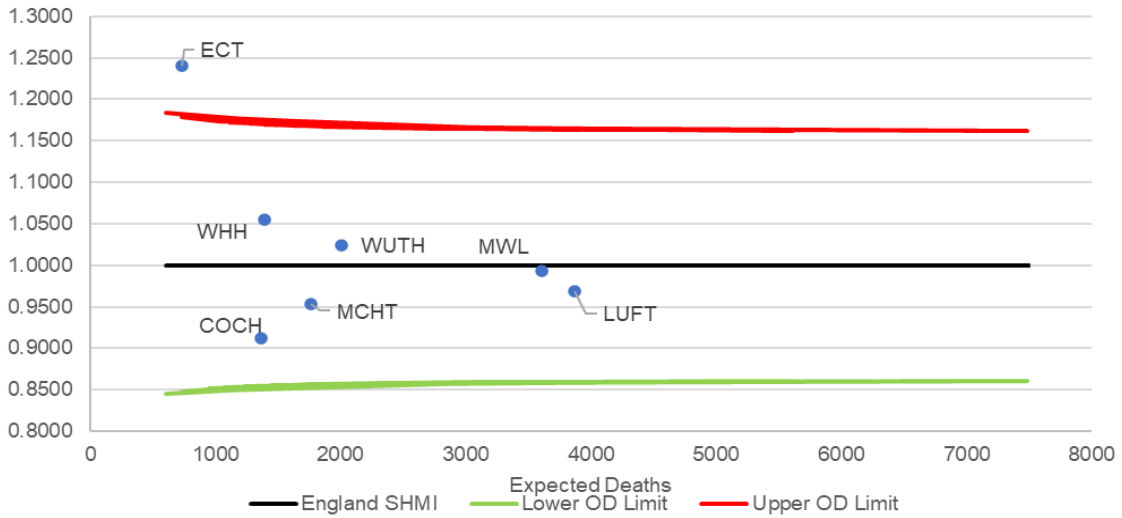
- Current rates are deteriorating, however within natural variation.

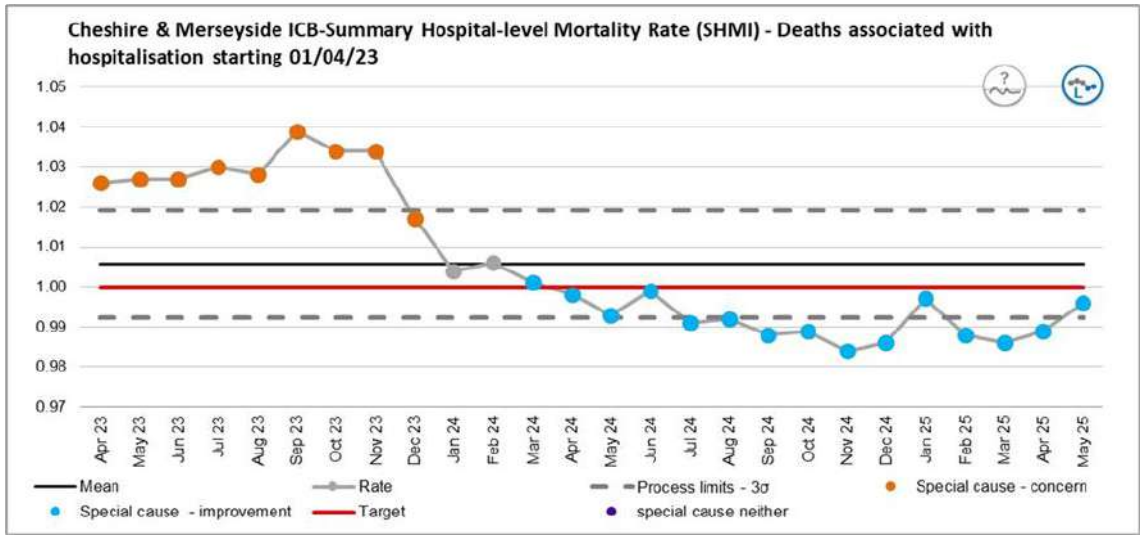
5. Exception Report – Quality

NHS Cheshire and Merseyside

Summary Hospital-level Mortality Indicator (SHMI)

Latest ICB Performance (May-25)	0.996	National Ranking	n/a
Provider Breakdown (May-25)*			Deteriorated





Issue

- C&M trusts are within expected tolerances except ECT, with a current value of 1.2410 against the upper control limit for ECT of 1.1723.

Action (ECT only)

- The trust has moved to quality improvement phase of quality governance/escalation.
- Scrutiny continues between the ICB and trust in board-to-board meetings and system oversight reviews ensuring the optimal support is in place to bring about best patient outcomes.
- Over the last 2 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.

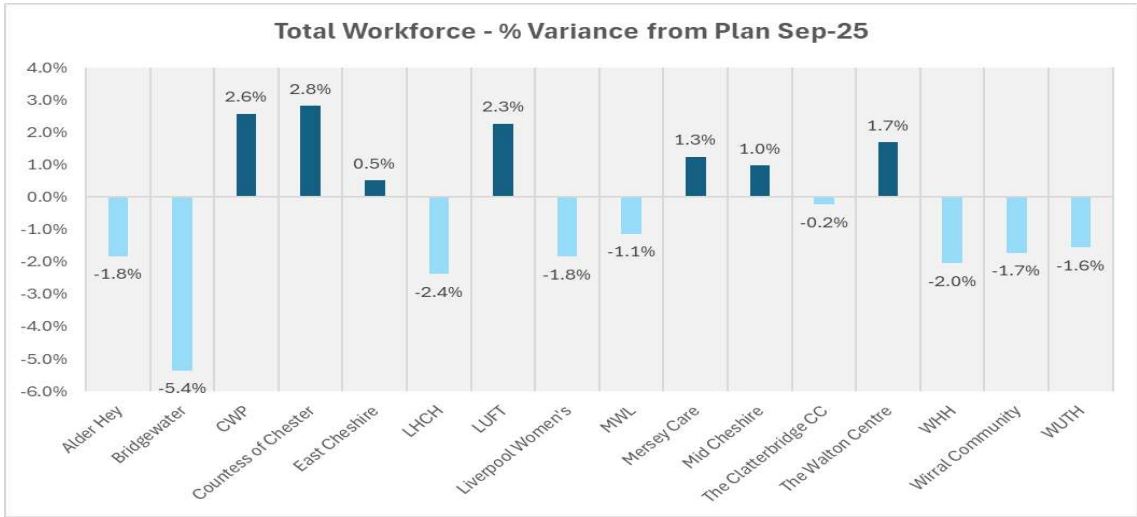
** OD, overdispersion, adds additional variance to the standard upper and lower control limits*

5. Exception Report – HR/Workforce

NHS Cheshire and Merseyside

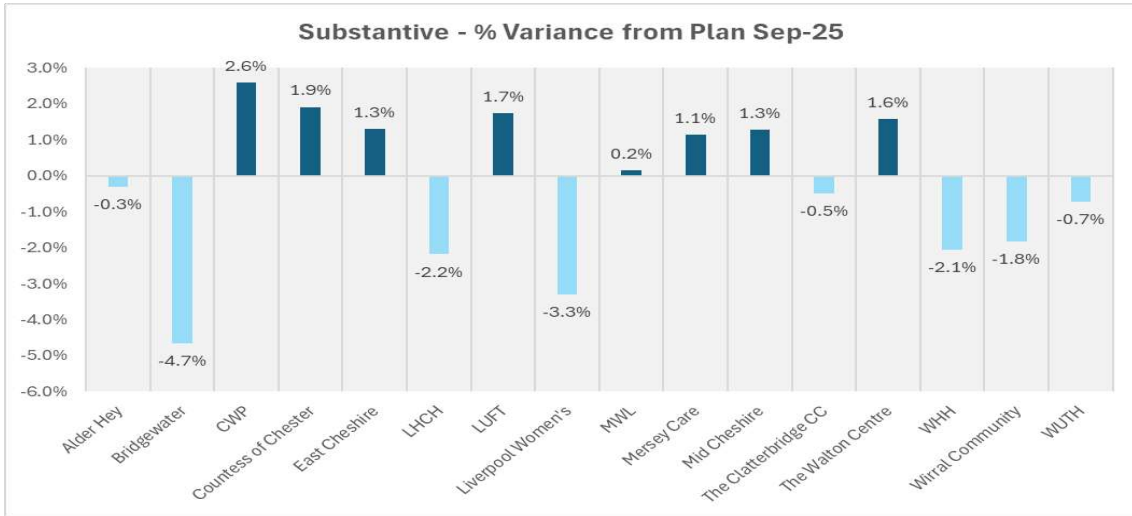
Total SiP (Substantive + Bank+ Agency) Variance from Plan % - via PFRs	
C&M ICB Performance (Sep-25)	**0.3%**

Provider Breakdown (Sep-25)



Substantive Variance from Plan % - via PFRs	
C&M ICB Performance (Sep-25)	**0.4%**

Provider Breakdown (Sep-25)



Issue

- In Sep-25, nine of the sixteen C&M Trusts reported their total workforce WTEs were below their planned figure as at M06, with a C&M variance above plan of 0.3% (224.7 WTE). These variances are based on the 2025/26 Workforce Operational Plan submissions with monthly forecasts for WTE for 25/26. Although overall WTE utilisation is reduced from the Mar-25 Baseline by (1137.8 WTE) the pay run has been flat over the last 2 month, where it had reduced in the 2 months prior. Original Workforce WTE plans as submitted have a further 2,304 (2.9%) WTE reduction by M12 compared to M5.
- Eight 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 0.4%. At a system level, substantive staff utilisation increased by 55.7 WTE / 0.1% from the previous month.

Action

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

Delivery

- Workforce workstreams for Sustainable Nursing Workforce Changes & Medical Workforce Changes has been stood up in May 2025 – reporting into FCOG – Financial Control & Oversight Group.
- C&M Trust Pay Deep Dive is planned for November 2025

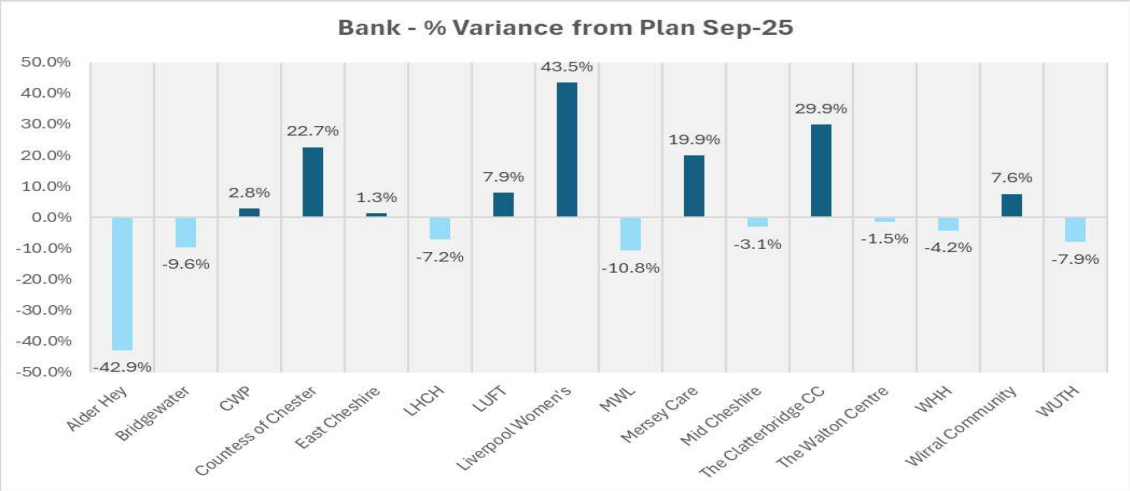
5. Exception Report – HR/Workforce

NHS Cheshire and Merseyside

Bank Variance from Plan % - via PFR

C&M ICB Performance (Sep-25)	2.1%

Provider Breakdown (Sep-25)



Issue

- Eight of sixteen C&M Trusts had Bank usage higher than that forecast in their operational workforce plans for the month of Sep-25. The total system performance was a variance from plan of 2.1% / 99.9 WTE
- At a system level, the total bank usage decreased by -73.7 WTE / -1.5% from the previous month.

Action

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

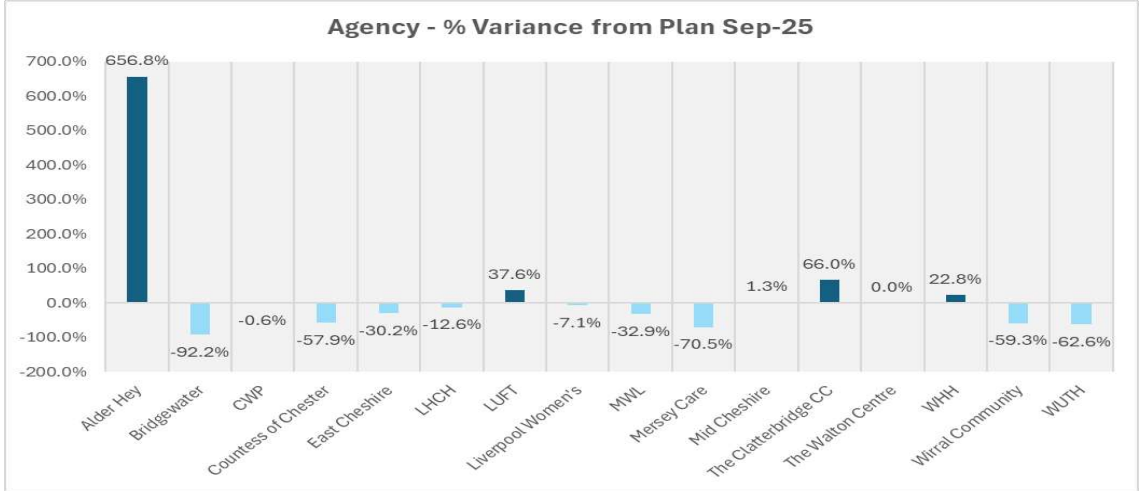
Delivery

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

Agency Variance from Plan % - via PFR

C&M ICB Performance (Sep-25)	-29.5%

Provider Breakdown (Sep-25)



Issue

- Ten of sixteen C&M Trusts had Agency usage lower than that forecast in their operational workforce plans for the month of September. The total system performance was a variance from plan of -29.5% / -204.3 WTE
- At system level, Agency usage reduced by -25.7 WTE / -5% from the previous month; this is -261.WTE from the Mar-25 baseline

To note: small numbers/WTE for Planned v Agency usage at Alder Hey & The Clatterbridge Cancer Centre 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 monitoring of workforce data & proposed actions/controls with Chief People Officers C&M Trust PDN Network focussed workstream
- Proactive communication to Chief People Officers, Workforce & Resourcing Teams about Off-Framework and Agency Spend data (by staff group) is shared monthly with additional input provided by NHSE North West.

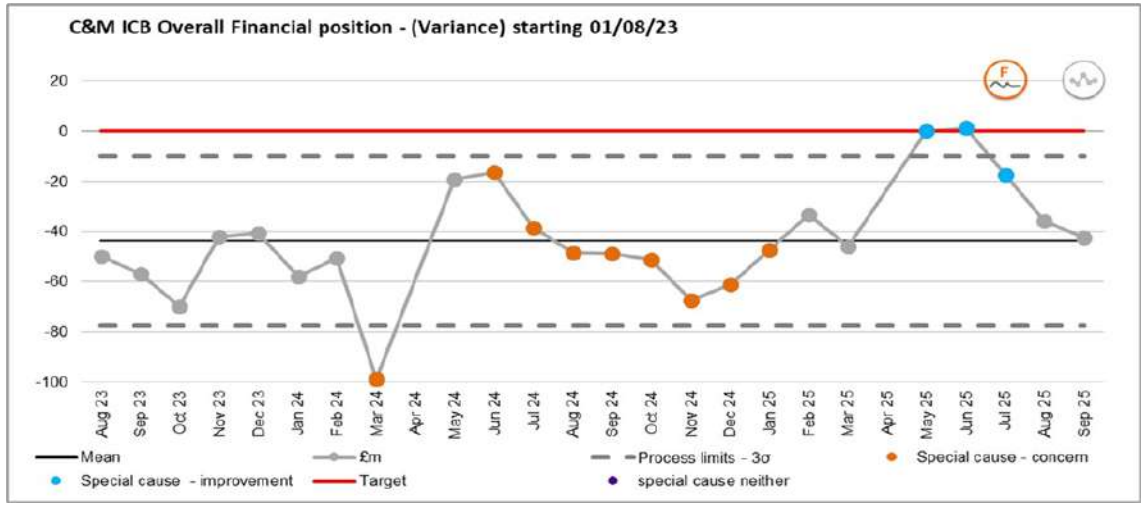
5. Exception Report – Finance

NHS Cheshire and Merseyside

Overall Financial position - YTD Surplus / (Deficit) (£m) - (including deficit support funding)

Latest ICS Performance (Sep-25)	-42.6	National Ranking	n/a

ICS Trend (Sep-25)



Issue

- System reported deficit of £124.8m against a year-to-date deficit plan of £82.2m as at M6 (ICB - £24.2m surplus, providers £148.9m deficit). This is an adverse system variance of £42.6m.
- The reported YTD position includes the negative impact of the system not being in receipt of deficit support funding (DSF) for months 4-6, which has an adverse YTD impact of £44.6m on provider plans.
- DSF has been withheld by NHS England for Q2 due to concerns over the deliverability of financial plans and the Q3 instalment has been withheld also. The system continues to forecast on the assumption that 100% of DSF will be provided and the withheld element retrospectively issued.
- Total deficit support funding assumed in the 2025/26 plans is £178.3m. Only Q1 (£44.6m) has been issued to date.
- Achievement of DSF will rely on the system fully delivering its efficiency plans and mitigating any unplanned pressures which is a significant risk at this stage.

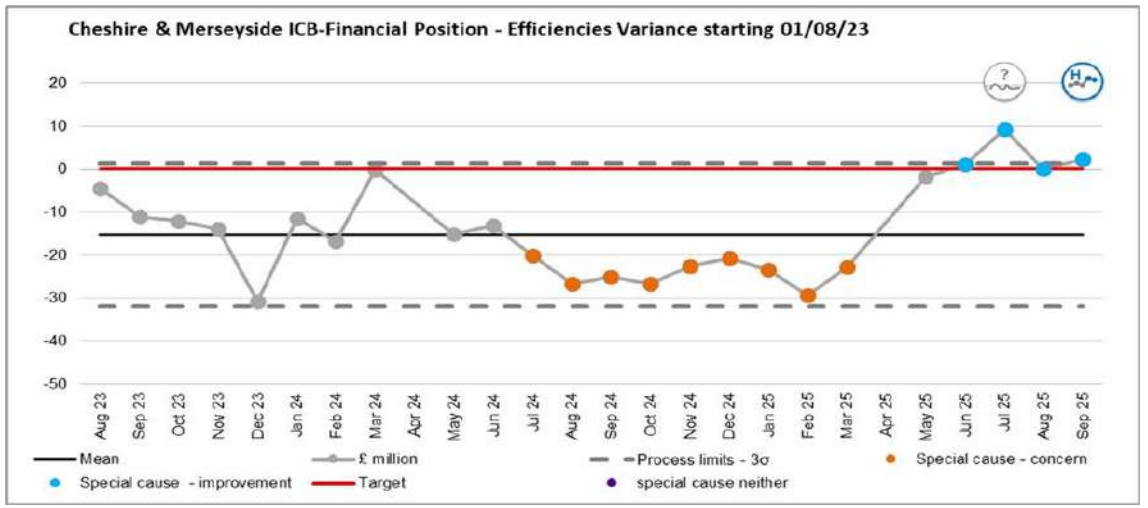
Action

- PwC and Simon Worthington are working alongside the region and ICB to assist delivery.
- Activity management plans being implemented to manage independent sector pressures.

Efficiencies Variance (£m)

Latest ICS Performance (Sep-25)	+2.2	National Ranking	n/a

ICS Trend (Sep-25)



Issue

- System delivered £226.1m of efficiencies as at month 6 against a plan of £223.9m therefore reporting a surplus delivery of £2.2m.
- The ICB reports a shortfall of £3.4m on delivery, offset by providers over-delivering efficiency by £5.6m
- 91% of ICB efficiency plans are either fully developed or plans are in progress.
- System forecasting £587.8m efficiency delivery against a total plan of £572.5m, exceeding the plan by £15.3m
- At this half-year stage 38% of the annual efficiency savings target has been delivered. While YTD savings are in-line with plan, the profiling of the efficiency plan means an acceleration of savings will be required in the second half of the year.

Action

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

Delivery

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

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 November 2025

Highlight report of the Chair of the Quality & Performance Committee

Agenda Item No: ICB/11/25/12

Committee Chair: Tony Foy, ICB Non-Executive Member

Highlight report of the Chair of the Quality & Performance Committee

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting (s)	16 December 2025

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.

Alerting (Immediate Risks / Escalations)

- Neurodevelopmental Delays - Highest scoring committee risk due to significant delays in ADHD and ASD assessments. National issue is acknowledged, and a regional summit is planned to address pathways and implement a 90-day collaborative improvement programme. The Neurodiversity Pathway profiling tool is being implemented across all C&M schools. The profiling tool is already in place within Wirral but is now also being rolled out across the other 8 Place areas from November 2025.

  New needs led model in Primary Care is being rolled out – Oct 25 to Jun 26. This aims to reduce the need for formal assessment by meeting the needs of some adults through a need-led support program as identified via a stratification assessment. Increasing the capacity in Primary Care aims to increase assessment capacity in Secondary Care for the most complex patients reducing long waits.

- Safeguarding & Continuing Care: Workforce shortages continue to impact statutory duties. Recruitment is underway but market constraints are noted

- East Cheshire Mortality measured by SHMI remains above expected range and the committee agreed that risk score is retained at 15, following recent deterioration in mortality index despite improvement work. Committee noted a wide range of targeted quality improvement work, however, it also noted significant high impact issues including fragile services/limited capacity, high bed occupancy, concerning AED 4-hour performance and recently worsening discharge delays. Committee acknowledged that there may need to be a reframed risk at a strategic level to reflect system-level factors of population health and health and social care capacity.

Advising

- Care Home Fragility: Winsford Grange Notice of Decision issued by CQC in December 2024 to remove registration remains, however the tribunal which was scheduled for October 2025 has now been moved to December; contingency plans for resident transfers in progress. Committee will review all homes under surveillance/reported concerns in the New Year – 11 care homes across 5 Places.

- System Quality Group: Falls prevention identified as a commissioning priority for 2026/27; work to align with frailty programme and provider collaboratives.
- Patient Safety: New report format introduced; system KPIs in development.
- Winter Planning: National mandate to eradicate 65-week waits by December remains on track. Escalation framework agreed with local authorities.
- Vaccinations: Uptake improving; Liverpool Women's increased from 13% to 25% following targeted support. Alder Hey and others exceed last year's rates. Committee endorsed the need for a co-ordinated and systemwide response from the ICB, primary care, secondary care, specialist trusts and Local Authorities to improve seasonal vaccination uptake in all eligible groups, including healthcare workers and domiciliary staff and that NHS Providers develop staff vaccination plans which act on the recommendations of the ICB commissioned Health Care Worker insight. Uptake against the 50% target will be monitored across the Winter period.

Assuring

- Infection Control: Countess of Chester C. difficile rates improving; enhanced monitoring continues.
- Mental Health Flow: Weekly reviews between CWP and acute providers addressing delays for patients awaiting beds.
- Updated Complaints policy approved.
- Committee endorsed the Emerging Concerns process at MCHT covering five areas. Draft Key Lines of Enquiry formed, and Place Director will commence informal discussions.

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**
• Neurodevelopmental assessment delays remain the highest risk; regional summit and 90-day improvement programme planned.	All risks reviewed and scoring confirmed – escalation to Board of key risks

Corporate Risk Register risks	
• Capacity risks within quality teams require review in light of future cost reductions (Safeguarding) • East Cheshire mortality risk retained at score 15; to be reframed to reflect system-level factors. • New risk added for systemic SEND failings following recent inspections.	

Board Assurance Framework Risks	
Risk Title	**Key actions/discussion undertaken**
P4 potential for major quality failures	Emerging Concerns process commenced at ECHT
P1 Health Inequalities	Vaccination Programme – clinical staff uptake and Provider variation reviewed. Whole system plan endorsed.

Achievement of the ICB Annual Delivery Plan

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

Service Programme / Focus Area	Key actions/discussion undertaken
Urgent and Emergency Care	Review of key measures for Winter planning

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 November 2025

Highlight report of the Chair of the System Primary Care Committee

Agenda Item No: ICB/11/25/13

Committee Chair: Erica Morriss, ICB Non-Executive Member

NHS
Cheshire and Merseyside

Highlight report of the Chair of the System Primary Care Committee

Committee Chair	Erica Morriss
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	16.10.25

Key escalation and discussion points from the Committee meeting

Alert

GP Prescribing Risk/Approach - Request from Finance, Investment and Resources Committee for SPCC to undertake a deep dive involving the PC Contractor groups and this will now be a standard detailed item following the PC Financial Report given the urgency & pace needed in delivery of the recovery plan & CRES. A presentation/deep dive was undertaken by SRO Susanne Lynch within the meeting with collaborative contractor discussion.

Quality - The Committee received an update from the Primary Care Quality Group which covers all four contractors. Issues in relation to the current procurement of clinical waste (for community pharmacy and general practice) were escalated including any contingency planning. It was agreed this would be escalated to the Executive Committee.

Advise

Community Pharmacy - An approach to support consistency of Bank Holiday Pharmacy Rota Payments was agreed. Approach will ensure costs stay within existing budget.

Estates - A proposed improved way forward for governance of estates issue was agreed, this change will need to be ratified against the full organisation governance review and any changes will be advised to SPCC.

Governance - A verbal update was given on the current position of the ICB's new governance structure which has been advised to Board in July with a further paper to be provided to Board in November. No change expected to general governance of SPCC and this will be confirmed at SPCC December meeting.

Neighbourhood Health - A verbal update on plans and progress was given – support / involvement of all primary care contractor groups was recognised as key to this work. There will be a standing update to the committee moving forward, much of this will be led at local/place level.

Improving Access to Dentistry - A presentation was given and it was noted that under the quality/access scheme, 68 practices had signed up with 12,192 new patients booked in based on the practice returns. The committee received assurance/update on all aspects including urgent dental care.

Digital - The committee were updated on the decision made at the Executive group to limit SMS/text funding, with implementation from January 26. Assurance was sought regarding the Quality/Equality Health Impact Assessment, & communication with contractors and further assurance will be provided to SPCC via EXO meeting in November.

End of Life / Community Pharmacy - The committee were updated on work undertaken to reduce unwarranted variation in the end of life stock holding by community pharmacies contractors across NHS Cheshire and Merseyside – The Committee supported a new contractual model that addresses variation in drugs held and payments deployed with a standard fee - and a rationalised list of 19 medicines held.

Place Escalation - Liverpool place outlined the transfer of a Liverpool-only contract for initial health assessments for asylum seekers, from NHS England to the ICB. The committee discussed funding risks, procurement timelines, translation costs, and alignment with local enhanced service arrangements. The committee supported the approach/transfer which is being managed at place level, noting it was in line with the commissioning role of the ICB.

Digital/GPIT Capital Allocation 25/26– System Primary Care Committee previously approved a 25/6 capital plan to spend the £4.7m BAU primary care capital allocation, plus the additional £0.7m ARRS GPIT capital allocation, on GPIT and is in progress.
In addition to this 25/26 Capital a separate fund limited to GP premises Improvement (GP Utilisation & Modernisation Fund - UMF) of £7.2m was approved by SPCC. The Comm. are working to ensure that the funds are utilised within the 25/26 window through timely procurement.£1.3m of BAU capital, originally held for IFRS16 requirements, has been released. The Digital and Estate teams will present a joint investment proposal at an ExO SPCC meeting in November.

Assure

Contracting and Policy -The committee were assured of actions to support new general practice (medical) contracting asks, in particular in relation to the availability of on line consultations during core hours (8am-6.30pm). Assurance re compliance was ongoing and an update would follow to the committee in December with the latest position. There was a recognition of the continued challenge and capacity of the small central teams undertaking these areas of national focus including access to dentistry and the eye care in special education settings (SES) programme.

The minutes of the **Pharmacy Services Regulations Committee** meeting held in September were approved.

Estates - Section 106 Funding - The Committee approved a formal Section 106 policy to secure developer contributions for NHS infrastructure. There was a recognition of the need for local authority engagement and system-level escalation

Estates (UMF) - The committee received an update in relation to current position of the Capital spent under the utilisation/modernisation fund (UMF). An additional ExO meeting in November will take place to ensure that all opportunities have been advanced.

Primary Care Finance – An update on Primary Care finance was given – noting the request for a detailed financial and contractor impact paper between Estates and Digital to come to the Public meeting of the Committee in December (referenced above).

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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
Access to Dentistry	Validation of improved metrics

Date of Next Meeting: 18 December 2025

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 November 2025

Highlight report of the Chair of the ICB Remuneration Committee

Agenda Item No: ICB/11/25/14

Committee Chair: Tony Foy, Non-Executive Member

NHS
Cheshire and Merseyside

Highlight report of the Chair of the ICB Remuneration Committee

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting(s)	17 October 2025, 06 November 2025, 17 November 2025

Key escalation and discussion points from the Committee meeting

Alert

n/a

Advise

The Remuneration Committee at its 17 October 2025 meeting:

- received a paper on the Pay Framework to be applied for the VSM positions within the proposed new Senior and Executive Leadership Team of the ICB. The Committee approved the use of the existing national NHS VSM Pay Framework, adapted to reflect the new model ICB structure and strategic commissioning focus., to allow for flexibility and alignment with market conditions and internal equity. The committee confirmed that the ranges within the Framework should be used for all new appointments, and any exceptions must return to the committee for approval.

The Remuneration Committee at its 06 November 2025 meeting:

- received the draft Consultation document for the ICB Senior and Executive Leadership Team consultation. The Committee supported the progression of the consultation in line with the timeframes as outlined, marking it as the starting point for the process, and that the ICBs Managing Organisational Change Policy would be observed. The Committee highlighted that it would like to see that the final document include information for staff that shows reciprocal feedback mechanisms, allowing staff to provide feedback on recruitment processes, inclusion, diversity, and psychological safety**.**

The Remuneration Committee at its 17 November 2025 meeting:

- received a paper on the proposed remuneration of the ICBs Interim Chief Executive position and approved the recommendation for the ICB Chair to be able to offer a salary that is within the Chief Executive salary range as outlined within the national VSM Pay Framework.

Assure

n/a

The next meeting of the Committee is scheduled for **09 December 2025.**

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 November 2025

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

Agenda Item No: ICB/11/25/15

Report approved by: Chris Douglas, Executive Director of Nursing and Care

NHS
Cheshire and Merseyside

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

Committee Chair	Raj Jain
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	08 October 2025

Key escalation and discussion points from the Committee meeting

Alert

- The Committee noted significant financial pressures and the need for system-wide consideration of social care budgets and advocacy access for children and young people. The urgency of developing a shared outcomes framework across partners was highlighted as a priority action.

- Concerns were raised regarding sustainability of successful programmes (e.g., CHEC intervention) and the need for ongoing funding and health sector involvement.

- The Committee recommended a system-wide review of admissions to Tier 4 LD/ASD services, with a commitment to understand the journey and earlier intervention opportunities for affected children and young people. This includes defining the scope of the cohort and aligning with the wider neurodevelopmental programme.

Advise

The Children and Young Peoples Committee at its 08 October Meeting 2025 meeting:

- received a presentation on the Health Equity Collaborative programme (CHEC), which emphasised the importance of capturing and acting on the voices of children and young people to inform system measures and priorities. The programme's rapid implementation included staff training and pragmatic approaches, resulting in notable early impact: a 44% increase in engagement and 22% rise in participant confidence. The Committee heard personal testimony from attendees which highlighted improvements in children's speech, vocabulary, and engagement through monthly interactive book reading, reinforcing the value of early literacy and parental involvement. The Committee noted the need for ongoing data monitoring, sustainable funding, and health sector involvement to maintain and grow the programme's benefits. Members were encouraged to ensure the voices and experiences of children and young people remain central to future system developments and strategic commissioning.

- received an update on a local authority-commissioned Neighbourhood Health CYP programme, which utilises multi-disciplinary teams (MDTs) to strengthen links between children's and adult services. Strong interfaces with primary and secondary care were highlighted as crucial, with public health engagement emphasised as essential. The Committee noted the importance of maintaining clear connections between child and adult pathways, ensuring that children's

priorities are not overshadowed by adult-focused issues such as frailty or length of stay.

- received the Transforming Care CYP Programme - CYP Tier 4 System Escalation Report where the Committee reviewed data showing a significant number of new admissions and readmissions to Tier 4 LD/ASD services, with most cases relating to ASD and rising demand for neurodevelopmental support. The Committee was informed that many young people could potentially have been supported earlier in the community, highlighting the need to understand their journeys prior to admission and identify opportunities for earlier intervention. The Committee noted that future changes in mental health legislation may require different approaches to care and urged ongoing evaluation of current models to ensure effectiveness and adaptability.

- received an Edge of Care Update. The Committee noted ongoing collaborative work between the ICB and DCS Forum, with a shared commitment to address financial pressures and improve outcomes for children and young people through joint leadership and partnership.

- received a report on the learning from Sefton Council regarding the Childrens Services Improvement Journey. The Committee commended Sefton Council's progress in children's services, noting that open culture, collaborative data interpretation, and strong partnership working have driven significant improvement. The Committee emphasised that sustained engagement and communication have strengthened relationships and leadership, supporting ongoing service transformation.

Assure

n/a

Committee Risk Management:
Risks discussed included financial sustainability of key programmes, system-wide coordination for Tier 4 admissions, and the need for a shared outcomes framework. Actions were agreed to address these areas through partnership working and further analysis.

Achievement of the ICB Annual Delivery Plan:
The Committee's work directly contributes to objectives in health equity, neighbourhood health models, early intervention for LD/ASD, and service improvement journeys, supporting delivery against the ICB Annual Delivery Plan.

NHS
Cheshire and Merseyside

NHS Cheshire & Merseyside Integrated Care Board

Proposal regarding an Interim Sub-Fertility Clinical Policy across Cheshire and Merseyside

27 November 2025

Agenda Item No: ICB/11/25/16

Responsible Directors: Prof. Rowan Pritchard Jones, Medical Director
Dr Fiona Lemmens, Deputy Medical Director

Proposal regarding an Interim Sub-Fertility Clinical Policy across Cheshire and Merseyside

1. Purpose of the Report

1.1 The purpose of the paper is to seek a decision from the Board of NHS Cheshire and Merseyside following a period of public consultation, regarding an interim clinical policy for access to subfertility services across Cheshire and Merseyside.

1.2 This paper and appendices provide an update on the work undertaken to date, an overview of the options appraisal presented at the May 2025 Board meeting, along with details of the Public Consultation outcomes, feedback from the Local Authority Health Oversight and Scrutiny Committees (HOSC) and updated post consultation Equality Impact Analysis.

2. Background

2.1 On formation of the Integrated Care Board (ICB), clinical policies were inherited from the 9 predecessor CCGs which covered patients registered with a GP Practice within the geographic areas of the nine Cheshire and Merseyside local authority Places. This means that patients have different access to services and care, based on their postcode/where they are registered with a GP Practice. The Reducing Unwarranted Variation programme set out to harmonise this approach to ensure we work to address health inequalities and provide a consistent offer across Cheshire and Merseyside.

3. Sub-Fertility Current Policy Position

3.1 At present each Place within NHS Cheshire and Merseyside (C&M) ICB has a separate unharmonised sub-fertility policy and therefore unwarranted variation in access to these services exists.

3.2 The main area of variation within the policies is the number of In vitro fertilisation (IVF) cycles offered which ranges from 1 to 3 cycles. As part of the work to harmonise policies a full options appraisal has been undertaken, which can be found within Appendix One.

3.3 There are other, less impactful aspects within the policies which are proposed to be harmonised in accordance with the latest available NICE guidance and local clinical and operational knowledge.

3.4 The scope of the new interim policy is for patients with health-related fertility issues, who are struggling to have a live birth and require fertility treatments. This policy has been reviewed in line with the latest evidence base and NICE guideline CG156; it is important to note that this will be an interim policy until the

new NICE guidance is published at which point another review of our subfertility and assisted conception policy will be undertaken.

4. Options for consideration

4.1 The current ICB spend on IVF treatment is £5.043m per year.

Option 1 maintain the current arrangements. This was dismissed due to the current unharmonised position.

Option 2 offer 1 cycle. This is the ICB Executive Committees preferred option, as it would offer the ICB an estimated £1.3m savings per year while maintaining access to fertility services equitably across Cheshire and Merseyside. This is the option that was put forward in the public consultation.

Option 3 offer 2 cycles This is the option supported by the clinical reference group and would result in an estimated additional cost of £40k per year.

Option 4 offer 3 cycles. NICE recommends offering patients 3 cycles of IVF. The cost of this would equate to a total spend for the ICB of £5.78m (additional circa £734k per year). This option was dismissed due to the financial position of the ICB.

4.2 The full options appraisal can be found in Appendix One of this report.

4.3 The ICB Executive Committee have proposed that one cycle of IVF (option 2) should be offered for Cheshire and Merseyside patients with the following rationale:

- this offer would be in line with 66% of ICB's across the country that currently offer 1 cycle of IVF.
- this offer is in line with our neighboring ICB's – including Lancashire and South Cumbria ICB, West Yorkshire ICB, Staffordshire and Stoke on Trent ICB. Greater Manchester ICB are currently going through a similar process to harmonise to one cycle.
- this offer would result in £1.3m of savings per year.
- offering 1 cycle of IVF in Cheshire and Merseyside would enable achievement of a harmonised policy and remove existing unwarranted variation in access to fertility services and the number of IVF cycles offered.

5. Public Consultation Process undertaken

5.1 NHS Cheshire and Merseyside ran a six-week public consultation from 3 June to 15 July 2025 on a proposal to harmonise by offering 1 cycle of IVF. The consultation also covered proposed changes to eligibility based on body mass index (BMI) in Wirral, eligibility based on smoking status, a change to the definition of childlessness in Cheshire East and West, a change to access to intrauterine insemination (IUI) in Wirral and clarification on the age limits for eligibility.

5.2 A questionnaire and supporting information were produced and made available online, printed/in alternative formats/languages on request. People could also provide their responses over the phone. Information was shared with partners, Liverpool Women's Hospital, GP practices, MPs, local authority leaders, Healthwatch organisations, NHS England, and a wide range of community and voluntary sector organisations.

6. Key themes and conclusions from the Public Consultation Report

6.1 The detailed Public Consultation Report can be found within Appendix Two

- in total, there were 2,124 responses to the questionnaire, from people across Cheshire and Merseyside.
- most indicated that they had personal experience of NHS fertility treatment, either personally or as a partner/spouse (38%) or as a relative/friend (34%).
- 86% of respondents disagreed or strongly disagreed with the proposed change to the number of IVF cycles that are funded.

7. Post Public Consultation Equality Impact Assessment (EIA)

7.1 Following the public consultation period, the EIA was revisited to ensure it examined the points raised during the consultation.

7.2 The EIA concluded that the proposal to offer patients one cycle of IVF is not direct discrimination against any specific group.

7.3 The EIA concluded that the proposal would result in indirect discrimination for certain groups. For example:

- Women who are the primary users of this service and will bear a disproportionate physical and emotional impact of limiting access.
- People from ethnic minorities who, because of systemic barriers, often start treatment later and have lower success rates.
- People from lower Socio-Economic backgrounds as they are less likely to be able to self-fund if one cycle is unsuccessful.

7.4 Please refer to Appendix Three for the revised EIA following Public Consultation period. The Boards attention is drawn to the following section of the Post consultation EIA report:

The Financial and Legal Context: Proportionality and Due Regard

7.5 <u>The Financial Imperative</u> –
The ICB is operating under significant financial pressures. The proposal to offer a single cycle of IVF is based on a legitimate objective: achieving necessary financial savings. Given the current financial constraints, the ICB must prioritise commissioning decisions and allocate funding to the most critical areas to ensure the long-term financial sustainability of the local NHS.

7.6 The Public Sector Equality Duty (PSED) in a Financial Crisis -
The PSED under Section 149 of the Equality Act 2010 is a continuous duty and is not suspended during a financial emergency. The duty to have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations is at its most critical when making difficult decisions that may cause harm. While saving money is a legitimate aim, it cannot be the only consideration.

Decision-makers must:

1. Properly understand the equality impacts.
2. Consider all possible mitigations to reduce those impacts.
3. Consciously weigh the equality impacts against the financial imperative in a proportionate way.

8. Engagement and Consultation with Local Authority Health Oversight and Scrutiny Committees (HOSC)

8.1 The eight impacted HOSCs all agreed that the proposal constituted substantial development or variation (SDV) to services therefore the Cheshire and Merseyside Joint HOSC protocol was enacted. The first Joint HOSC meeting was held in October, with a follow up meeting in November 2025 to enable the JOSC to scrutinise the ICBs proposals.

8.2 At the first meeting in October 2025, the conclusion of the JOSC was that the ICB proposal is not in the best interest of the local population. The JOSC chair shared detailed rationale for this conclusion in a letter and requested a further meeting to consider the post-consultation EIA in detail. The JOSC letter and ICB response are in Appendix Five.

8.3 This response informed discussions at the subsequent HOSC meeting, where both the ICB's response and the post-consultation Equality Impact Assessment (EIA) were shared with members.

8.4 At its second meeting in November 2025, the JOSC reaffirmed its strong opposition to the ICB proposal to reduce the number of IVF cycles to one, stating that this approach does not serve the best interests of the local population. The Committee voted unanimously that should the ICB decide to reduce access to one cycle of IVF, the OSC will ask the Secretary of State to call in the decision for review.

9. Recommendations

9.1 Having considered the ICB's competing duties to meet the needs of the population and address health inequalities, and the statutory financial duties, and given due regard to Public Sector Equality Duty, the ICB Executive Committee recommend to the Board **Option 2, to offer 1 cycle of IVF**.

9.2 The Executive Committee commit to following the recommended actions to mitigate the indirect discrimination identified in the Equality Impact Analysis.

10. Ask of the Board Members:

10.1 **The Board members are asked to:**

- note the work undertaken to date, the Public Consultation feedback and the feedback of the Joint Health Oversight and Scrutiny Committee.
- to pay close regard to the Board's Public Sector Equality Duties while noting the risks and mitigations as described within the QIA and EIA documentation.
- to consider the recommendation of the Executive Committee to adopt an interim clinical policy that offers patients in Cheshire and Merseyside 1 cycle of IVF treatment.
- to make a decision on a single option, to determine the interim policy position for NHS Cheshire and Merseyside, so that a harmonised policy position can be implemented.

11. Appendices

CLICK HERE to access all Appendices as a combined document

Appendix One: Options Appraisal document (as of Board May 2025) *(14 pages)*

Appendix Two: Public Consultation Report *(47 pages)*

Appendix Three: EIA Post Public Consultation Period *(9 pages)*

Appendix Four: QIA (Original as of Board May 2025) *(15 pages)*

Appendix Five: Joint Health Scrutiny Committee concerns and ICB response *(6 pages)*

27 November 2025

ICB Board Meeting

Agenda item: ICB/11/25/16

APPENDIX ONE

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NHS
Cheshire and Merseyside

Subfertility Clinical Policy

Options Appraisal for harmonisation of

In vitro fertilisation (IVF) cycles

Glossary

Term	Definition
In vitro fertilisation (IVF)	A full cycle of IVF (with or without ICSI) is defined as one episode of ovarian stimulation and the transfer of all resultant fresh and/or frozen embryo(s). If there are any remaining frozen embryos, the cycle is only deemed to have ended when all these embryos have been used up or if a pregnancy leading to a live birth occurs or the patient adopts a child (i.e. in accordance with the ICB's policy on "Childlessness").
Embryo	A fertilised egg.
Egg collection	As part of the IVF cycle, eggs are collected from the womb. The collection involves attempts to retrieve all eggs within the stimulated follicles in the ovary.
Embryo transfer	After egg collection, the embryos are transferred into the womb. The best quality embryo available is transferred.
Frozen embryo transfer (FET)	Treatment involves freezing and storing embryos, the embryo(s) is warmed and transferred into the womb.
Intra-cytoplasmic sperm injections (ICSI)	Intra-cytoplasmic sperm injection. A common treatment for sperm-related male infertility. It is performed as part of IVF and involves the sperm being injected directly into the egg.
Intrauterine insemination (IUI)	Sperm is put directly into the womb when the female is ovulating. This can also be called artificial insemination.

1. Background

On formation of the Integrated Care Board (ICB), clinical policies were inherited from across the 9 places. This meant that patients had different access to services and care, based on their postcode. The Reducing Unwarranted Variation programme set out to harmonise this approach to ensure we work to address health inequalities and provide a consistent offer across Cheshire and Merseyside.

The NHS faces significant financial challenges, necessitating careful balancing of population needs, clinical risk, and commissioning decisions to address health inequalities. This paper is written in the context of ensuring commissioning decisions prioritise the most pressing needs of the population, recognising the potential for increased demand in areas like mental health, urgent care and community services, whilst addressing unwarranted variation and the need for a consistent offer.

At present each Place within NHS Cheshire and Merseyside (C&M) ICB has a separate unharmonised fertility policy and therefore unwarranted variation in access to these services exists.

The main area of variation within the policies is the number of In vitro fertilisation (IVF) cycles offered which ranges from 1 to 3 cycles. This document focuses on the options to harmonise IVF cycles. It is of note that other aspects within the policy are proposed to be harmonised in accordance with the latest available NICE guidance and local clinical and operational knowledge.

The scope of this policy is for patients with health-related fertility issues, who are struggling to have a live birth and require fertility treatments. This policy has been reviewed in line with the latest evidence base and NICE guideline CG156; it is important to note that this will be an interim policy until the new NICE guidance is published when a broader review of subfertility and assisted conception will be undertaken.

NICE recommends offering patients with infertility 3 cycles of IVF. The cost of this would equate to a total spend for the ICB of £5.78m. (The current spend is £5.043m so there would be an additional annual spend of circa £734k).

Due to the financial constraints of the ICB and the need to prioritise commissioning decisions and funding against the most critical needs, it is important that all options are considered which may not always result in adherence to guidance including NICE recommendations.

1.1 National Policy Position:

Nationally there is variation in the number of IVF rounds offered.

The table below shows the number of ICBs offering 1, 2 or 3 cycles excluding C&M:

CYCLES	No. ICBs	%
1	27	66%
2	7	17%
3	3	7%
Currently unharmonised position under review	4	10%

Source: ICB websites (March 2025)

It is important to note that the majority of neighbouring ICBs offer 1 IVF cycle, with the only exception Greater Manchester. Following a similar review undertaken, colleagues in GM are working up a proposal and plan for Public Consultation following discussion planned at their Board meeting in May.

- Lancashire and South Cumbria offer 1 IVF cycle.
- Greater Manchester is currently under review - varies from 1 to 3.
- West Yorkshire offer 1 IVF cycle.
- Staffordshire and Stoke-on-Trent offer 1 IVF cycle.

1.2 Current C&M Position

There are currently 10 subfertility policies across C&M. Depending on where the patient lives, will determine the number of IVF cycles that they are eligible for, the number of cycles range from 1 – 3. Below is the current offer:

Place / Legacy CCG	Offer
Liverpool	2 cycles (additional cycle available via an IFR)
St Helens	2 cycles
Warrington	3 cycles
Southport & Formby	3 cycles

South Sefton	3 cycles
Halton	3 cycles
Knowsley	3 cycles
Wirral	2 cycles
Cheshire East	1 cycle
Cheshire West	2 cycles (Unless IUI has been undertaken, then 1 cycle)*

*This document discusses IVF cycles; it does not include IUI cycles as activity is minimal.

Within Cheshire and Merseyside, we only have one provider for IVF, The Hewitt Fertility Centre at Liverpool Women's Hospital. Previously and until September 2023, Care Fertility provided fertility treatment for some of our Cheshire based patients at the Countess of Chester Hospital. Historic activity data from both sites has been used to model the proposal.

1.3 Current activity levels with cost to NHS C&M

This table below shows the month 7 activity and the forecast outturn for 2024/2025 activity.

		Based on LWH's Month 7 2024/25 actual position, forecasted to year-end using agreed					
	IVF		FET		Total		
Sub ICB Location	Actvity	Spend	Activity	Spend	Activity	Spend	
Southport & Formby	48	£ 231,494	5	£ 6,227	53	£ 237,721	
South Sefton	87	£ 415,617	9	£ 10,378	96	£ 425,995	
Liverpool	322	£ 1,559,470	56	£ 68,497	378	£ 1,627,967	
Knowsley	72	£ 350,088	14	£ 16,605	86	£ 366,694	
Halton	39	£ 189,913	9	£ 10,378	48	£ 200,291	
St Helens	46	£ 225,057	8	£ 10,378	54	£ 235,435	
Warrington	51	£ 242,471	12	£ 14,530	63	£ 257,001	
Cheshire E	101	£ 492,606	27	£ 32,185	128	£ 524,792	
Cheshire W	115	£ 555,761	30	£ 36,311	145	£ 592,073	
Wirral	117	£ 566,810	7	£ 8,303	124	£ 575,113	
TOTAL	**998**	**£ 4,829,289**	**177**	**£ 213,793**	**1175**	**£ 5,043,081**	

(Please note BI data still represents former CCG allocations and therefore Cheshire data is not split out into Cheshire East and Cheshire West. In the above table this split has been modelled based on previous years' activity as provided by LWH and Care Fertility).

2. Approach

As part of the CPH programme, a subfertility working group was convened to review the current policies and support the harmonisation. This multi-disciplinary working group included Secondary care local fertility specialists, GPs, health watch colleagues, commissioners, Equality & Diversity colleague and policy development specialists. The group reviewed each of the policy positions within the current policies and made recommendations in line with evidence base to shape the proposed policy, the policy has also been reviewed by the Clinical Network and feedback has been considered. A summary of these and the changes can be found in **Appendix 1.1**.

The data used is the 2024/25-month 7 activity reported by SLAM and the remainder of the year forecast outturn. The reason for using this data set is because the month 7 position will be used as the basis for the 2025/26 forecast and activity plan for LWH. The data provided is non patient identifiable, therefore, modelling has been carried out by C&M BI Team to determine the current allocation of first, and where applicable second and third cycles with the support and validation from operational and finance staff at LWH. The data modelling is available upon request by the Board.

Based on the data modelling an options appraisal process considered a do-nothing option, 1 cycle, 2 cycle and 3 cycle options. A do-nothing option was not supported by the group, this is because this would leave C&M in an unharmonised position and unwarranted variation would remain.

A 3-cycle option was also not supported by the group, this is because our data shows that 2 cycles would support majority of patients, and harmonising to 2 cycles would enable equity of access whilst maintaining current activity levels; a 3-cycle option would increase activity levels and which would impact LWH capacity to deliver and increase the annual cost of funding this service.

An Equality Impact Assessment and Quality Impact Assessment have been completed for the recommended option of 2 cycles and a 1 cycle option. This is to consider the impact on patients with protected characteristics and patient safety and experience.

2.1 Clinical effectiveness of IVF cycles

NICE Health Economics analysis describes the effectiveness of each cycle with regard to cumulative live birth rate and shows that whilst the chances of having a live birth increase with each cycle, the effectiveness and cost effectiveness of each cycle is reduced.

For example, in the case of an average 34-year-old, the 1st cycle is c 30% effective, the 2nd cycle is c 15% and the 3rd cycle is less than 10% effective.

2.2 Activity data and options modelling

To determine the average number of cycles and frozen embryo transfers (FET) each patient receives, historical data from Care Fertility and LWH has been used. This data along with outcome information and Tariff detail (as described in the table below) has been used to model the options with validation undertaken by LWH operational and finance teams.

An IVF cycle is deemed complete when all quality embryos have been transferred. The IVF cycle tariff allows for one fresh and one frozen embryo transfer, with any remaining required FET being charged at the subsequent FET tariff.

	IVF cycles	Subsequent FETs
Number (average)	1.36	1.88 (All frozen transfers)
Tariff	£4,862.34	£1,210.80

Based on the 2024/25 actuals and forecast, data has been extrapolated from those Places already providing 3 cycles to enable options to be modelled across all C&M Places based on %s of activity for each cycle:

- Percentage of patients receiving 1 cycle: 64%
- Percentage of patients receiving 2 cycles: 23%
- Percentage of patients receiving 3 cycles: 13%

2.3 Modelling of IVF cycles and FETs

Baseline – current unharmonised position

Sub ICB Location	1 cycle		2 cycle		3 cycle		Total	
	IVF	FET	IVF	FET	IVF	FET	IVF	FET
Southport & Formby	31	3	11	1	6	1	48	5
South Sefton	56	6	21	2	11	1	88	9
Liverpool	236	41	86	15	0	0	322	57
Knowsley	46	9	17	3	9	2	72	14
Halton	25	6	9	2	5	1	39	9
St Helens	34	6	12	2	0	0	46	8
Warrington	33	8	12	3	6	1	51	12
Cheshire E	101	27	0	0	0	0	101	27
Cheshire W	84	22	31	8	0	0	115	30
Wirral	85	5	31	2	0	0	116	7
TOTAL	**731**	**133**	**230**	**38**	**37**	**6**	**998**	**178**

1 cycle

The table below shows the modelled activity data if NHS C&M were to offer 1 cycle of IVF.

Sub ICB Location	1 Cycle		2 cycle		3 Cycle		Total	
	IVF	FET	IVF	FET	IVF	FET	IVF	FET
Southport & Formby	31	3	0	0	0	0	31	3
South Sefton	56	6	0	0	0	0	56	6
Liverpool	236	41	0	0	0	0	236	41
Knowsley	46	9	0	0	0	0	46	9
Halton	25	6	0	0	0	0	25	6
St Helens	34	6	0	0	0	0	34	6
Warrington	33	8	0	0	0	0	33	8
Cheshire E	101	27	0	0	0	0	101	27
Cheshire W	84	22	0	0	0	0	84	22
Wirral	85	5	0	0	0	0	85	5
TOTAL	**731**	**132**	**0**	**0**	**0**	**0**	**731**	**132**
Difference in activity (to baseline)							**-267**	**-46**

2 cycles

The table below shows the modelled activity data if NHS C&M were to offer 2 cycles of IVF.

Sub ICB Location	1 Cycle		2 cycle		3 Cycle		Total	
	IVF	FET	IVF	FET	IVF	FET	IVF	FET
Southport & Formby	31	3	11	2	0	0	42	5
South Sefton	56	6	21	2	0	0	77	8
Liverpool	236	41	86	16	0	0	322	57
Knowsley	46	9	17	3	0	0	63	12
Halton	25	6	10	2	0	0	35	8
St Helens	34	6	12	3	0	0	46	9
Warrington	33	8	12	3	0	0	45	11
Cheshire E	101	27	37	9	0	0	138	36
Cheshire W	84	22	31	8	0	0	115	30
Wirral	85	5	32	2	0	0	117	7
TOTAL	**731**	**132**	**269**	**50**	**0**	**0**	**1000**	**182**
Difference in activity (to baseline)							**2**	**4**

3 cycles

The table below shows the modelled activity data if NHS C&M were to offer 3 cycles of IVF.

	1 Cycle		2 cycle		3 Cycle		Total	
Sub ICB Location	**IVF**	**FET**	**IVF**	**FET**	**IVF**	**FET**	**IVF**	**FET**
Southport & Formby	31	3	11	2	6	0	48	5
South Sefton	56	6	21	2	10	1	87	9
Liverpool	236	41	86	16	44	7	366	64
Knowsley	46	9	17	3	9	2	72	14
Halton	25	6	10	2	4	1	39	9
St Helens	34	6	12	3	7	1	53	10
Warrington	33	8	12	3	6	1	51	12
Cheshire E	101	27	37	9	19	5	157	41
Cheshire W	84	22	31	8	15	4	130	34
Wirral	85	5	32	2	15	1	132	8
TOTAL	**731**	**132**	**269**	**50**	**135**	**23**	**1135**	**205**
Difference in activity (to baseline)							**137**	**27**

2.4 Guiding Principles

- To reduce unwarranted variation and harmonise access to services across Cheshire and Merseyside.
- Use the latest evidence base to develop harmonised policies.
- Consider sustainability of Cheshire and Merseyside ICB in context of financial requirements.

2.5 Strategic Context

The harmonisation of the policies and in particular IVF cycles meets the “Tackling health inequality, improving outcomes and access to services” and ‘Enhancing productivity and value for money’ strategic objectives:

Objective 1	
Objective	Tackling health inequality, improving outcomes and access to services
Current Arrangement	Inequity in the number of IVF cycles offered across C&M. Places currently offer either 1, 2 or 3 cycles and therefore there is unwarranted variation. There is a reputational risk, as we are one organisation, but patients are not being treated equitably, which is a risk to quality.
Gap/Business Needs	To harmonise the IVF rounds offered within the NHS C&M subfertility policy.

Objective 2	
Objective	Enhancing Productivity and Value for Money
Current Arrangement	Inequity in the number of IVF cycles offered across C&M. Places currently offer either 1, 2 or 3 cycles and therefore there is unwarranted variation.
Gap/Business Needs	To harmonise the IVF rounds offered within the NHS C&M subfertility policy whilst maintaining existing levels of activity and cost to support our Providers to continue to deliver against their operational plans.

3 Options and considerations:

Option	Description	Outcome	EIA feedback	QIA feedback	Financial impact
1	Do nothing • ***Discounted option***	This is not a viable option as this would leave the ICB and its patients with an unharmonised position and therefore unwarranted variation in access to fertility services.	Not completed	Not completed	**£5,043,081 per year**
2	NHS C&M offer patients 1 round of IVF treatment. • ***Executive Committee preferred option***	This option would disadvantage a cohort of patients who require additional cycles to have a live birth, as the average number of cycles that our patients have is 1.36. Clinically this is not supported due to the benefits in being able to take the learnings from an unsuccessful first cycle to improve chances of success in a second cycle. Whilst this option will reduce the cost of this service to the ICB, it is not supportive of NICE recommendation and would attract negative publicity. A public consultation exercise would be required in 8 Places.	The number of cycles does not affect protected characteristics. This option will affect those patients and families who are on a low income, if the patient does not have a successful live birth following a single round of IVF, they would have to self-fund to try again. This may mean they cannot have a biological child. **See Appendix 1.2 for EIA.**	There would be a negative impact for patients who are currently eligible for either 2 or 3 cycles. Without additional attempts at subsequent IVF cycles, there is a risk that patients would be detrimentally impacted and may not be able to have a biological child if they cannot afford to privately fund. Data shows the average number of IVF cycles that our patients are having is 1.36. Therefore, there is a risk that if those patients are not successful in the first IVF round, they would be disadvantaged by not being able to try a different approach in the second cycle. Knowledge is gained from the first cycle such as optimum dose of stimulation and best methods used for fertilisation. These are then implemented for subsequent attempts. **See Appendix 1.3 for QIA** **Overall risk rating: 16 (High)**	This would result in an estimated cost of **£3,728,347 per year.** Comparing this to the current position, this would result in estimated **savings of £1,315,732 per year.** (This cost includes the modelled cost of additional FETs – on average patients have an additional 1.88 FETs)

3	NHS C&M offer patients 2 rounds of IVF treatment. • ***Clinical Working Group Preferred Option***	This option is the preferred clinical option and is supported by the data that patients are having an average of 1.36 IVF cycles. Knowledge is gained from the first cycle such as optimum dose of stimulation and best methods used for fertilisation. These are then implemented for subsequent attempts. A public consultation would be required in 4 Places.	The number of cycles does not affect protected characteristics. **See Appendix 1.4 for EIA.**	According to the data analysis allowing 2 cycles of IVF would benefit the majority of patients, with the average number of IVF cycles being 1.36. Because the estimated number of 2nd IVF cycles for Cheshire East is equal to the existing number of 3rd cycles in Sefton, Knowsley, Warrington and Halton, the number of FETs is assumed to be the same based on this average. Once harmonised, this will mean that there is a consistent equitable offer for patients accessing subfertility treatments. See **Appendix 1.5** for QIA **Overall risk rating: 4 (Moderate)**	This would result in an estimated cost of **£5,084,437.** Comparing this to the current position, this would result in an estimated **cost increase of £40,357 per year.** (This cost includes the modelled cost of additional FETs – on average patients have an additional 1.88 FETs)
4	NHS C&M offer patients 3 rounds of IVF treatment. • ***Unsupported option***	This option is not supported because data suggests that the average number of IVF rounds is 1.36. Also, this option would require additional funding of over c.£734k pa and therefore does not support the ICB to meet its financial objectives.	The number of cycles does not affect protected characteristics.	Not completed as not supported.	This would result in an estimated cost of **£5,778,295.** Comparing this to the current position, this would result in an estimated **cost increase of £734,217 per year.**

3.4 Risks, Constraints & Dependencies

The following risks, constraints and dependencies have been highlighted as part of the development of the case for change.

Risks

The following risks have been identified:

Risk	Mitigating actions
Option 2: There is a risk of challenge during the public consultation from those patients in Knowsley, Halton, Warrington, Southport & Formby and South Sefton where currently 3 cycles are offered, and Liverpool, Wirral, Cheshire West and St Helens where currently 2 cycles are offered. If we reduce the number of cycles to 1, patients living in these Places may feel disadvantaged	There is an option to submit an Individual Funding Request if the patient could demonstrate clinical exceptionality. It should be noted however, that Liverpool Place have a policy of 2 cycles and 3 if clinical exceptionality is evidenced and there have been no instances of a 3rd IVF round approved. Whilst not a mitigation for these patients, reducing the IVF offer to 1 cycle would support the ICB to deliver savings in support of the financial challenge, and ensure that we can continue to provide this treatment across the whole of Cheshire and Merseyside
Option 2: If C&M ICB offers patients 1 cycle of IVF there is a risk that LWH would not receive enough income and therefore would not be sustainable as a Provider	This option would reduce LWH income by between £1m - £1.5m. A small element of this may be mitigated by planned productivity initiatives but would leave a deficit.
Option 3: There is a risk of challenge during the public consultation from those patients in Knowsley, Halton, Warrington, Southport & Formby and South Sefton where currently 3 cycles are offered, If we reduce the number of cycles to 2, patients living in these Places may feel disadvantaged.	C&M data shows that the average number of cycles patients have is 1.36, so the option to move to 2 cycles would support the majority of our patients. There is an option to submit an Individual Funding Request if the patient could demonstrate clinical exceptionality. It should be noted however, that Liverpool Place have a policy of 2 cycles and 3 if clinical exceptionality is evidenced and there have been no instances of a 3rd IVF round approved.
Option 3: There is a risk that unknown activity in non C&M Providers may mean that there is a significant number of CE patients having treatment out of area, due to geographical location.	Because of historic data reporting, we know that under £70,000 was spent in Cheshire with Greater Manchester providers. Assuming all of these are Cheshire E patients, there would be an estimated number of 4 patients requiring a 2nd cycle – Which would cost around £20k.
Option 3: If C&M ICB offers patients 2 IVF cycles, there is a risk that there will be increased activity levels for our provider Liverpool Women's Hospital. This increase will come from patients in Cheshire East who currently are eligible to 1 cycle. This would potentially increase waiting lists for treatment and will have a negative effect on women aged 40 and over, who are eligible for 1 cycle and may miss out on treatment due to a longer wait.	Offering 2 cycles of IVF for C&M patients will mean reducing the offer in Warrington, Halton, Sefton and Knowsley where patients are currently eligible for 3 cycles. Our data shows that the number of patients having 3 cycles per year and the estimated number of Cheshire East patients having a second cycle would result in minimal change to the activity levels and therefore minimal risk of introducing patient waiting lists. Patients in Cheshire East will sometimes choose to have their treatment in one of the Greater Manchester Trusts due to locality, so it is not expected that all of the estimated increased activity fall wholly on LWH.
All Options: Data from our providers has been used to inform the recommendations regarding the number of IVF cycles. There is a risk that this data may not be accurate as it is not patient identifiable – and is therefore based on averages.	To make for a richer data set, data has been collated and validated with LWH and Care Fertility. This will give a more accurate understanding of both Cheshire patients and Mersey patients. The options have been modelled using month 7 actuals with forecast end of year outturn for 2024/25 using SLAM data and verified by LWH finance and operational team.

Constraints

- The review is being undertaken in context of the reducing unwarranted variation recovery programme and the current financial climate.
- Due to the significance of the change, a public consultation exercise would be required in Cheshire and Merseyside to support either proposal to harmonise to one or two IVF cycles. In addition, it would be necessary to engage and consult with the Health Oversight and Scrutiny Committees in all affected Places for them to determine if this proposal is a significant development or variation. If so, a joint OSC would need to be formed. The availability and timing would largely be dictated by the Local Authorities, this would impact the timing of benefits delivery.
- Engagement/communication would also be required with local MPs.
- Consideration is needed regarding any delays to benefits delivery caused by the potential for 'call in' to the Secretary of State for Health & Care of any proposed service change – members of the public or organisations can write to the Secretary of State at any stage of the process.

Dependencies

- NHS C&M's communications and engagement team are currently focused on a number of pieces of public involvement work. Any public involvement requirements around IVF cycles will need to be considered alongside existing work plans.

4 Options Appraisal

For completeness, a range of options have been considered as part of the case for change, a brief description of the options, including subsequent actions required for Options 2, 3 or 4 is below:

Option 1: Do nothing (Option discounted)

Pros	Cons
• There would be no change in the ICB financial position.	• This would leave NHS C&M with an unharmonised position, patients would continue to have unequal access to IVF rounds. • There is an increased risk of challenge by Equalities and Human Rights commission re inequality in service access.

Option 2: Offer patients 1 cycle of IVF

Pros	Cons
• This offer is in line with most of our neighbouring ICBs offer. • Offering 1 cycle provides the greatest financial savings opportunity. • 661% of ICBs across the country offer 1 cycle.	• Data shows that the average number of cycles patients require is 1.36. Therefore offering 1 cycle would disadvantage patients who require an additional cycle. If the first cycle is not successful, observation and learnings are used to inform the second cycle in order to increase the potential for a successful live birth. This is especially relevant as patients are becoming more complex, are older, have comorbidities which affect their fertility or are under time pressure (e.g. fertility preservation). Although it is of note that patients could choose to fund this privately.

	• Risk of negative publicity for the ICB in those places that currently offer 2 or 3 cycles - patients will be generally dissatisfied, and this may result in an increase of complaints, therefore more time will need to be allocated to respond to these. • Patients on low income in 8 Places could be disadvantaged as they either receive 2 or 3 cycles currently, and if they fail to have a live birth in the first cycle, they would be required to self-fund which may not be financially possible. • A public consultation exercise would need to be held within 8 Places which would impact the time taken to implement and could be costly. • Does not match current NICE guidance of three cycles. • There is a sustained decline in birth rates across Cheshire and Merseyside. The OECD identifies a replacement fertility rate of 2.1 children per woman as necessary to maintain population levels. ONS data shows that the total fertility rate in C&M has been in consistence decline since 2021, falling to 1.49 in 2022. This trend presents significant long-term risks to the region's workforce and the sustainability of health and social services. Therefore, a reduction in cycles will undermine efforts to support population health and long-term system planning. • There is a risk on the mental health impact that childlessness has on couples, research shows that this is coupled with grief, depression and emotional stress which can impact on quality of life, this can be expected to increase. • Reducing NHS IVF cycles will potentially increase cost elsewhere as more patients will turn to cheaper IVF options in other countries with less regulation and potentially increasing the rates of multiple pregnancies, leading to maternal and neonatal morbidity and placing a greater financial and clinical burden on the NHS services downstream. • Data shows that 1 cycle of treatment (with subsequent FET's) gives a 56% chance of a live birth whereas with 2 cycles couples have a cumulative 68% chance of a live birth.

Option 3: Offer patients 2 cycles of IVF

Pros	Cons
• The average number of cycles patients currently have is 1.36, therefore the proposal of 2 cycles of IVF would support these findings and would enable learning to be taken from the first cycle and a different approach to be used for the second cycle with an aim to improving success. • Offering 2 cycles would be a positive for Cheshire East patients, as currently they are eligible for 1 cycle. • This option is supported by all clinicians including the Obs & Gynae clinical network and LWH Finance and Operational teams who will deliver the service.	• Patients in the 4 Places who offer 3 cycles, particularly if on low income, may feel they are disadvantaged by a reduction in the IVF cycle offer and this may generate negative publicity for the ICB. • A public consultation exercise would need to be held within 4 Places which would impact the time taken to implement. • Does not match current NICE guidance of three cycles, (NICE data shows that whilst the effectiveness of each cycle with regard to cumulative live birth rate increases with each cycle the effectiveness of each cycle is reduced). Our data modelling showing the average number of cycles per patient is 1.36. • This offer is higher than the national average (71% offering 1 cycle), our neighbouring ICB Cumbria and Lancashire offer patients 1 cycle of IVF. (Greater Manchester are in the process of harmonising their cycles offer). This would mean there is continued variation in access to subfertility services within the Northwest region and surrounding areas.

Option 4: Offer patients 3 cycles of IVF (Option discounted)

Pros	Cons
• Often if the first cycles are not successful, learnings are taken from this, and a different approach is used for the second and third cycles with an aim to improving success. • Offering 3 cycles would be a positive for Cheshire East, Cheshire West, Liverpool, St Helens and Wirral patients, currently they are eligible for 1 or 2 cycles. • A public involvement exercise could be a light touch communication approach. • Meets current NICE guidance, NICE data shows that whilst the effectiveness of each cycle with regard to cumulative live birth rate increases with each cycle, the effectiveness of each cycle is reduced.	• This offer is higher than our neighbouring ICB, Cumbria and Lancashire who offer 1 cycle. (Greater Manchester are in the process of harmonising their cycles offer). • This offer is higher than the country average, with 71% of ICBs offering 1 cycle. • This results in estimated additional cost to the ICB of £734k pa • The average number of cycles patients currently have is 1.36, therefore this option does not support data findings.

5.1 Financial Case

Options	Description (*Committed costs)	Recurrent cost annual	Comments
Option 1: Do nothing – Variation would remain in the number of IVF cycles offered across C&M	£5,043,081	£5,043,081	
Option 2: Offer patients 1 cycle of IVF across C&M	N/A	£3,728,347	This would result in estimated savings of £1,315,732 per year.
Option 3: Offer patients 2 cycles of IVF across C&M	N/A	£5,084,437	This would result in an estimated cost increase of £40,357 per year**.**
Option 3: Offer patients 3 cycles of IVF across C&M	N/A	£5,778,295	This would result in an estimated cost increase of £734,217 per year.

Appendices

Appendix 1.1 proposed other changes within policy document

Appendix 1.2 EIA for 1 IVF Cycle option

Appendix 1.3 QIA for 1 IVF Cycle option (post panel review)

Appendix 1.4 EIA for 2 IVF Cycles option

Appendix 1.5 QIA for 2 Cycles option

27 November 2025

ICB Board Meeting

Agenda item: ICB/11/25/16

APPENDIX TWO

NHS Cheshire and Merseyside

Proposed changes to fertility treatment policies in Cheshire and Merseyside

Public consultation feedback report

Report prepared by NHS Cheshire and Merseyside's communications and engagement team

Summer 2025

Contents

Executive summary

This report presents findings from a public consultation on proposed changes to NHS subfertility policies across Cheshire and Merseyside, which ran for six weeks between 3 June and 15 July 2025.

Currently, there are ten separate policies covering NHS fertility treatments for people in Cheshire and Merseyside. Because there are some variations in these policies, it means that people's access to fertility treatments depends on where they live.

The public consultation presented a proposal for a new, single policy for the whole of Cheshire and Merseyside, which would mean that everyone would get equal access to treatment across the area. The proposed policy includes a number of changes based on the latest national guidance, but it also includes a change to the number of in vitro fertilisation (IVF) cycles the NHS funds, which was a proposal made for financial reasons.

People were asked to respond to a questionnaire or provide feedback by phone or email. A consultation summary booklet was made available alongside the questionnaire. This was also produced in Easy Read, with other formats and languages available on request. The opportunity to take part in the consultation was promoted across NHS channels, and by asking partners to share information using their own networks.

In total, there were 2,124 responses to the questionnaire. Most respondents indicated that they had personal experience of NHS fertility treatment, either personally or as a partner/spouse (38%) or as a relative/friend (34%). Responses were received from people across the nine 'Places', or areas, of Cheshire and Merseyside.

86% of respondents disagreed or strongly disagreed with the proposed change to the number of IVF cycles that are funded.

46% agreed or strongly agreed with the proposed change to the eligibility on BMI (body mass index) in Wirral. 25% neither agreed nor disagreed, and 29% disagreed or strongly disagree.

72% agreed or strongly agreed with the proposed change to eligibility on smoking.

44% disagreed or strongly disagreed with the proposed change to the definition of 'childlessness' in Cheshire East and Cheshire West. 32% answered agree or strongly agree, 25% answered neither agree nor disagree.

42% agreed or strongly agreed with the proposed change to IUI commissioning in Wirral. 37% answered neither agree nor disagree, and 21% answered disagree or strongly disagree.

In total, respondents provided more than 1,000 individual comments to elaborate on or support their answers. These comments analysed for key themes, which have been summarised in this report.

This report will be presented to the Board of NHS Cheshire and Merseyside, along with a final proposal for the policy, as part of the decision-making process.

Introduction

NHS Cheshire and Merseyside Integrated Care Board (ICB) is responsible for planning local NHS services. Currently, there are ten separate policies covering NHS fertility treatments for people in Cheshire and Merseyside. These are called *NHS Funded Treatment for Subfertility* policies.

NHS Cheshire and Merseyside is proposing a new single policy for the whole area.

The new policy would include a number of changes based on the latest national guidance, but for financial reasons we are also proposing to make some changes to the number of in vitro fertilisation (IVF) cycles funded for eligible patients.

We are expecting new national guidance on fertility treatments to come out from the National Institute for Health and Care Excellence (NICE) in early 2026, so our new policy would be an interim one. When this new guidance is published, we will review it to make sure our interim policy is up to date with the latest medical evidence.

Content and purpose

This report describes the feedback received during a six-week public consultation about the proposal for a new singe subfertility policy for Cheshire and Merseyside, which was held between 3 June and 15 July 2025.

The consultation attracted responses from a range of stakeholders, including patients and the public, carers, health professionals, and charities, regarding both their views about the proposed changes to fertility treatment policies, and – where relevant – their experiences of fertility services.

This feedback will be used to inform the final version of the new interim subfertility policy for Cheshire and Merseyside.

Background

NHS Cheshire and Merseyside was established in July 2022, taking on the responsibilities of nine former clinical commissioning groups (CCGs). When this happened, we inherited each CCG's commissioning policies, which set out the circumstances when treatments and procedures are provided on the NHS. Many of these policies were old and not up to date with the latest medical evidence and guidance. Additionally, whilst some policies were the same or similar across all CCGs, there were differences between others.

Because there are some variations in the ten current policies we have for subfertility, people's access to fertility treatments can be different, depending on where they live.

We are proposing a new, single policy for the whole of Cheshire and Merseyside, which would mean that everyone would get equal access to treatment in our area.

Scope of public consultation

The consultation explored five proposed changes:

- Change to the number of IVF cycles funded
- Change to eligibility on BMI (body mass index) in Wirral

- Change to eligibility on smoking
- Change to the definition of ‘childlessness’ in Cheshire East and Cheshire West.
- Change to intrauterine insemination (IUI) commissioning in Wirral.

Additional clarifications were also proposed regarding age limits for treatment eligibility.

Proposed changes

The table on the next page is a summary of the proposed changes. For a full description of the changes see Summary booklet – Share your views on changes to fertility policies.[1]

[1] Fertility treatment policies - NHS Cheshire and Merseyside

Proposed change	Current situation	Proposed policy	Impact on patients	Reason for change
Standardisation of NHS-funded IVF cycles	Varies by area: Between 1 and 3 cycles for under 40s; 1 cycle for 40–42	1 full cycle for all eligible patients (including fresh and frozen transfers)	Reduction in funded cycles for all areas except Cheshire East; no change for 40–42 age group	Financial sustainability and equitable access
Alignment of BMI eligibility criteria	Wirral requires both partners to meet BMI criteria – others only require this of female partner	Only the female partner must have BMI between 19–29.9; male partners with a BMI over 30 advised to lose weight, but this would not be a barrier to treatment	Removal of potential barrier to access for couples in Wirral, and alignment with the rest of Cheshire and Merseyside	Align with NICE guidance and ensure there is equal access across Cheshire and Merseyside
Inclusion of smoking status for both partners	In some areas, only female partner must be a non-smoker	Both partners must be non-smokers (includes vaping/e-cigarettes)	Stricter criteria in Halton, Knowsley, Liverpool, Sefton, St Helens	Improve treatment outcomes and align with NICE guidance, and ensure equal access across Cheshire and Merseyside
Revision of definition of childlessness	In most areas of Cheshire and Merseyside, IVF is only made available on the NHS where a couple has no living birth children or adopted children, either from a current or previous relationship. However, Cheshire East and West allow continued embryo transfers even after a live birth or adoption during cycle	No further transfers once a live birth or adoption occurs	Stricter eligibility in Cheshire East and West	Standardise definition to ensure equal access across Cheshire and Merseyside
Commissioning of IUI in Wirral	IUI not routinely commissioned in Wirral	IUI to be funded in Wirral for specific groups (e.g., same-sex couples, physical psychosexual issues, HIV considerations)	More equitable access in Wirral	Align with NICE guidance and ensure consistency of access across Cheshire and Merseyside
Additional clarification: Age limits	IVF available from age 23 to 42	No lower age limit: upper limit clarified as up to 43rd birthday	Minimal impact; clearer eligibility	Align with NICE guidance and reduce ambiguity

Public consultation objectives

- To inform patients and the public, carers/family members, and key stakeholders about the proposal to have a single subfertility policy for Cheshire and Merseyside and explain what changes this would mean.

- To gather feedback on the proposal, including from people who are currently accessing or have accessed fertility services, organisations who support them (where applicable), their carers/family members, and the wider public, to understand views, including how people might be impacted if changes were to go ahead.

- To understand where there might be differences in responses between different groups/communities, including those with protected characteristics, in line with equalities duties.

- To use public consultation feedback to inform final decision-making around the proposal.

Consultation approach – involvement methods

The following approaches were utilised to create opportunities and mechanisms for people to engage during the public consultation:

Questionnaire

A short set of questions (Appendix A) was used to gather both qualitative and quantitative data about people's views and experiences. The questionnaire was hosted online, with paper copies and alternative languages/formats made available on request by emailing or calling NHS Cheshire and Merseyside's communications and engagement team.

Phone line and email account

NHS Cheshire and Merseyside's communications and engagement team took feedback from several members of the public over the phone. People who called were also asked to complete the questionnaire – either online or on a printed copy, which could be sent to them. The same telephone number was used to request alternative versions of materials.

Similarly, the email account was used for organising one to one telephone conversations, resolving queries and managing requests for printed engagement resources.

Consultations approach - communication and promotion

Online

NHS Cheshire and Merseyside's website was used as a repository of information for the consultation, hosted in the 'Get involved' section of the site: Share your views on proposed changes to fertility treatment policies in Cheshire and Merseyside - NHS Cheshire and Merseyside

The following resources were made available:

- Online consultation questionnaire
- 16-page information booklet
- Easy Read version of the booklet
- List of frequently asked questions (FAQs)
- Communication toolkit, developed for use by partners – including social media assets, a media release, and a shorter version of the news content

Webpage analytics

Over the six-week consultation period, the main consultation website page (which people were signposted to in order to take part) was accessed by 3,821 active users and received a total of 5,277 page views.

An article about the consultation which was hosted in the 'News' section of the website was accessed by an additional 509 active users and received a total of 734 page views.

Social media

NHS Cheshire and Merseyside promoted the consultation across its social media channels. All of these posts were organic (not paid-for).

Across the six-week consultation period (3 June – 15 July) there were a total of 22,437 social media impressions (the number of times the content was viewed), and 5,701 engagements (direct actions taken such as shares, likes, comments) across these 13 posts.

A total of 20 direct messages were sent to our social media accounts, and NHS Cheshire and Merseyside was tagged in comments on a further 17 public posts during the consultation period.

Social media posts also generated a total of 1,055 link clicks to the main consultation website page.

Partner organisations promoted the engagement through their own online channels, directing people to the NHS Cheshire and Merseyside website for further information and to complete the online questionnaire.

Media

NHS Cheshire and Merseyside issued a media release to promote the consultation to local and regional media channels. This resulted in a number of pieces of coverage over the six-week consultation period, including two BBC regional TV news pieces, a print newspaper article, and several online news stories.

For a full breakdown of all media coverage generated during the consultation period, please see Appendix B.

Utilising existing networks and groups

NHS Cheshire and Merseyside briefed a wide range of stakeholders at the outset of the consultation period in order to maximise awareness and encourage wider sharing of information. This included MPs, local authority leaders, Healthwatch organisations, NHS England, NHS trusts, and a wide range of community and voluntary sector partners.

The consultation was also publicised through a range of internal and external NHS Cheshire and Merseyside mechanisms, including during our all-staff meeting and in the staff newsletter; primary care bulletin; Health and Care Partnership newsletter; and monthly public email update.

Information was also shared via NHS Cheshire and Merseyside's Community Voices email list. Community Voices is an online group made up of local residents who have agreed to give their views on a number of health and care topics throughout the year.

NHS Cheshire and Merseyside worked closely with the communications team at Liverpool Women's NHS Foundation Trust, as well as colleagues at the Hewitt Fertility Centre, the provider of NHS fertility treatment in Cheshire and Merseyside, to promote the opportunity to take part in the consultation. Importantly, this helped to target current and previous users of fertility services.

The consultation was publicised on the trust's main website and social media channels, including LinkedIn, Instagram, Facebook and X (previously Twitter), on the Hewitt Fertility Centre's dedicated website and social media channels, and via internal staff communications at the trust.

In addition, posters and handouts with QR codes signposting patients to the consultation questionnaire were displayed around waiting rooms in the Hewitt Fertility Centre. A push notification/alert to a clinic news webpage was sent to registered patients of the service so that they could access further. Information about the consultation was also shared via their Patient Support Group and through the trust's patient experience team.

To help promote the consultation as widely as possible, a communications toolkit was shared with a range of partners at the outset of the six-week period. This included communications teams in local authorities and NHS trusts, Healthwatch organisations, GP practices, and other relevant networks.

The toolkit and supporting briefing information was also shared with a range of regional and national fertility charities, advocacy organisations and groups.

NHS Cheshire and Merseyside also contacted a range of relevant local voluntary, community, faith and social enterprise (VCFSE) groups who work with diverse communities and asked them to share the information and encourage people to take part.

Individual groups and networks were given the opportunity to invite NHS Cheshire and Merseyside to attend meetings or events to provide additional briefings about the public consultation. As part of this, we met with Fertility Action – you can read a summary of that meeting, and Fertility Action's consultation submission, in Appendix C. Key themes from this discussion included: Equity and access, wait times for NHS fertility treatments, mental health impacts of fertility policies, falling fertility rates, clearer policy communication and clarity for patients, and primary care education around male fertility issues.

A review was undertaken three weeks into the six-week consultation period, providing an opportunity to identify any gaps in responses from people of different demographic groups or geographical areas. At this point it was noted that the majority of responses came from people who indicated that their ethnicity was white, so additional promotion was put in place, aimed at encouraging more diverse participation.

In support of this, we did a further promotional push to remind people that it was still not too late to take part in the public consultation. This involved use of social media platforms, additional activity by Liverpool Women's, and further communication with voluntary and community sector partners (particularly those focused on reaching diverse communities).

Summary of findings from questionnaire

The main findings section (page 12 onwards below) contains a detailed breakdown of the questionnaire responses, however the following is a summary of some of the key findings in response to each proposed change.

Response to proposed change to the number of IVF cycles that are funded

- 86% (1,532) of respondents disagreed or strongly disagreed with the proposed change to the number of IVF cycles that are funded.
- Of those disagreeing with the proposal, many emphasised the psychological toll of infertility and the stress of limiting access to treatment, on the basis that IVF can require more than one cycle for a successful outcome.
- Many of those disagreeing with the proposal questioned the financial logic of reducing IVF cycles, with some comparing its broader impact on NHS budgets with the potential costs of mental health support to those left without children after only one round. Many respondents also compared the cost of providing one IVF cycle or two IVF cycles across Cheshire and Merseyside and said that the difference in cost seemed to signal that two rounds would be the most sensible option.
- There were concerns that the impact of this proposal would be to widen inequalities in access to care and increase the financial burden on individuals.
- The personal challenges associated with IVF, including emotional strain, financial burden, and relationship pressures, were consistently highlighted amongst respondents.

Response to the proposed change to the eligibility on BMI (body mass index) in Wirral

- 46% agreed or strongly agreed with the proposal, 25% neither agreed nor disagreed, and 29% disagreed or strongly disagree.
- Many respondents emphasised the importance of being in good physical condition before undergoing IVF. They linked healthy weight and lifestyle choices to improved fertility outcomes, reduced pregnancy risks, and better long-term health for parents and children.
- Many respondents shared their own journeys with IVF, weight loss, or navigating BMI requirements. These stories often highlighted the emotional and physical challenges of meeting eligibility criteria.
- Respondents frequently discussed the importance of removing barriers to treatment.
- There were calls for consistent policies across areas and genders.

Response to the proposed change to eligibility on smoking

- 72% (1,110) answered ‘agree’ or ‘strongly agree’ in response to the question about the proposed change to eligibility on smoking.
- Responses acknowledged that smoking affects fertility and pregnancy outcomes.
- There was broad agreement that support should be provided to help individuals quit smoking, rather than using smoking status as a barrier.
- Concerns about equity were voiced, especially regarding penalising individuals based on partner behavior.
- There were concerns about how smoking status would be verified and enforced.

Response to the proposed change to the definition of ‘childlessness’ in Cheshire East and Cheshire West

- 44% answered disagree and strongly disagree in response to the question about the proposed change to the definition of ‘childlessness’ in Cheshire East and Cheshire West. 32% answered agree or strongly agree, 25% answered neither agree nor disagree,
- Respondents emphasised the need for consistent policies across areas to avoid a 'postcode lottery'.
- Some respondents discussed the importance of prioritising NHS resources for those who don’t already have children, while others expressed concern about financial limitations.
- There were mixed views on whether NHS should support treatment for additional children beyond the first
- Respondents highlighted the challenges of secondary infertility and called for case-by-case consideration.
- Emotional and ethical concerns were raised about the psychological impact and fairness of the proposed policy.

Response to proposed change to IUI commissioning in Wirral

- 42% answered agree or strongly agree, 37% answered neither agree nor disagree, and 21% answered disagree or strongly disagree in response to the question about the proposed change to IUI commissioning in Wirral.
- Fairness in access to fertility treatment was a recurring concern. Respondents emphasised that policies should not discriminate based on relationship type, geography, or personal circumstances.
- Many respondents highlighted the perceived inequality in requiring same-sex couples to self-fund IUI.
- IUI was frequently described as a gentler and more affordable alternative to IVF, with many advocating for its use as a first-line treatment.
- There was support for following national standards.

Main questionnaire findings

Respondents and their characteristics

The questionnaire was open between 3 June and 15 July 2025. There were 2,124 responses overall, with 71% of respondents reaching the end of the questionnaire. People could choose which questions they wished to answer, so the number of responses to individual questions varies.

Respondents were self-selecting, meaning they chose to participate in the consultation, rather than being sampled or assigned. The profile of respondents by interest, geographical area and how they found out about the consultation are shown in Tables 1 to 3 below.

The methodology is described above. The questionnaire is shown in Appendix A and the responses to the equality monitoring questions in Appendix D.

The results are presented as statistical summaries for the fixed response (quantitative) questions together with, where relevant, a thematic analysis of the free-response (qualitative) questions. The aim of the thematic analysis is to identify themes or patterns in the data that are relevant to the objectives of the consultation and identifying side issues. This analysis is a way of identifying deeper insights and meanings about the views of respondents. Not all respondents provided a comment justifying their response, and therefore the number of free responses is always fewer than the number of people answering the fixed response question.

1,129 respondents completed in part or full the equality monitoring questions, which were optional.

Please note: Percentages are only used as an indication of the proportion of people who answered that question, figures have been rounded up or down to the nearest whole number.

Table 1: Respondents' interest in fertility treatment policies

Answer choices	Responses	
Someone who has accessed (or is accessing) NHS fertility treatment, either personally or as a partner/spouse	38%	804
The carer of someone who has accessed (or is accessing) NHS fertility treatment	0.4%	9
A relative/friend of a patient who has accessed (or is accessing) NHS fertility treatment	34%	712
Someone who has accessed (or is accessing) privately funded IVF (in vitro fertilisation)	9%	187
Someone interested in responding, but without personal experience of fertility treatment.	26%	544
A health professional working in fertility services in Cheshire and Merseyside. (You will have an opportunity to complete a section for health professionals later in the questionnaire.)	4%	79
Other (please specify)	4%	82
	Answered	**2,121**

N.B. Respondents could select more than one category; therefore, percentages don't add up to 100.

Table 2: Where respondents live

Answer choices	Responses	
Cheshire East	6%	120
Cheshire West	9%	197
Halton	7%	143
Knowsley	6%	132
Liverpool	20%	429
Sefton	12%	244
St Helens	12%	246
Warrington	12%	258
Wirral	8%	159
Outside of Cheshire and Merseyside (please specify)	9%	191
	Answered	**2,119**

Table 3: How respondents found out about the consultation

Answer choices	Responses	
An email or text from the NHS	6%	90
Social media (Facebook, X etc.)	49%	775
NHS website (for example, NHS Cheshire and Merseyside or hospital trust website)	6%	87
Through a patient group and/or voluntary sector organisation I am connected to	5%	86
NHS staff communication	6%	99
Friend or family member	34%	532
I don't know	0.7%	11
Other (please specify)	5%	76
	Answered	**1,575**

Analysing qualitative feedback

To provide more detailed insights into why respondents agreed or disagreed with the proposed changes, people completing the questionnaire were asked to explain the reason(s) behind their views on each proposed change, with more than 1,000 comments provided.

To analyse and structure these comments into a meaningful summary, a thematic analysis was used to identify the most frequently occurring opinions and concerns. To provide balance to the analysis, the most frequently occurring themes were identified for both those in favour and against each proposal.

Questionnaire responses from the public were analysed for recurring themes and sentiments using Copilot, a Microsoft artificial intelligence (AI) tool. Ahead of this, responses were manually reviewed to remove anything which might identify individuals, ensuring compliance with data protection principles. Copilot was used in a secure, browser-based environment by a trained staff member, only cleaned, non-identifiable text was inputted, and outputs were also manually checked to ensure that any risks around misinterpretation were mitigated.

Response to proposed change to the number of IVF cycles that are funded

The proposed change

If the new single policy was introduced, it would mean everyone in Cheshire and Merseyside who is eligible for IVF would have one cycle paid for by the NHS. The number of cycles funded would reduce for people aged up to 39 in all areas of Cheshire and Merseyside, except in Cheshire East, where it would stay the same as it is now.

There would be no change for eligible people aged between 40 and up to 42, as they are already offered one cycle in all areas of Cheshire and Merseyside.

For a full explanation of the proposed change to the number of IVF cycles see the consultation summary booklet.

Respondents were asked **"To what extent do you agree/disagree with the proposed change to the number of IVF cycles that are funded?"** The results were as follows:

Answer choices	Responses	
Strongly agree	6%	114
Agree	5%	85
Neither agree nor disagree	2%	33
Disagree	9%	166
Strongly disagree	77%	1,366
	Answered	**1,764**

Respondents who disagree or strongly disagree

86% of 1764 respondents answered 'disagree' or 'strongly disagree' to the proposed change to the number of IVF cycles that are funded.

There wasn't any significant difference of opinion based on groups of respondents by equality characteristics or other groupings – differences in opinion were based on respondents' interest in the consultation.

Of the respondents who answered 'disagree' or 'strongly disagree', 65% indicated they were either 'someone who has accessed (or is accessing) NHS fertility treatment, either personally or as a partner/spouse' or 'a relative/friend of a patient who has accessed (or is accessing) NHS fertility treatment.'

1,291 respondents provided further explanation of why they selected 'disagree' or 'strongly disagree' with the proposal, with the following themes identified:

Mental/emotional impact - respondents highlighted the psychological and emotional toll of infertility and IVF treatment. With many describing how hard it is trying to maintain hope and keep a positive mental attitude whilst trying to conceive.

"Reducing access to further attempts can cause significant emotional distress."

"This change will strip so many people of the chance to get pregnant. IVF and infertility are hard enough."

Success rates and medical rationale - many respondents cited reasons that supported their view that IVF often requires multiple cycles.

"The first round is very often treated as a test round to test the efficacy of the treatment plan and often fails."

NHS funding concerns - respondents questioned the financial logic of reducing IVF cycles, in the context of the estimated financial impact.

"The additional £40,000 cost is small when considered in the context of the total budget for local health care."

"Reducing to one cycle will widen inequalities in access to care between those who can afford additional private cycles and those who cannot."

Equity and fairness - respondents criticised the policy as short-sighted and poorly justified**.** Respondents shared their own personal IVF journeys about fairness and equal access to care.

"Reducing everyone to one cycle to make it the same doesn't seem fair."

"I had to pay privately for my IVF, and this is something that not everyone can do."

Societal impact - some respondents pointed to broader consequences like declining birth rates.

"Fertility treatment is an investment in the future stability of our community."

Women's health - respondents reported a gender bias in healthcare decisions.

"Women's health is always targeted…"

Regional differences - respondents expressed frustration that Cheshire and Merseyside going to one IVF cycle meant it would fall into line with other regions in England.

"Just because other areas of the country only offer 1 cycle of IVF doesn't mean we should follow suit."

Impact on relationships - some respondents noted the strain the proposed change would have on relationships.

"This change would impact mental health and relationships."

Interpreting Strongly Agree, Agree, and Neutral Responses

There were far fewer comments made in explanation of these categories, and less distinct themes arose. Responses covered areas such as a concern for financial fairness, and recognition of financial constraints.

Common themes from all comments in response to the proposed change to the number of IVF cycles that are funded

Equity and consistency - many respondents expressed a desire for equal access to IVF treatment, regardless of geography or personal circumstances. The concept of eliminating a perceived postcode lottery was widely supported. There was a shared belief that consistency in policy is important, even if the number of funded cycles is limited.

"It should be the same for everyone, either 1 for all or more for everyone."

"I think access to the number of IVF cycles via the NHS should be equal in all areas and should not be a postcode lottery."

Financial realism - respondents acknowledged the financial constraints facing the NHS. Some saw limiting IVF funding as a necessary compromise to preserve resources for other essential services. There was a recognition that one cycle may be a fair offer, especially if it includes multiple embryo transfers.

"The NHS cannot fund everything."

Inclusive access - respondents highlighted the importance of inclusive eligibility criteria, especially for solo parents, LGBTQ+ families, and those with complex family situations. There was concern that current policies may exclude certain groups unfairly.

"I want everyone to be able to have the opportunity to be able to have IVF even if they are a solo parent, non-binary/trans."

Alternative priorities - a small number of respondents questioned whether IVF should be funded at all, suggesting that life-saving treatments should take precedence.

Impact

In response to the question **'Please use this space to let us know how the proposed change to the number of IVF cycles that are funded would impact you'** There was a clear convergence of themes and opinions that reflect the personal challenges associated with IVF and wider fertility treatments. Emotional strain, financial burden, and relationship pressures were consistently highlighted amongst respondents.

"The anxiety and stress that would be caused by knowing that you only have one round to make it work is indescribable."

"I couldn't access the current proposals because I am single. The criteria for single people were erroneous and not practicable for any person to consider. I therefore went into debt to go private."

Many respondents emphasised the importance of maintaining hope and the need for multiple IVF cycles due to low success rates, aligning with broader concerns about fairness, equity, and the logic of NHS funding decisions. People shared personal stories of loss, grief, and resilience, and talked about additional factors such as the physical toll of treatment, the stigma surrounding infertility, and the tension between career and family planning.

"I've attended support groups for those facing infertility and baby loss, and I've seen the toll it takes."

Response to proposed change to eligibility on BMI (body mass index) in Wirral

The proposed change

BMI (body mass index) is a measure of whether you are a healthy weight for your height.

Currently, nine out of ten Cheshire and Merseyside subfertility policies state that women need to have a BMI of between 19 and 29.9 in order to begin NHS fertility treatment. In

Wirral the policy says that a male partner should also meet this BMI in order for a couple to be eligible.

In the proposed new Cheshire and Merseyside policy it would state that women intending to carry a pregnancy need a BMI of between 19 and 29.9 for fertility treatment to begin. Men with a BMI of more than 30 would be advised to lose weight to improve their changes of conceiving, but this would not necessarily be a barrier to the couple accessing NHS fertility treatment.

If the new single policy was introduced, it would mean that in the future, people living in Wirral would have the same access to fertility treatment based on BMI as people in other parts of Cheshire and Merseyside.

For a full explanation of the proposed change to eligibility on BMI in Wirral please see consultation summary booklet.

Respondents were asked **"To what extent do you agree/disagree with the proposed change to the eligibility on BMI (body mass index) in Wirral?"** The results were as follows:

Answer Choices	Responses	
Strongly agree	19%	303
Agree	27%	424
Neither agree nor disagree	25%	383
Disagree	12%	181
Strongly disagree	17%	270
	Answered	**1,561**

Given that this change focussed on a particular area, we examined responses based on where people lived, but we did not find significant differences to the way respondents answered.

Simiarly, we looked at responses according to gender. Broadly speaking, there was no significant difference in the way respondents answered the question. There were slightly more males in agreement (agree/strongly agree) with the change and slightly more females in disagreement (disagree/strongly disagree) with the changes however this difference may be due to respondents understanding of the proposed changes as described in the report below (further observations and considerations). It should also be noted that there were significantly more responses from those who identified as female (941 respondents) than male (88 respondents).

Not all respondents chose to leave a comment to explain more about why they agreed or disagreed with the proposed policy change, and fewer again left a comment to describe the impact of the proposed policy change.

Common themes in feedback on proposed BMI eligibility changes in Wirral

Health and lifestyle - many respondents emphasised the importance of being in good physical condition before undergoing IVF. They linked healthy weight and lifestyle choices to improved fertility outcomes, reduced pregnancy risks, and better long-term health for parents and children.

“In order for the treatment to be successful patients need to be in the best physical health they can be. To avoid wasting funds recipients of fertility treatment should be prepared to make some sacrifices to help achieve their desired outcome.”

“People should be at their healthiest to have a child, being overweight comes with risks.”

Respondents discussed the importance of being healthy, the limitations of BMI in reflecting true health, and the role of fitness, diet, and muscle mass.

“Completely understand that you require individuals to be at their best health wise in order for the cycles to have more chance of working but I think other factors should be considered as women with PCOS often find it difficult to lose weight.”

Respondents emphasised that people can be healthy and active even with a higher BMI, and that muscle mass or body composition should be considered.

"I have a high BMI, but I believe myself to be fit, active and healthy — I exercise 5 times a week and play contact sports regularly."

Personal experience - many respondents shared their own journeys with IVF, weight loss, or navigating eligibility requirements. These stories often highlighted the emotional and physical challenges of meeting eligibility criteria.

“I had to lose over 4 stone to be eligible for IVF on the NHS. Although it was hard, I was happy to do so as being overweight can negatively impact fertility and IVF.”

"In my experience, my BMI was 31 when we were assessed, and I was told I needed to lose weight before we could proceed. Although I accepted this because I knew I had some weight to lose, the pressure it added was overwhelming — both emotionally and physically — at an already difficult time."

Access to treatment - respondents frequently discussed the importance of removing barriers to treatment. Some expressed the view that BMI should not prevent couples from accessing IVF, especially when male BMI was not a requirement in other areas.

“By changing the guidelines for a male partner's BMI (if above 30) to be an advisory rather than an ineligibility is a good idea as this shouldn't be a hurdle which blocks access to a patient having treatment.”

Respondents raised concerns about BMI acting as a barrier to IVF, especially for those with medical conditions or atypical body compositions.

"My partner was 0.1 over the BMI for treatment and so we had to go private. It was suggested she lose weight without considering the fact her medical condition hinders this."

Fairness and equity – a strong theme was the desire for consistency across different areas. Many people criticised the “postcode lottery” and called for equal treatment regardless of where someone lives.

“It would be fair to have the same policy across the board instead of just having a postcode lottery.”

Comments focused on the need for consistent policies across regions and equal treatment for men and women. Some respondents criticised the policy for being discriminatory, especially toward women, and called for equal standards across genders and regions.

Support for policy change – some respondents expressed agreement with the proposed change, describing it as "sensible," "logical," or "in line with NICE guidance." These responses often supported the idea of aligning Wirral's policy with the rest of Cheshire and Merseyside.

> *"Yes, strongly agree. Sounds a suitable approach. Female BMI needs to be under 30. Male BMI not so imperative but should be encouraged to be healthy due to sperm etc. Fine policy. Should be equal across whole area – zero variation by postcode please."*

Respondents who supported the proposed change, often made further caveats or suggestions.

> *"I welcome the proposal to make the male BMI guidance more flexible and believe the same compassion and flexibility should apply to women as well."*

Additional views that arose in the comments that were not specifically about the proposed changes included:

BMI as a measure of healthy weight - respondents questioned the use of BMI to measure a person's healthy weight. BMI as a tool was sometimes described as outdated, inaccurate, or inappropriate for determining health or treatment eligibility.

Poorer mental health - respondents described how trying to reach the BMI requirements to access fertility treatment could lead to poor mental health outcomes and have a high emotional impact.

Impact

In response to the question **'Please use this space to let us know how the proposed change to the eligibility on BMI in Wirral would impact you'** 444 respondents stated that the change would not impact them, sometimes describing that they had already completed their IVF treatment, others stating that they did not live in Wirral, but most saying not applicable or similar. There were indications that some respondents might not have fully understood the proposed change, with just over 100 responses explicitly referencing female BMI requirements, implying that they believed the proposed change was to introduce or enhance BMI requirements for women.

However, a few respondents did talk explicitly about the removal of male BMI criteria in Wirral.

> *"This won't impact me directly, as I've already been through IVF, but I think it's a sensible and balanced update. Removing the male BMI restriction where it existed removes confusion and brings consistency to the policy. Couples already face enough stress and complexity when dealing with fertility — this helps remove one unfair barrier."*

Response to proposed change to eligibility on smoking

The proposed change

If the new single policy was introduced, it would mean that in future people in Halton, Knowsley, Liverpool, Sefton and St Helens would not be eligible for NHS-funded fertility treatment if either partner was a current smoker.

This wouldn't be a change for people in Cheshire East, Cheshire West, Wirral or Warrington, because the policies for these areas already say this.

For a full explanation of the proposed change to eligibility on smoking please see consultation summary booklet.

Respondents were asked **"To what extent do you agree/disagree with the proposed change around smoking and eligibility?"** The results were as follows:

Answer Choices	Responses	
Strongly agree	42%	645
Agree	30%	456
Neither agree nor disagree	18%	275
Disagree	6%	89
Strongly disagree	5%	80
	Answered	**1,545**

Not all respondents chose to leave a comment to explain more about why they agreed or disagreed with the proposed policy change.

There wasn't any significant difference of opinion based on groups of respondents by equality characteristics or other groupings.

Common themes in feedback on proposed change to eligibility on smoking

Health and treatment outcomes - people across all response categories acknowledged that smoking affects fertility and pregnancy outcomes, though their views on how this should influence eligibility differed.

Those who strongly agreed or agreed with the proposed change referred to smoking negatively impacting fertility, IVF success rates, and pregnancy outcomes.

> *"Agree with the proposed changes around eligibility and smoking to access NHS funded IVF. Both parents need to consider the health implications of smoking not only to their own health but potentially to that of their baby should treatment be successful."*

Those who neither agreed nor disagreed talked about the benefit of trying to promote healthy lifestyles but highlighted the need for a multi-disciplinary approach.

Those who disagreed and strongly disagreed felt that smoking should only be used as a determining factor if it is significantly affecting the health of the would-be parents.

Support for smoking cessation - there was broad agreement that support should be provided to help individuals quit smoking, rather than using smoking status as a barrier.

Fairness and discrimination - some respondents expressed concerns about equity, especially regarding penalising individuals based on partner behavior or past smoking history. Those who strongly agreed and agreed felt the proposal applies fair and medical-based criteria to improve chances of success.

Policy clarity and enforcement - some respondents expressed concerns about how smoking status would be verified and enforced.

Less frequently mentioned concerns included the issue of partner smoking and individual eligibility, where respondents strongly objected to the idea that one partner's smoking status — typically the male — could disqualify the other from accessing treatment. This was seen as unfair and overly punitive, particularly when the non-smoking partner may be fully compliant with health guidelines.

Another concern involved vaping and evidence concerns, with mixed views on whether vaping should be treated the same as smoking. While some felt vaping should be included due to its potential health risks, others questioned whether there was sufficient scientific evidence, particularly regarding its impact on male fertility.

Finally, several respondents highlighted the perceived double standards between natural conception and IVF, arguing that individuals who conceive naturally are not subject to the same lifestyle scrutiny or restrictions.

Impact

In response to the question **'Please use this space to let us know how the proposed change around smoking and eligibility would impact you'** the majority of respondents indicated that the proposed change around smoking and eligibility for fertility treatment would not affect them personally. This was often because they were non-smokers or had already completed treatment. Some highlighted health benefits, noting that smoking cessation could lead to better physical outcomes and safer pregnancies. Others expressed concern for child welfare, emphasising the importance of a smoke-free environment for newborns.

A few respondents questioned the broader implications for the NHS, critiquing what they saw as a "nanny state" approach and calling for consistency across lifestyle-related policies. There were also voices advocating for support and cessation, stressing the need for robust programs to help individuals quit smoking rather than excluding them from treatment.

Response to proposed change to the definition of 'childlessness' in Cheshire East and Cheshire West

The proposed change

If this change went ahead, it would mean that people in Cheshire East and Cheshire West would no longer be offered more embryo transfers once they have become a parent.

This would not be a change for people living in Halton, Knowsley, Liverpool, Sefton, St Helens, Warrington or Wirral because the policies for these areas already say this.

For a full explanation of the proposed change to the definition of 'childlessness' in Cheshire East and Cheshire West please see consultation summary booklet.

Respondents were asked **"To what extent do you agree/disagree with the proposed change to the definition of 'childlessness' in Cheshire East and Cheshire West?"** The results were as follows:

Answer Choices	Responses	
Strongly agree	14%	183
Agree	18%	268
Neither agree nor disagree	25%	364
Disagree	18%	259
Strongly disagree	26%	384
	Answered	**1,458**

When looking at the responses from Cheshire East and Cheshire West for those who disagreed or strongly disagreed with the proposed change, responses were broadly in line with other areas, apart from St Helens which had a higher number of respondents indicating disagree/strongly disagree.

Not all respondents who answered this question chose to leave a comment to explain more about why they agreed or disagreed with the proposed policy change, and fewer again left a comment to describe the impact of the proposed policy change.

Common themes from all comments in response to the proposed change to the definition of 'childlessness' in Cheshire East and Cheshire West

Health and lifestyle - respondents across all categories emphasised the need for consistent policies across regions to avoid a 'postcode lottery'.

> *"It would be fair to have the same policy across the board instead of just having a postcode lottery."*

Allocation of NHS resources - some respondents discussed the importance of prioritising NHS resources for those who do not already have children, while others expressed concern about financial limitations.

> *"The NHS should help people have one child, but further children should be self-funded."*

There were mixed views on whether NHS should support treatment for additional children beyond the first.

> *"We would love a sibling for our child, but we understand the NHS has limited resources."*

Secondary infertility - some respondents highlighted the challenges of secondary infertility and called for case-by-case consideration.

"Just because we have one child doesn't mean we aren't struggling to conceive again."

“This again should be circumstantial. For example, if one person has a child from a previous relationship but wants to have a child with a new partner, I do not believe that they should be excluded.”

Emotional and ethical considerations - emotional and ethical concerns were raised about the psychological impact and fairness of the proposed policy.

"It feels like we're being punished for needing help to conceive."

“This proposal feels like a technicality used to withhold care, not a compassionate or patient-centred policy.”

Impact

In response to the question **‘Please use this space to let us know how the proposed change to the definition of ‘childlessness’ in Cheshire East and Cheshire West would impact you’** a small number of respondents expressed general dissatisfaction with the proposed policy changes, even if not directly impacted and objected to the definitions of childlessness, especially in blended families. ‘I do not agree with the definition of childlessness referring to any living child of either partner.’ In the opinion of some respondents, the impact of such a proposed policy would lead to anxiety and emotional distress.

Equally some respondents called for NHS fertility treatments and services to be applied consistently ‘I am childless and would like to start a family, but I cannot do so naturally. It would be unfair if someone who already is a parent got access to NHS fertility treatment, but that I as a childless person would have my opportunities limited due to this.’

Response to proposed change to IUI commissioning in Wirral

The proposed change

Currently in most areas of Cheshire and Merseyside, in line with NICE guidance, the use of NHS funded IUI is permitted for treating each of the following groups:

- People who are unable, or would find it difficult to, have vaginal intercourse because of a clinically diagnosed physical disability or psycho-sexual problem, who are using partner or donor sperm
- People with conditions that require specific consideration in relation to methods of conception (for example, after sperm washing where the man is HIV positive)
- People in same sex relationships

However, the Wirral policy currently states that IUI is not routinely commissioned, and this does not reflect NICE recommendations, nor is it consistent with neighbouring areas.

We are therefore proposing that the single Cheshire and Merseyside policy would allow NHS funded IUI in the groups listed above, across all areas. This change would not impact on the current requirement for self-funded IUI for same sex couples.

For a full explanation of the proposed change to IUI commissioning in Wirral *please see consultation summary booklet.*

Please note: an update was made to the consultation information and questionnaire on 6 June 2025. A previous version of the consultation information and questionnaire referred to proposed changes to the requirement for IUI before IVF treatment in Cheshire East, Cheshire West and Wirral. This was an error – the actual proposed change was for the new policy to allow NHS-funded IUI for a number of specific groups across Cheshire and Merseyside, when currently it is not routinely commissioned in Wirral. Analysis of comments indicates that this change made little or no difference to the responses received.

Respondents were asked **"To what extent do you agree/disagree with the proposed change to IUI commissioning in Wirral?"** The results were as follows:

Answer choices	Responses	
Strongly agree	19%	239
Agree	23%	292
Neither agree nor disagree	37%	469
Disagree	7%	85
Strongly disagree	14%	179
	Answered	**1,264**

Not all respondents who answered this question chose to leave a comment to explain more about why they agreed or disagreed with the proposed policy change, and fewer again left a comment to describe the impact of the proposed policy change.

Common themes from all comments in response to the proposed change to IUI commissioning in Wirral

Fairness and equality - fairness in access to fertility treatment was a recurring concern. Respondents emphasised that policies should not discriminate based on relationship type, geography, or personal circumstances.

"Everyone needs a fair chance"

Access for same-sex couples - many respondents, regardless of stance, highlighted the perceived inequality in requiring same-sex couples to self-fund IUI, calling for NHS-funded cycles for all.

"IUI should be free for same sex couples"

Consistency across regions - there was strong support for aligning policies to eliminate postcode-based disparities.

"Consistent criteria across the ICB"

IUI as a less invasive and cost-effective option - IUI was frequently described by respondents as a gentler and more affordable alternative to IVF, with many advocating for its use as a first-line treatment.

"IUI is often the first and less invasive treatment option... more physically and emotionally manageable than IVF."

Alignment with NICE guidelines - respondents supported aligning local policies with national NICE guidelines to ensure best practice and fairness, though some expressed confusion about selective adherence.

> ***"****You should not pick and choose which NICE guidelines to follow."*

Impact

In response to the question **'Please use this space to let us know how the proposed change to IUI commissioning in Wirral would impact you'** many comments repeated the themes above however, several responses highlighted specific concerns for medical conditions (e.g., Klinefelter syndrome, endometriosis, PCOS) that complicate fertility and increase reliance on assisted reproduction.

General additional comments

After answering questions around the five proposed changes, respondents were presented with an opportunity to provide any further information they wished to share. In response to the question "**Please use this space to share any additional information that you feel is relevant to the proposed changes to fertility treatment policies in Cheshire and Merseyside."** 514 people provided additional comments, sharing emotional, financial, and systemic concerns surrounding fertility treatment access. The most prominent theme was the emotional impact of infertility, with respondents describing their experiences.

Treatment experiences were the most frequently mentioned theme, with respondents describing IVF cycles, miscarriages, and clinical interactions. Many advocated for increased NHS support, with repeated calls for two IVF cycles to be available on the NHS. This overlapped with themes on advocacy for change and frustration with the system, where respondents criticised postcode-based inequalities and funding cuts.

Other significant themes included the financial burden of private IVF, with one respondent noting, *"I have had to secretly save all my wages all my life and never had a holiday because I wanted a baby."*

Concerns about discrimination and equality highlighted unequal treatment of same-sex couples and single women.

Response from health professionals

In response to the question **"If you are answering as a health professional, please use the space below to provide additional comments"** a total of 46 comments were received, offering a blend of clinical insight, personal experience, and policy critique. Many professionals highlighted the financial burden on both patients and the NHS, warning that underfunding IVF could lead to greater long-term costs. There were also reflections on the quality and availability of fertility services, with concerns about infrastructure and service provision.

Others emphasised the mental health impact, ethical concerns, and the importance of adhering to NICE guidelines. The comments also touched on equity and access, with professionals warning against postcode-based inequalities, and advocating for transparent communication and evidence-based policy implementation.

"I understand you need to save money however I strongly believe that underfunding IVF will cost the NHS more money. Please do more research into the cost of underfunding IVF

before making changes. In your consultation you have only looked at the money you will save by cutting cycles and it seems you haven't considered the true cost of cutting cycles. It will also make ethical decision making more difficult and negatively impact the mental health of patients requiring IVF treatment."

Further observations and considerations

In addition to the main findings outlined above, some further observations were made from the public consultation questionnaire responses:

Language and terminology – In some cases, comments received in the questionnaire indicated that there might be different interpretations of some key terminology. In particular, while the supporting information produced for the consultation outlined what an IVF cycle consisted of, this was potentially an area where respondents' understanding might have varied. It is therefore important that any future communications continue to clearly define key terms and definitions.

Rationale for proposals – While supporting information provided the rationale for each proposed change, in some cases this was not reflected in the responses people provided. For example, while the proposed change around BMI criteria was made in order to align the Wirral policy with the rest of Cheshire and Merseyside – and put it in line with clinical evidence – some respondents perceived this as representing a disadvantage to females, and didn't recognise the clinical rationale. Again, it is important that any future communications around this programme of work continue to clearly articulate the rationale behind any changes.

Evidence base – The summary booklet provided clinical evidence and rationale for each proposal, however, some respondents also quoted their own evidence, for example around the success rates of fertility treatments. While we have not quoted these figures in this report, we have included the sentiments expressed by respondents in the themes presented above.

Next steps

- This report was produced by the NHS Cheshire and Merseyside's communications and engagement team, which was also responsible for leading the consultation activity. It will be presented to the Board of NHS Cheshire and Merseyside, along with a final proposal for the policy.

- Once the Board has made a decision about what happens next, NHS Cheshire and Merseyside will share further information.

- If the proposed change to the number of NHS-funded IVF cycles goes ahead, there would be no change for people who had already been told by the Hewitt Fertility Centre how many cycles they would be entitled to during their care. Therefore, there would be no impact mid-treatment. However, any future change would apply to people who had not yet started their care with the Hewitt Fertility Centre at the point a decision to change the policy was made.

Ends.

Appendices

Appendix A – Consultation questionnaire

Proposed changes to fertility treatment policies in Cheshire and Merseyside

This questionnaire is for you to share your views on NHS Cheshire and Merseyside's proposal for a single subfertility policy.

Currently, there are ten separate policies covering NHS fertility treatments for people in Cheshire and Merseyside. These are called NHS Funded Treatment for Subfertility policies. You can view them at: https://www.cheshireandmerseyside.nhs.uk/your-health/clinical-policies/. Simply scroll to the map at the end of the page and click on the area you want to see the policy for.

NHS Cheshire and Merseyside is proposing a new single policy for the whole of Cheshire and Merseyside. The new policy would include a number of changes based on the latest national guidance, but we are also proposing to make some changes for financial reasons. This includes reducing the number of in vitro fertilisation (IVF) cycles the NHS funds (pays for).

You should read the supporting information booklet before answering this questionnaire. You can find the booklet on the NHS Cheshire and Merseyside website by clicking here.

If you wish to respond to this consultation on behalf of a group, charity or organisation, send your response via email to engagement@cheshireandmerseyside.nhs.uk

How will my information be used?
Your responses to these questions are anonymous - we don't link this information with anything that identifies you. We might use comments you make in our consultation report, which will be published on the NHS Cheshire and Merseyside website. Again, these won't be linked to you.

Your data will be treated confidentially and stored in accordance with Data Protection law and NHS Cheshire and Merseyside's Privacy Notice. You can read NHS Cheshire and Merseyside's Privacy Notice at Privacy Notice - NHS Cheshire and Merseyside

Any questions marked with a * are must answer questions.
Thank you.

Q1. I am completing this questionnaire as (tick as many as apply): *Please note this questionnaire is intended for individual responses. If you are helping someone else to complete this questionnaire, please answer all the questions on their behalf rather than your own.*

- Someone who has accessed (or is accessing) NHS fertility treatment, either personally or as a partner/spouse.
- The carer of someone who has accessed (or is accessing) NHS fertility treatment.
- A relative/friend of a patient who has accessed (or is accessing) NHS-funded IVF (in vitro fertilisation) in Cheshire and Merseyside

- I am interested in responding, but I haven't had experience of NHS-funded IVF (in vitro fertilisation) in Cheshire and Merseyside as a patient/partner/spouse/relative/friend
- Someone who has accessed (or is accessing) or are aware of someone else (partner/spouse, family member, etc.) who has accessed (or is accessing) privately funded IVF (in vitro fertilisation) in Cheshire and Merseyside
- I am a health professional working in NHS fertility service in Cheshire and Merseyside. (You will have an opportunity to complete a section for health professionals later in the questionnaire).
- Other. Please state:

Q2. Where do you live?

- Cheshire East
- Cheshire West
- Halton
- Knowsley
- Liverpool
- Sefton
- St Helens
- Warrington
- Wirral
- Outside of Cheshire and Merseyside (please specify)

Proposed changes

In the next five sections, you'll have the opportunity to share your views on each of the following proposed changes to fertility treatment policies:

- A change to the number of IVF cycles that are funded
- A change to the BMI (body mass index) eligibility criteria in Wirral
- A change to the eligibility criteria related to smoking
- A change to how 'childlessness' is defined in Cheshire East and Cheshire West
- A change that would require IUI (intrauterine insemination) before accessing IVF in Cheshire East, Cheshire West, and Wirral

If you don't want to comment on this change, click 'Next Page' to continue.

Change to the number of IVF cycles that are funded

We are proposing that in the new policy, everyone in Cheshire and Merseyside who is eligible for IVF would have one cycle paid for by the NHS.

If the change went ahead, it would mean that the number of cycles of IVF paid for by the NHS would reduce for people aged up to 39 in all areas of Cheshire and Merseyside, except in Cheshire East, where it would stay the same as it is now.

There would be no change for people aged between 40 and up to 42, as they are already offered one cycle in all of our areas.

Why are we proposing this?

We believe that moving to a single IVF cycle across our area is the best way to continue providing this treatment, while making sure that it remains affordable for the NHS.

We also want to ensure that people are offered the same number of NHS funded IVF cycles, wherever in Cheshire and Merseyside they live or are treated, which isn't the case at the moment.

Q3. To what extent do you agree/disagree with the proposed change to the number of IVF cycles that are funded?

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Q4. Please use this space to explain more about your answer to the question above.

Q5. Please use this space to let us know how the proposed change to the number of IVF cycles that are funded would impact you.

If you don't want to comment on this change, click 'Next Page' to continue.

Change to eligibility on BMI (body mass index) in Wirral

BMI (body mass index) is a measure of whether you are a healthy weight for your height.

Currently, nine out of ten Cheshire and Merseyside policies state that women need to have a BMI of between 19 and 29.9 in order to begin NHS fertility treatment. In Wirral the policy says that a male partner should also meet this BMI in order for a couple to be eligible.

We are proposing that the new Cheshire and Merseyside policy would state that women intending to carry a pregnancy need a BMI of between 19 and 29.9 for fertility treatment to begin and men with a BMI of more than 30 would be advised to lose weight to improve their changes of conceiving, but this would not necessarily be a barrier to the couple accessing NHS fertility treatment.

If the new single policy was introduced, it would mean that in the future people living in Wirral would have the same access to fertility treatment based on BMI as people in other parts of Cheshire and Merseyside.

Why are we proposing this?

To bring our local approach in line with national guidance, and to ensure that the same approach is taken for everyone across Cheshire and Merseyside.

Q6. To what extent do you agree/disagree with the proposed change to the eligibility on BMI (body mass index) in Wirral?

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Q7. Please use this space to explain more about your answer to the question above.

Q8. Please use this space to let us know how the proposed change to the eligibility on BMI (body mass index) in Wirral would impact you.

If you don't want to comment on this change, click 'Next Page' to continue.

Change to eligibility on smoking
If the new single policy was introduced, it would mean that in future people in Halton, Knowsley, Liverpool, Sefton and St Helens would not be eligible for NHS funded fertility treatment if either partner was a current smoker.

This wouldn't be a change for people in Cheshire East, Cheshire West, Wirral or Warrington, because the policies for these areas already say this.

Why are we proposing this?

To bring our local approach in line with national guidance, and to ensure that the same approach is taken for everyone across Cheshire and Merseyside.

Q9. To what extent do you agree/disagree with the proposed change around smoking and eligibility?

- Strongly agree
- Agree
- Neither agree nor disagree

- Disagree
- Strongly disagree

Q10. Please use this space to explain more about your answer to the question above.

Q11. Please use this space to let us know how the proposed change around smoking and eligibility would impact you.

If you don't want to comment on this change, click 'Next Page' to continue.

Definition of 'childlessness' in Cheshire East and Cheshire West
If this change went ahead, it would mean that people in Cheshire East and Cheshire West would no longer be offered more embryo transfers once they have become a parent.

This would not be a change for people living in Halton, Knowsley, Liverpool, Sefton, St Helens, Warrington or Wirral because the policies for these areas already say this.

Why are we proposing this?
To ensure that the same approach is taken for everyone across Cheshire and Merseyside and be consistent with the majority of other areas across England.

Q12. To what extent do you agree/disagree with the proposed change to the definition of 'childlessness' in Cheshire East and Cheshire West?

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Q13. Please use this space to explain more about your answer to the question above.

Q14. Please use this space to let us know how the proposed change to the definition of 'childlessness' in Cheshire East and Cheshire West would impact you.

If you don't want to comment on this change, click 'Next Page' to continue.

Change to IUI commissioning in Wirral
Currently in most areas of Cheshire and Merseyside, in line with NICE guidance, the use of NHS funded IUI is permitted for treating each of the following groups:

- People who are unable, or would find it difficult to, have vaginal intercourse because of a clinically diagnosed physical disability or psycho-sexual problem, who are using partner or donor sperm
- People with conditions that require specific consideration in relation to methods of conception (for example, after sperm washing where the man is HIV positive)
- People in same sex relationships

However, the Wirral policy currently states that IUI is not routinely commissioned, and this does not reflect NICE recommendations nor is it consistent with neighbouring areas.

We are therefore proposing that the single Cheshire and Merseyside policy would allow NHS funded IUI in the groups listed above, across all areas.

This change would not impact on the current requirement for self-funded IUI for same sex couples.

This would mean NHS funded IUI is only offered to those patients who meet the above criteria, in line with NICE guidance. However, with such low numbers of patients accessing IUI, we believe that there would be minimal impact on people if this change went ahead.

Q15. To what extent do you agree/disagree with the proposed change to IUI commissioning in Wirral?

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Strongly disagree

Q16. Please use this space to explain more about your answer to the question above.

Q17. Please use this space to let us know how the proposed change to IUI commissioning in Wirral would impact you.

Q18. Please use this box to share any additional information that you feel is relevant to the proposed changes to fertility treatment policies in Cheshire and Merseyside.

Q19. If you are answering as a health professional, do you have any further comments you wish us to take into consideration. *

- This question does not apply to me
- Yes, I would like to make a further comment
- No, I do not wish to make a further comment

Q20. If you are answering as a health professional, please use the space below to provide additional comments.

Q21. Where did you hear about this questionnaire (tick all that apply)?

- An email or text from the NHS.
- Social media (Facebook, X etc.).
- NHS website (for example, NHS Cheshire and Merseyside or hospital trust website).
- Through a patient group and/or voluntary sector organisation I am connected to.
- NHS staff communication
- Friend or family member
- I don't know
- Other (please state)

Equality monitoring questions.

To make sure we deliver our services in a fair way for everybody, we would also like to ask you to provide a little bit of information about yourself. However, you do not have to complete this section if you would prefer not to.

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

Your data will be treated confidentially and stored in accordance with Data Protection law and NHS Cheshire and Merseyside Privacy Notice.

Thank you.

Q22. Are you happy to complete this section to help us better understand who we are reaching? *

- Yes
- No

Respondents who answered 'yes' were then directed to a detailed set of equalities questions. A breakdown of the responses is included as Appendix D.

Ends.

Appendix B - Media

Media Coverage (3 June – 15 July 2015)

1. **Local and regional media**

Media title & date	**Link**
BBC News 12 July 2025	Merseyside and Cheshire IVF rules on smoking and vaping to tighten - BBC News
Cheshire Live 24 June 2023	Major blow could be dealt to women seeking IVF treatment in Cheshire borough
Runcorn and Widnes World 23 June 2025	Number of IVF cycles for Halton women could be reduced
Warrington Worldwide 23 June 2025	MP opposes proposed changes to fertility treatment in Warrington
Liverpool Echo 22 June 2025	'Hardship and heartache' as Merseyside IVF NHS cycles to be slashed
Warrington Guardian 20 June 2025	Warrington South MP opposes proposed IVF cuts
St Helens Star 18 June 2025	NHS plan to reduce rounds of IVF treatment in Cheshire and Merseyside
Southport Lead 15 June 2025	IVF options slashed for couples in £1.3m money-saving plan
Knowsley News 9 June 2025	Share your views on proposed changes to fertility treatment policies
Runcorn Widnes and World 9 June 2025	Consultation opens on proposed changes to fertility treatment policies
Warrington Guardian 8 June 2025	Consultation opens on proposed changes to fertility treatment policies
Warrington Worldwide 4 June 2025	Fertility treatment: public asked for their views - Warrington Worldwide
BBC North West Tonight 3 June 2025	Brief mention as read out on 6.30pm, 10.30pm

2. Fertility news sites

Fertility Network UK	Have Your Say; Proposed changes to fertility treatment policies in Cheshire and Merseyside | Fertility Network

Fertility Fusion	Fertility Fusion | News
Fertility Insider	New plans for just one round of IVF funded by NHS in Warrington instead of three | Fertility Insider

3. NHS and partner websites

Organisation	**Link**
Liverpool Women's	Public asked for views on proposed changes to fertility treatment policies - Liverpool Womens NHS Foundation Trust
Hewitt Fertility Centre	Public asked for views on proposed changes to fertility treatment policies | The Hewitt Fertility Centre
Alder Hey Children's Hospital	Public asked for views on proposed changes to fertility treatment policies - Alder Hey Children's Hospital Trust
Clatterbridge Cancer Centre	Public asked for views on proposed changes to NHS fertility treatment policies in Cheshire and Merseyside :: The Clatterbridge Cancer Centre
Countess of Chester Hospital	NHS Cheshire and Merseyside launches consultation on proposed changes to fertility treatment policies | Countess of Chester Hospital
Healthwatch Cheshire East	Consultations - Healthwatch Cheshire East
Healthwatch Halton	Public asked for views on proposed changes to fertility treatment policies. | Healthwatch Halton
Healthwatch St Helens	Consultation Launched On Proposed Changes To Fertility Treatment Policies In Cheshire And Merseyside | Healthwatch Sthelens
Healthwatch Sefton	Share your views on proposed changes to fertility treatment policies in Cheshire and Merseyside - Healthwatch Sefton

Ends.

Appendix C - Fertility Action meeting notes and submission

Meeting notes: Public consultation - proposed changes to fertility treatment policies in Cheshire and Merseyside

Meeting between NHS Cheshire and Merseyside and Fertility Action

Meeting date: 9 July 2025

Held online

Attendees

3 representatives from Fertility Action Charity
4 staff from NHS Cheshire and Merseyside

Purpose of the meeting

The meeting was arranged to discuss the proposed changes to fertility treatment policies in Cheshire and Merseyside

Context

NHS Cheshire and Merseyside Integrated Care Board (ICB) is responsible for planning local health care services.

Currently, there are ten separate policies covering NHS fertility treatments for people in Cheshire and Merseyside who are having problems getting pregnant. Because there are some variations in these policies, it means that people's access to fertility treatments depends on where they live.

NHS Cheshire and Merseyside is proposing a new, single policy for the whole of Cheshire and Merseyside, which would mean that everyone would get equal access to treatment.

The new policy would include a number of changes based on the latest national guidance, but some changes are also being proposed for financial reasons. This includes reducing the number of in vitro fertilisation (IVF) cycles the NHS funds.

The policy is pending updated National Institute for Health and Care Excellence (NICE) guidelines, which have been delayed. When this new guidance comes out, NHS Cheshire and Merseyside will review it again to make sure the policy is up to date with the latest medical evidence.

Key themes raised by Fertility Action representatives:

- **Equity and access:** Concerns were raised about inequitable access for LGBTQ+ individuals and single people. It was pointed out that same-sex couples are required to self-fund six cycles of IUI before qualifying for NHS-funded treatment, and male same-sex couples and people in varying family formations are currently excluded from consideration.
- **Time sensitivity:** The importance of quick turnaround time between testing and treatments was emphasised, particularly as age is so critical to fertility, with reports of patients experiencing delays and having to repeat tests due to long NHS waiting times for treatments.

- **Mental health impacts:** The psychological toll of infertility and reducing access to treatment was discussed, with this linked to potential additional pressure on mental health services, affecting both men and women.
- **Falling fertility rate**: It was noted that the proposal to reduce the number of IVF cycles is being made at a time when there is a national and global fall in fertility rates, as well as going against the recommendation within NICE guidelines.
- **Male fertility and primary care education:** Insights were offered about the lack of understanding of male fertility issues in primary care issues, which it was suggested could be leading to secondary care fertility referrals which ultimately prove unsuccessful. The importance of improving early male fertility testing in primary care to reduce unnecessary secondary care fertility referrals was highlighted. It was argued that this could save ICBs money in the long term.
- **Cycle definitions and embryo banking:** Questions were raised about embryo banking and whether new egg collections are allowed before all frozen embryos from an individual cycle have been transferred. It was noted that there were disparities in the approach to this between ICBs across the country. It was stated that 80.6% of GP's surveyed by Fertility Action had little or no education on male fertility.
- **Policy communication and clarity:** The need for the new policy to include clearer language and patient guidance was highlighted.

Next Steps

- Fertility Action will continue promoting the consultation and may host a recorded support group to gather more feedback – time allowing.
- Fertility Action to share any relevant information and research e.g. around male fertility factors.
- The NHS team is open to reviewing language and clarity in new policy.
- Although outside the scope of this consultation, there was recognition of the opportunity to explore a more holistic, end-to-end fertility pathway, which also considers primary care education and referral processes.

Submission from Fertility Action Charity on the Proposed IVF Policy Change – Cheshire & Merseyside ICB Consultation (June 2025)

4th June 2025

Dear Cheshire & Merseyside ICB,

On behalf of **Fertility Action Charity**, we write to express our strong opposition to the proposed change in the IVF funding policy that would reduce provision across Cheshire & Merseyside to **one NHS-funded cycle**.

This change represents a serious and unjustified "**levelling down" of care**. Equalising access to IVF should be about **raising the standard** of care across all boroughs, not aligning to the **lowest common provision**. Equality in healthcare should mean **equal access to adequate treatment**, not equal access to inadequate care.

As one of our founding Trustees Dr Carole Gilling-Smith says "there is no justification for the NHS to exclude fertility treatment from funding when NICE guidelines clearly state that 3 cycles of IVF should be offered in cases where fertility is unexplained or due to male factor, tubal disease etc. This is based on reasonable cumulative rates of conception being achieved after 3 fresh cycles and all associated frozen cycles as opposed to a single cycle".

Why This Proposal Is Harmful:

1. It undermines the principles of the NHS

The NHS was founded on the principle of providing care based on **clinical need, not postcode or personal wealth**. Infertility is a recognised medical condition by the **World Health Organization**, and IVF is a **medically recommended treatment** for around 1 in 6 people - we must stop treating it as an elective luxury. The current proposal contradicts these principles by restricting access to those who cannot afford private care and reducing medically supported options for those who need more than one cycle to conceive.

2. It will worsen mental health outcomes

We have submitted evidence of the **extreme emotional and psychological toll** of infertility and unsuccessful treatment. Our charity supports **around 40-50 people** across Cheshire & Merseyside in our support groups, and that number is **rapidly growing**. Many of these individuals are navigating not only the physical and financial demands of fertility treatment but also the **devastating emotional aftermath** of failed IVF attempts.

The idea that one funded cycle is enough is **clinically and psychologically out of step** with the lived experience of those undergoing treatment. The NICE guideline clearly recommends **up to three cycles** for women under 40, because success rates improve significantly with multiple cycles. Reducing access to only one undermines both science and compassion.

3. It deepens health inequality rather than achieving your desired "fair approach for everyone"

If implemented, the "one cycle" model would **strip access from those who previously qualified for two or three cycles**, while **failing to raise the standard** for those with only one. This is not equity - it's austerity masked as fairness.

In reality, this policy would **create a two-tier system**:

- Those who can afford private IVF will continue treatment.
- Those who can't will face the trauma of halted care after a single failed attempt.

This disproportionately affects **low-income families, minority ethnic groups, and those already facing barriers to healthcare access**, including single people, members of the **LGBTQIA+ community** and those with medical complexities.

4. It disregards clinical evidence and established medical guidelines

The **NICE guidance** (CG156) recommends up to **three full IVF cycles** for eligible women under 40 because this significantly increases the chance of success. It also reduces emotional stress, as couples are not burdened with the unrealistic expectation that IVF must work on the first try. Success rates increase significantly (~62%) with 3 cycles whilst offering fewer cycles leads to worse outcomes and wasted investment. This is a long-term investment which leads to taxpayers and contributors to the economy - which in a country with a severely declining Fertility Rate - is something we need to seriously consider. It is important to consider also that this will encourage increased reliance on unregulated or unsafe overseas fertility options.

5. It undermines trust in the NHS

When guidelines like those from NICE are ignored or inconsistently applied, it not only damages the trust in the fairness and integrity of the NHS, but it also signals to the public that their needs are secondary to short-term budget concerns. Fertility treatments are continually under-prioritised.

Other Considerations

1. Male fertility needs focus

Evidence shows that **education surrounding male fertility and preliminary testing/early diagnosis is extremely poor in the UK currently** (with 80% of GP's that we surveyed saying they have no education on this topic. We know that men contribute to up to 50% of infertility/sub-fertility diagnosis, and have recently sent this submission to The Men's Health Strategy to highlight this important issue.

2. Other countries provide better - the UK is falling behind

Sweden, Finland, Denmark and France all offer more cycles, better access and include single people and those from the LGBTQIA+ community, setting an international standard of

reproductive support. The UK appears increasingly regressive in stark comparison sending a message that only certain family make-ups are “worthy” of support. Surely our country can do better.

3. We’re not listening to the people who are affected

Our support groups are growing, and we are continually hearing stories of serious mental health impacts. Male fertility is drastically declining. Nutritional and holistic practitioners are telling us that lifestyle factors and choices might improve chances. Research is showing us that DNA Fragmentation testing might avoid recurrent baby loss in females. Fertility and Reproductive Health needs so much more conversation, education and understanding.

What Should Happen Instead:

- Maintain a **minimum of two funded IVF cycles** across all boroughs as a baseline, aligning with the most common current offer in Cheshire & Merseyside.
- Create a plan to **expand toward the NICE-recommended three cycles** in future phases.
- Conduct **further consultation with lived-experience groups**, including the voices of the 40–50 individuals we support weekly, who face infertility with resilience but need a system that doesn’t give up on them after one try.
- Ensure **equity-enhancing policies** that support people from **diverse socioeconomic, racial, cultural, and sexual backgrounds** who are already underrepresented in successful fertility outcomes.

Final Statement from Katie Rollings, Founder & CEO of Fertility Action:

Reducing funded IVF cycles to a single attempt is not equality - it is, simply put, **levelling-down** medical treatment. In the name of “consistency,” we risk making care worse for thousands of people across Cheshire & Merseyside who already face tremendous barriers and trauma in accessing fertility treatment.

We urge the Board to reconsider this proposal and uphold the NHS’s duty to provide **evidence-based, compassionate, and equitable** care to all who need it.

Yours sincerely,

Katie Rollings

Founder & CEO
Fertility Action Charity

katie@fertilityaction.org
www.fertilityaction.org
Registered Charity number: 1212260

Ends.

Appendix D - Equality monitoring responses

Please note.

- To simplify tables and presentation percentages have been rounded up or down to the nearest whole number.
- Some tables use one percentage decimal point to ensure small groups are represented. Therefore, percentages do not always add to 100 because of rounding errors.

I am completing this questionnaire as (tick as many as apply):

Answer Choices	Responses	
Someone who has accessed (or is accessing) NHS fertility treatment, either personally or as a partner/spouse	38%	804
The carer of someone who has accessed (or is accessing) NHS fertility treatment	0.4%	9
A relative/friend of a patient who has accessed (or is accessing) NHS fertility treatment	34%	712
Someone who has accessed (or is accessing) privately funded IVF (in vitro fertilisation)	9%	187
Someone interested in responding, but without personal experience of fertility treatment.	26%	544
A health professional working in fertility services in Cheshire and Merseyside. (You will have an opportunity to complete a section for health professionals later in the questionnaire.)	4%	79
Other (please specify)	4%	82
	Answered	**2121**
	Skipped	**3**

N.B. Respondents taking part in the questionnaire could self-select more than one category therefore percentages don't add up to 100.

Where do you live?

Answer Choices	Responses	
Cheshire East	6%	120
Cheshire West	9%	197
Halton	7%	143
Knowsley	6%	132
Liverpool	20%	429
Sefton	12%	244
St Helens	12%	246
Warrington	12%	258
Wirral	8%	159
Outside of Cheshire and Merseyside (please specify)	9%	191
	Answered	**2119**
	Skipped	**5**

Where did you hear about this questionnaire (tick all that apply)?

Answer Choices	Responses	
An email or text from the NHS.	6%	90
Social media (Facebook, X etc.).	49%	775
NHS website (for example, NHS Cheshire and Merseyside or hospital trust website).	6%	87
Through a patient group and/or voluntary sector organisation I am connected to.	5%	86
NHS staff communication	6%	99
Friend or family member	34%	532
I don't know	0.7%	11
Other (please specify)	5%	76
	Answered	**1575**
	Skipped	**549**

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

Answer Choices	Responses	
White: English/Welsh/Scottish/Northern Irish/British	94%	1062
White: Irish	0.8%	9
White: Gypsy or Irish Traveller	0.1%	1
White: Any other White background (please specify below)	2.4%	27
Mixed/Multiple ethnic groups: White and Black Caribbean	0.2%	2
Mixed/Multiple ethnic groups: White and Black African	0.2%	2
Mixed/Multiple ethnic groups: White and Asian	0.4%	5
Mixed/Multiple ethnic groups: Any other Mixed/Multiple ethnic background (please specify below)	0.1%	1
Asian/Asian British: Indian	0.4%	4
Asian/Asian British: Pakistani	0.2%	2
Asian/Asian British: Bangladeshi	0.1%	1
Asian/Asian British: Chinese	0.0%	0
Asian/Asian British: Any other Asian background (please specify below)	0.2%	2
Black/African/Caribbean/Black British: African	0.3%	3
Black/African/Caribbean/Black British: Caribbean	0.2%	2
Black/African/Caribbean/Black British: Any other Black/African/Caribbean background (please specify below)	0.1%	1
Other ethnic group: Arab	0.0%	0
Prefer not to say	0.4%	5
Any other ethnic group (please specify below)		20
	Answered	**1129**
	Skipped	**995**

How old are you?

Answer Choices	Responses	
Under 18	0%	0
18-24	2%	24
25-34	45%	507
35-44	33%	372
45-54	8%	94
55-64	8%	88
65-69	2%	21
70-74	0.9%	10
75-79	0.1%	1
80 and over	0.3%	3
Prefer not to say.	0.4%	5
	Answered	**1125**
	Skipped	**999**

What is your religion or belief?

Answer Choices	Responses	
No religion	51%	570
Christian (including Church of England, Catholic, Protestant and all other Christian denominations)	47%	520
Buddhist	0.2%	2
Hindu	0%	0
Jewish	0.3%	3
Muslim	0.4%	4
Sikh	0.1%	1
Prefer not to say	2%	18
Any other religion (please specify)		6
	Answered	**1118**
	Skipped	**1006**

How do you identify?

Answer Choices	Responses	
Male	8%	94
Female	91%	1017
Trans-Man	0%	0
Trans-Woman	0%	0
Non-binary	0.3%	3
Gender-non-conforming	0.1%	1
Prefer not to say	0.5%	6
Other (please specify)		3
	Answered	**1121**
	Skipped	**1003**

What is your sexual orientation?

Answer Choices	Responses	
Heterosexual	90%	1012
Lesbian	3%	39
Gay	0.3%	3
Bisexual	4%	47
Asexual	0.4%	4
Prefer not to say	2%	19
Other (please specify)		3
	Answered	**1124**
	Skipped	**1000**

What is your relationship status?

Answer Choices	Responses	
Married	59%	661
Civil Partnership	2%	17
Single	9%	100
Lives with Partner	26%	298
Separated	0.5%	6
Divorced	2%	21
Widowed	0.5%	6
Prefer not to say	1%	17
Other (please specify)		5
	Answered	**1126**
	Skipped	**998**

The equality Act 2010 protects people who are pregnant or have given birth within 26-week period. Are you pregnant at this time?

Answer Choices	Responses	
Yes	8%	91
No	91%	1022
Prefer not to say	1%	13
	Answered	**1126**
	Skipped	**998**

Have you recently given birth? (Within the last 26-week period)

Answer Choices	Responses	
Yes	5%	51
No	94%	1062
Prefer not to say	1%	14
	Answered	**1127**
	Skipped	**997**

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

Answer Choices	Responses	
Yes, limited a lot	4%	45
Yes, limited a little	10%	113
No	86%	968
	Answered	**1126**
	Skipped	**998**

Do you consider yourself to have a disability? (The Equality Act 2010 states a person has a disability if they have a physical or mental impairment which has a long-term (12-month period or longer) or substantial adverse effects on their ability to carry out day-to-day activities).

Answer Choices	Responses	
Physical disability (please describe)	3%	36
Sensory disability e.g., Deaf, hard of hearing, Blind, visually impaired (please describe below)	1%	14
Mental health condition	4%	42
Learning disability or difficulty	1%	16
Long-term illness e.g., cancer, diabetes, COPD (please describe below)	5%	50
Prefer not to say	4%	39
No, I do not consider myself to have a disability	82%	914
Other (please describe)		67
	Answered	**1111**
	Skipped	**1013**

Do you provide care for someone? A carer is defined as anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support (Tick as many as appropriate)

Answer Choices	Responses	
Yes - Care for young person(s) aged 24 and under	6%	63
Yes - Care for adult(s) aged 25 to 49	2%	17
Yes - Care for older person(s) aged 50 and over	7%	76
No	85%	952
Prefer not to say	2%	20
	Answered	**1120**
	Skipped	**1004**

Have you ever served in the armed services?

Answer Choices	Responses	
Yes	0.62%	7
No	99%	1108
Prefer not to say	0.80%	9
	Answered	**1124**
	Skipped	**1000**

Ends.

27 November 2025
ICB Board Meeting
Agenda item: ICB/11/25/16

APPENDIX THREE

Equality Impact Assessment (EIA)

Proposal: Introduction of a Single Interim Subfertility Policy for Cheshire and Merseyside

1. Introduction and Proposal Summary

NHS Cheshire and Merseyside ICB proposes to replace ten existing local subfertility policies with a single, interim policy to standardise access across to fertility services across the region. The primary driver is to ensure equitable access, while also achieving essential financial savings to stabilise the local health system.

The key proposed changes are:
1. Standardise NHS-funded IVF cycles to one full cycle for all eligible patients (a reduction for most areas).
2. Align BMI eligibility criteria in Wirral with the rest of the region (removing the requirement for male partners to meet BMI criteria).
3. Standardise smoking eligibility so both partners must be non-smokers across all areas (a new requirement in five areas).
4. Revise the definition of 'childlessness' in Cheshire East and West to exclude those who have had a live birth or adopted a child from further embryo transfers.
5. Commission IUI in Wirral for specific groups, aligning with NICE guidance and other areas.

This EIA has been revised in light of the extensive feedback from the public consultation (3 June – 15 July 2025), which received 2,124 responses. The EIA draws on the data provided by those who shared their demographic details, please note not all respondents answered these questions. (The skip rate on these questions, were between 995 and 1013).

2. Summary of Consultation Findings Relevant to Equality

The strength of opposition across all protected groups, particularly women, disabled people, and those from lower socio-economic backgrounds, underscores the disproportionate impact of the proposed policy. The consultation responses provide compelling evidence of lived experience, emotional distress, and systemic disadvantage. This feedback is a critical source of equality intelligence that must inform decision-making.

The consultation revealed profound concerns regarding the equitable impact of the proposals, particularly the reduction in IVF cycles.

- Overwhelming Opposition: 86% of respondents (1,532 people) disagreed or strongly disagreed with the reduction to one IVF cycle. All protected groups consistently opposed the proposal.

- Lived Experience: 72% of respondents had direct personal experience with subfertility treatment (as patients, partners, or close relatives), lending significant weight to the feedback.

Key Equality Themes (see Appendix A- consultation equality analysis). Respondents highlighted potential for:

- Indirect Discrimination: Against women, people with disabilities, racially minoritised and those from lower socio-economic backgrounds.
- Widening Inequalities: Creating a two-tier system where only those who can afford private treatment have a realistic chance of conceiving.
- Adverse Mental Health Impacts: The emotional toll of subfertility would be exacerbated by the pressure of a single cycle.
- Lack of Reasonable Adjustment: A blanket one-cycle policy fails to account for individual circumstances.

3. The Financial and Legal Context: Proportionality and Due Regard

The Financial Imperative -
The ICB is operating under significant financial pressures. The proposal to offer a single cycle of IVF is based on a legitimate objective: achieving necessary financial savings. Given the current financial constraints, the ICB must prioritise commissioning decisions and allocate funding to the most critical areas to ensure the long-term financial sustainability of the local NHS.

The Public Sector Equality Duty (PSED) in a Financial Crisis -
The PSED under Section 149 of the Equality Act 2010 is a continuous duty and is not suspended during a financial emergency. The duty to have "due regard" to the need to eliminate discrimination, advance equality of opportunity, and foster good relations is at its most critical when making difficult decisions that cause harm. While saving money is a legitimate aim, it cannot be the only consideration.

Decision-makers must:

1. Properly understand the equality impacts. (Appendix A -Consultation Equality Analysis)
2. Consider all possible mitigations to reduce those impacts.
3. Consciously weigh the equality impacts against the financial imperative in a proportionate way.

4. Detailed Equality Analysis and Consideration of Mitigations

The following analysis applies a structured equality lens to each protected characteristic, identifying potential negative impacts, potential mitigations, and proportionality considerations. It is important to note that many impacts intersect—particularly those related to sex, disability, race, and socio-economic status. These intersections compound disadvantage and must be considered holistically, not in isolation.

This analysis assesses the impact of the proposal against the three aims of the PSED and documents the consideration of mitigations.

Protected characteristic	Potential Negative Impact & Evidence	Potential Mitigation & Actions	Points of consideration for decision makers
Age	Severe negative impact for women under 40. Feedback stressed that IVF success often requires multiple cycles. The pressure of a single cycle could cause significant psychological distress. Women's most fertile period coincides with the crucial period for becoming established in a career. As a result, many women delay childbearing then some may suffer consequences in struggling to conceive as subfertility decreases Waiting lists or other operational issues might reduce the time available for multiple attempts.	Strengthen signposting to mental health support. Commit to a full review once new NICE guidance is published. Consider: maintaining two cycles for all patients. For the full policy review, work with our provider to understand delays and waiting lists.	The severe impact is acknowledged. The interim nature as a partial mitigation. The financial and equity imperatives are deemed as a legitimate aim. Decision makers to consider maintaining two cycles and weight the harm with its duty to make system wide financial savings Consider mitigations in light of consultation findings.
Disability	Negative impact. Respondents with conditions like PCOS, endometriosis highlighted that BMI criteria can create a significant barrier Disabled people are more likely to have low incomes and therefore are less likely to self-fund. Overall disabled people and people with impairments strongly opposed the proposal for one cycle.	Strengthen signposting to weight management support services Ensure access to appropriate gynaecological services If there was clinical exceptionality around patients with disabilities, the IFR process would be in place.	Decision makers to note the negative impact for disabled people.
Sex	Significant and disproportionate	Acknowledge the disproportionate	The severe disproportionate

	negative impact on women. Women bear the physical and emotional burden of treatment. The cycle reduction disproportionately targets women's healthcare. Significant opposition to the proposal from both women and men. (Appendix A)	impact in communications. Ensure support services are tailored to women's needs.	impact is acknowledged. The service is, by nature, disproportionately accessed by women. The mitigations of clear communication and tailored support are accepted. The aim of creating a single, equitable regional policy is considered a legitimate and proportionate counterweight, despite the negative impact. Decision makers to consider mitigations in light of the findings.
Race	Substantial risk of adverse impact. HFEA data shows Black patients start treatment later (avg. 36.4 yrs) and have the lowest success rates (e.g., 23% live birth rate for Black patients aged 30-34 vs. 30% for White patients). A single cycle policy limits the opportunity to overcome these systemic disparities. Cultural, linguistic, and trust barriers can also delay presentation, reducing the window for successful treatment. The proposals risk undermining trust between minority communities and the NHS.	Mitigating action - Work with community partners to ensure clear, accessible communications about the policy and pathways to care. Mitigating action – The working group reviewed data on child mortality in BAME groups to help develop the storage periods in the interim policy. Aim to ensure a targeted involvement model supports the future review of the policy. Work with the provider to understand what	The risk of exacerbating existing health inequalities and disproportionate impact is acknowledged and should be taken into consideration by decision makers.

		data they are collecting around ethnicity to support the future review. Mitigating action - Ensure communication is transparent.	
Sexual orientation	Significant negative impact from the continued requirement for same-sex couples to self-fund IUI. This was widely perceived as systemically discriminatory factor and falls outside of the current scope of the consultation.	Consider specific mitigations for same-sex couples as per the Women's Health Strategy. This issue is currently outside the financial and scope parameters of this harmonisation specific review.	The discrimination is acknowledged. The commitment to a priority review of this specific issue is a critical mitigation, making the interim policy a proportionate stepping stone to a fairer system.
Religion and belief	Religion or Belief - potential for conflict and distress. While no specific consultation insight was raised, some religious positions (e.g., Catholicism) may morally object to IVF, while others (e.g., Judaism) may strongly encourage it. The policy may cause internal conflict for some, and the reduction in cycles may be particularly distressing for those from communities where there is high cultural or religious pressure to have children. The potential for indirect impact via community pressure is acknowledged. The mitigation of culturally competent care is a proportionate and	Ensure patient care is sensitive to diverse religious and belief systems. Support clinical staff to have sensitive conversations with patients about their beliefs in the context of treatment. The policy is neutral in its application to religion or belief.	The policy is neutral in its application to religion or belief. The potential for indirect impact via community pressure is acknowledged. The mitigation of culturally competent care is a proportionate and necessary measure to ensure respect for all patients.

	necessary measure to ensure respect for all patients.		
Marriage and civil partnership	In the majority of areas in Cheshire and Merseyside, IVF will only be made available on the NHS where a couple has no living birth children or adopted children, either from a current or any previous relationship. This is consistent with the majority of other areas across England too. This means that if someone had a baby through IVF, they would not be eligible for any further funded IVF cycles either. However, the current policies for Cheshire East and Cheshire West state that where a patient has started a cycle of IVF treatment, they can have further embryo transfers to complete their current cycle, even if they achieve a pregnancy leading to a live birth or adopt a child during the cycle. We are proposing that the new policy would not include this wording, meaning that funding would only be made available where a couple have no living children. The ‘childlessness' definition means a partner with a child from a previous relationship would make the couple ineligible. This specific issue is not in scope,	Mitigating action: Communicate the rationale (equity and resource prioritisation)	Consider the negative impact on those in Cheshire East and West who have remaining embryos in storage, following a live birth. The policy is deemed proportionate as it consistently applies the principle of prioritising NHS resources for those without any children, which is a legitimate aim for equitable resource allocation.

	however some respondents felt this was unfair for blended families.		
Transgender / gender reassignment	Risk of lack of access and inclusive care. No specific negative impacts were raised in the consultation, but this may indicate a lack of visibility or engagement with this patient group. Transgender individuals may have complex subfertility preservation and treatment need that require sensitive, informed care.	Mitigating action: Ensure all patient-facing communications, intake forms, and staff training are inclusive of transgender and non-binary people. Consider issues raised in Appendix A, in full future review.	Gender Reassignment The risk of indirect exclusion is acknowledged. The mandated mitigations of inclusive communications and training are considered essential to prevent discrimination and are a proportionate step to ensure equitable access within the constraints of the policy.
Pregnancy and maternity	Pregnancy and Maternity Neutral/Negative. This characteristic relates to those who are already pregnant or on maternity leave. The policy itself does not directly impact them. However, the distress of secondary subfertility (inability to conceive a second child) is a significant issue, and the 'childlessness' criteria explicitly excludes this group from treatment.	Action: Ensure clear public communication that the policy for secondary subfertility is standardised across the region, even though it is restrictive. Signpost to support services for those experiencing secondary subfertility.	The policy does not adversely impact those who are pregnant or on maternity leave. The negative impact on those experiencing secondary subfertility. This is a direct consequence of the 'childlessness' criteria, which is considered a proportionate means of prioritising limited resources.
Socio economic disadvantage	Socio-Economic disadvantage - The most significant and cross-cutting impact. The policy changes risks creating a two-tier system, making biological parenthood for those who require subfertility treatment a potential privilege of wealth and systematically	The primary mitigation is the provision of any funded NHS cycle, which remains a valuable service for those who cannot afford private care. Consultation feedback	This is the most significant equality trade-off. The ICB recognises the profound impact. The decision is that providing one universal, standardised cycle rather than having a fragmented or means-tested approach.

	reducing opportunity for those on low incomes. This intersects with disability and race. Consultation feedback across all protected groups raised this issue consistently. (appendix A).	suggested means-testing or offering more cycles to low-income groups. However, this would be contrary to the NHS constitution.	Decision makers to consciously consider feedback against the legitimate aims of financial challenges and eradicating a postcode lottery approach. .

5. Public Sector Equality Duty (PSED) and Health Inequalities Act 2012: Comprehensive Analysis

The policy's blanket approach fails to account for differential need and structural barriers. A one-cycle policy, while administratively simple, risks entrenching disparities. The duty to advance equality of opportunity requires commissioners to go beyond formal equality and consider substantive equity—tailoring provision to meet different needs where justified.

A. Rigorous Application of the Public Sector Equality Duty (PSED - s149, Equality Act 2010)

The PSED is a continuous, proactive duty that requires the ICB to have "due regard" to the need to achieve the three aims. This decision has been tested against each objective.

1. **Eliminate Discrimination, Harassment, Victimisation**

- Direct Discrimination: The policy is neutral in its wording and does not directly discriminate against any group.
- Indirect Discrimination: The evidence in this EIA is unequivocal. The one-cycle policy constitutes indirect discrimination against:
    - Women: As the primary users of the service, they bear the disproportionate physical, emotional, and life-impact of the restriction.
    - Disabled people
    - People from Ethnic Minorities: Specifically Black patients who, due to systemic barriers, start treatment later and have lower success rates, making them disproportionately disadvantaged by a one-cycle limit.
    - People from Lower Socio-Economic Backgrounds: indirectly discriminating on the grounds of socio-economic status, which intersects with multiple protected characteristics.

"Due regard" has been demonstrated by this detailed EIA, undertaking a comprehensive public consultation, and explicitly acknowledging these discriminatory impacts in this document.

2. **Advance Equality of Opportunity**

This aim requires the ICB to consider the need to:

- Remove or minimise disadvantages suffered by people due to their protected characteristics.

- Take steps to meet the needs of people from protected groups where these are different from the needs of others.
- Encourage persons with protected characteristics to participate in public life or in any other activity in which participation by such persons is disproportionately low.

The proposed policy actively works against this aim. It:

- Institutionalises disadvantage for the groups listed above
- Fails to meet different needs.
- The perception of an unfair and discriminatory system may deter future engagement from these communities with NHS services more broadly, damaging trust and participation.

3. Foster Good Relations

This aim involves tackling prejudice and promoting understanding between groups. The consultation feedback indicates that implementing this policy could damage good relations. The overwhelming opposition (86% against the cycle reduction) and the powerful, emotional testimony highlight a sense of injustice and a perception that the NHS is abandoning women and the most vulnerable. These risks fostering alienation and mistrust, rather than understanding.

B. Compliance with the Health and Social Care Act 2012 (Health Inequalities Duty)

In addition to the PSED, the ICB has a legal duty under Section 14G of the Health and Social Care Act 2012 to have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved.

This duty is central to the ICB's core purpose. The analysis reveals that the proposed policy presents a direct conflict with this obligation:

- Inequalities in Access: The policy standardises nominal access (one cycle for all). It fails to address the existing inequalities in access faced by ethnic minority groups and those in deprived areas.
- Inequalities in Outcomes: The policy changes could lead to a widening of outcomes.

C. The Balancing Test: Proportionality in the Face of Competing Duties

The ICB is faced with a direct conflict between its duties:

- The PSED and Health Inequalities Duty point towards the need for a more nuanced, clinically responsive, and equitable subfertility policy.
- The fiduciary and strategic duty to ensure the financial sustainability of the entire local health system points towards the need for significant savings.

Having rigorously applied "due regard" by identifying, evidencing, and acknowledging these severe impacts, the ICB must now make a conscious, reasoned judgement on proportionality.

The interim nature of the policy, the commitments to future review, and the specific mitigations are integral to the final decision the ICB must make.

This report was reviewed and discussed by the ICB QEIA panel and will be subject to further review and discussion at our ICB Board meeting.

Recommendation:

To reach a decision, the Board must formally review and acknowledge this EIA, including its identified disproportionate impacts and the key mitigation measures.

End

NHS
Cheshire and Merseyside

Quality Impact Assessment

27 November 2025

ICB Board Meeting

Agenda item: ICB/11/25/16

APPENDIX FOUR

NHS Cheshire and Merseyside

QUALITY IMPACT ASSESSMENT

Project/Proposal Name	Unwarranted Variation Recovery Programme – Subfertility policy option 1 IVF round	Date of completion	06/05/2025
Programme Manager	Katie Bromley	Clinical Lead	Rowan Pritchard Jones

Background and overview of the proposals (can be copied from PID on Verto or from National/Regional commissioning guidance)

The Subfertility policy was included in the scope of the Clinical Policy Harmonisation programme, as currently each Place has its own policy and there is variation in access to these services across Cheshire and Merseyside. The Clinical Policy Harmonisation programme used an evidence-based approach to develop harmonised policies. There is currently disparity across Cheshire and Merseyside on the number of IVF rounds offered as part of the sub-fertility policies:
1 cycle - Cheshire East
2 cycles – Liverpool, St Helens, Wirral, Cheshire West
3 cycles – Warrington, Southport & Formby, South Sefton, Halton, Knowsley
The clinical policy harmonisation programme undertook an exercise to harmonise the number of cycles and a working group was set up to work through this. The working group proposed 1 or 2 cycles, an options appraisal is being undertaken to explore offering patients either 1 or 2 cycles of IVF.

Whilst NICE specifies 3 cycles should be offered, their Health Economics analysis describes the effectiveness of each cycle with regard to cumulative live birth rates and shows that whilst the chances of having a live birth increase with each cycle, the effectiveness and cost effectiveness of each cycle is reduced. For a woman aged 34, the birth rates for each cycle are estimated: 1 cycle: 30%, 2 cycles: 15%, 3 cycles 10%.
In addition, research shows that 73% of those ICBs that have already harmonised their position will fund only 1 cycle and 19% currently fund 2 cycles with <10% funding the full 3 cycles as recommended by NICE.

It is worth noting that our neighbouring ICBs offer the following:

- Lancashire and South Cumbria offer 1 IVF cycle.
- Greater Manchester currently under review.
- West Yorkshire offer 1 IVF cycle.
- Staffordshire and Stoke-on-Trent offer 1 IVF cycle.

Data from our provider Liverpool Women's Hospital shows that the average number of cycles that patients are currently having is 1.36 cycles (this was based on reviewing patient outcomes for patients receiving 2 and 3 IVF cycles over a 5 year period who did not have a live birth after the first cycle), therefore offering patients 2 cycles of IVF would enable the majority of our patients to achieve a successful outcome.

However, there is a requirement for the ICB to review its costs and use of resources, and therefore the option of reducing the offer to 1 cycle has been modelled and offers a potential saving of £1.3m.

To develop a harmonised policy, a decision needs to be made on the number of IVF cycles that patients are offered. An options appraisal is being undertaken to explore offering patients either 1 or 2 cycles. This QIA considers the impact of a 1 IVF cycle policy.

There are a number of other changes that have been made to bring the policy in line with NICE guidance e.g. minimum age, smoking status, weight requirements, definition of childness and right to a family definitions, which are documented in the corresponding EIA but where appropriate are called out in this document.

Reason For Change/Proposal

Currently C&M ICB has an unharmonised position with regard to the number of IVF cycles offered. A 2-cycle option is clinically recommended; however, a 1 cycle approach has been modelled due to our current financial situation and this reduction would offer savings.

This option would mean reducing the offer in 8 Places, who all currently offer either 2 or 3 cycles. Only Cheshire East patients would not be affected by this option as they are already entitled to 1 cycle, this option would result in estimated savings of £1.3m per year.

Who is likely to be Impacted?	Public	X	Patients	X	Workforce		Other parts of the system	X
Please provide additional details, including scale	671 per year (2019 data)						
Who has been consulted with as part of the QIA development	There has been no formal consultation, a request to Board in May 25 is being made to request permission to progress a public consultation, however, the Obs & Gynae Clinical Network and Liverpool Women's Hospital Clinical, Operational and Finance Teams have all be involved in reviewing the options, proposed policy and supporting with activity and finance modelling.						
Financial Considerations	Current Costs		£5,043,081 per year		Proposed Costs		£3,727,350 per year

Place/Local Sign off:						
Sign off group	Stage 2 QIA Panel	Date of meeting	12/05/25	Post mitigation risk score *(Likelihood x Consequence)*	Safety	3
					Effectiveness	12
					Experience	16
					Workforce/system	15

Has an EIA been completed?	Y	Has a DPIA been completed?	Y – full DPIA not required	Have identified risks been added to risk register?	N

Risk scores above 12 in any area of quality, including patient safety, clinical effectiveness or experience will be taken to QIA panel and must be included within the corporate risk register.

Patient safety						
Will the project or proposal impact on patient safety?	Positive impact Improved patient safety, such as reducing the risk of adverse events is anticipated	Neutral Impact May have an adverse impact on patient safety. Mitigation is in place or planned to mitigate this impact to acceptable levels	Negative impact Increased risk to patient safety. Further mitigation needs to be put in place to manage risk to acceptable level	Pre-mitigation Identified Risk Score (Prior to Mitigations)		
				L	C	Total L x C
Please consider… • Will this impact on the organisation's duty to protect children, young people and adults? • Impact on patient safety? • Impact on preventable harm? • Will it affect the reliability of safety systems? N/A • How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections to patients is reduced? N/A	There is no additional impact on adults and children at risk, however, the inclusion of males in the smoking and drug and alcohol intake criteria for Merseyside patients would have a positive impact on the child. If non-compliance evidence is found this could trigger a pause in treatment with possible referral for a welfare of the child assessment and/or further information sought from the GP. This is a positive impact on all patients including welfare of the child. The proposed policy is that both partners should be confirmed non-smokers due to the harmful impact nicotine	The proposals regarding the number of IVF cycles doesn't impact the risk of harm. If implemented the policy would impact patients positively as it would eliminate inequity across C&M.	For those patients who currently receive 2 or 3 cycles there may be an impact on their mental health if they were relying on NHS funded cycles to have a family, but aren't successful during the first cycle.	3	1	3

	has on fertility and foetal development. Likewise, the proposed policy on drug and alcohol intake applies to both partners as in the current Cheshire policy not just the partner undergoing treatment as in the current Mersey policy. This is a positive impact on all patients including welfare of the child.					

Mitigations					
Action	**Owner**	**Expected date of completion**	**Date completed**		
No specific mitigating actions identified for this section					
A comms and engagement approach would be developed to explain the rationale for the decision.	Katie Bromley	tbc			
		Post Mitigation Risk Score	3	1	3

Clinical Effectiveness	
Please confirm how the project uses the best, knowledge based, research	The proposed interim subfertility policy has, where possible, been developed using the latest NG156 NICE guidance and input from local expertise and knowledge. With regard to IVF cycles, it should be noted that NICE guidance (NG156) suggests 3 IVF cycles, however, this has been in place for over 10 years and processes are much improved. NICE Health Economics analysis describes the effectiveness of each cycle with regard to cumulative live birth rates and shows that whilst the chances of having a live birth increase with each cycle, the

	effectiveness and cost effectiveness of each cycle is reduced. For a woman aged 34, the birth rates for each cycle are estimated: 1 cycle: 30%, 2 cycles: 15%, 3 cycles 10%. The Working Group who helped develop the harmonised policy comprised fertility & GP clinicians who supported the review of number of IVF rounds based on this, however, 1 cycle is not an option that is supported clinically. C&M data shows that the average number of cycles is 1.36, with an average of 1.88 subsequent Frozen embryo transfers. For those patients who do not have a successful pregnancy after the first IVF round, there is an opportunity to learn from this and change the approach for the 2nd to increase the risks of success. If the ICB were to offer 1 cycle of IVF, this would remove this opportunity for those patients.					
Will the project or proposal impact on Clinical effectiveness?	**Positive impact** Clinical effectiveness will be improved resulting in better outcomes anticipated for patients	**Neutral Impact** May have an adverse impact on clinical effectiveness. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	**Negative impact** Significant reduction in clinical effectiveness. Further mitigation needs to be put in place to manage risk to acceptable level	Identified Risk Score (Prior to Mitigations)		
				L	C	Total L x C
Please consider… • How does it impact on implementation of evidence based practice? • How will it impact on clinical leadership N/A • Does it reduce/impact on variation in care provision? • Does it affect supporting people to stay well? N/A • Does it promote self-care for people with long term conditions? N/A • Does it impact on ensuring that care is delivered in the most clinically and cost effecting setting? N/A • Does it eliminate inefficiency and waste by design? N/A • Does it lead to improvements in care pathways? N/A	Where possible, the harmonised policy has been brought in line with NICE guidance. The harmonisation of policy in regard to childlessness, weight, smoking and drugs and alcohol intake and approach to Intra-Uterine Insemination (IUI) and ovarian reserve testing should support more patients to be successful in treatment. Outcomes will be monitored in the same way as they are now.	There would be no change to number of cycles for Cheshire East patients. There is a risk that for those patients are not successful in the first IVF cycle, would be disadvantaged by not being able to try a different approach in the second cycle.	The C&M Clinical Network do not support a 1 cycle option. The clinically supported option would be to offer 2 cycles of IVF; however, this QIA considers the impact of 1 cycle. NICE guidance NG156 advises that 3 cycles should be offered. However, C&M data suggests that the numbers of patients requiring 3 cycles is minimal with the average number of cycles being 1.36. Therefore a 1 cycle option is difficult to provide a clinical evidence base for, however, this proposal	3	4	12

	The subfertility policy has been developed with a MDT working group that consisted of Local Fertility Specialists, GPs, Healthwatch, Commissioners who helped to shape the policy. The working group recommended 1 or 2 cycles of IVF. The policy has been shared with the relevant clinical networks who were supportive of the alignment to NICE guidance across the whole of C&M and supported the "interim" approach whilst waiting for revised NICE guidance to ensure new policy positions are developed using all evidence.		would bring NHS C&M in line with over 70% of the ICBs who have already harmonised their policies (4 others have yet to do so). NICE health economics analysis describes that the effectiveness of each cycle with regard to cumulative live birth rate is reduced with each cycle (although there is still a greater chance of a live birth). For an average 34 year old, the 1st cycle is c 30% effective, the 2nd cycle is c 15% and the 3rd cycle is less than 10%.			

Mitigations					
Action	**Owner**	**Expected date of completion**	**Date completed**		
There are no mitigating actions specific to this criteria					
		Post Mitigation Risk Score	3	4	12

Patient Experience				
	Positive impact	Neutral Impact	Negative impact	Identified Risk Score (Prior to Mitigations)

Will the project or proposal impact on patient experience?	Improved patient and carer experience anticipated	May have an adverse impact on patient and carer experience. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	Significant reduction in patient and carer experience. Further mitigation needs to be put in place to manage risk to acceptable levels	L	C	Total L x C
Please consider… • What is the impact on protected characteristics, such as race, gender, age, disability, sexual orientation, religion and belief for individual and community health, access to services and experience? • What impact is it likely to have on self-reported experience of patients and service users? (Responses to national/local surveys/complaints/PALS/incidents) • How will it impact on the choice agenda? N/A • How will it impact on the compassionate and personalised care agenda? N/A • How might it impact on access to care or treatment? N/A	The proposed harmonised policy will ensure that patients have equal access to subfertility treatments in Cheshire and Merseyside. It will remove the current variation in the number of IVF cycles offered. The proposed harmonised policy would have a positive impact on patients younger than 23 years who want to start treatment as this minimum age has been removed as per NICE guidance. Women aged 42 are included in the policy in line with NICE guidance – previously the cut off was up to 42nd birthday. The current Mersey position on IUI / Donor Insemination (DI) has been introduced to Cheshire (clarification to number of cycles required before IVF) and Wirral (not routinely commissioned) however, activity for these treatments is minimal.	With regard to IVF cycles, a 1 cycle approach would have a neutral impact on Cheshire East patients as their offer would be in line with all other Places. Definitions of childlessness and right to a family have been clarified, however, this doesn't change the policy position except in Cheshire where previously patients were able to continue to use any remaining eggs following a live birth. The Department of Health (DoH) position on Overseas Visitors is now included in the proposed policy statement, however, this is not a change to process as it reflects the existing rules.	With regard to IVF cycles, a 1 cycle approach would negatively impact those patients who would have had a second or third attempt at IVF. They will have a worsened patient experience if they are unsuccessful in their first cycle particularly if they are unable to self-fund further cycles, they will be unable to have a biological family. • Patients in Knowsley, Halton, South Sefton, Southport & Formby & Warrington who currently are eligible for 3 cycles. • Patients in Liverpool, St Helens, Cheshire West and Wirral currently eligible for 2 cycles. The likelihood of PALS and complaints are expected to increase in these Places if the offer is reduced.	4	4	16

			With regard to the definition of childlessness, the current Cheshire policy implies that even if a patient had a live birth or adopted a child, they could continue with using all frozen embryos. This was not aligned across C&M and is not usual practice, so this has been removed, therefore these patients could feel disadvantaged. Because the status of male partners with regard to smoking & alcohol and drug use has an impact on eligibility in the proposed policy, treatment will only be provided if both partners comply with the requirements. This cohort could feel disadvantaged by this revised approach; however, the smoking requirement follows NICE CG156: “smoking can adversely affect fertility and the success rates of assisted reproductive techniques (in both men and women).” And the drugs and alcohol are based on evidence that			

			alcohol and recreational drugs reduce the chance of conception in both men and women.			

Mitigations					
Action	**Owner**	**Expected date of completion**	**Date completed**		
A comms and engagement approach would be developed to explain the rationale for the decision.	K Bromley / Olivia Billington	Tbc			
		Post Mitigation Risk Score	4	4	16

Workforce/System						
Will the project or proposal impact on the workforce or system delivery?	Positive impact Improved patient and carer experience anticipated	Neutral Impact May have an adverse impact on patient and carer experience. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	Negative impact Significant reduction in patient and carer experience. Further mitigation needs to be put in place to manage risk to acceptable levels	Identified Risk Score (Prior to Mitigations)		
				L	C	Total L x C

Please consider… • Capacity and demand on services • Changes in roles N/A • Training requirements • Staff experience & morale • Redundancies N/A • Opportunities (including staff development) N/A • Impact on other parts of the system, including changes in pathways or access N/A • Increased demand • Financial stability • Safety N/A	The relaunch of the revised policy would require strong communications with the provider in order to ensure any new elements were understood and implemented correctly.	The move to 1 cycle would negatively impact demand at our provider Liverpool Women's (LWH) as their current plans contain greater activity than is needed to deliver activity for 1 cycle.	It is likely that moving to 1 cycle will have a negative impact on staff experience and morale for those working in our Provider organisation as they were supportive of the 2 cycle option. LWH have confirmed that reducing to 1 cycle would have a detrimental financial impact of between £1m and £1.5m and whilst they can identify some productivity improvements, it won't mitigate this financial loss.	5	3	15

Mitigations					
Action	**Owner**	**Expected date of completion**	**Date completed**		
Discussions will be had with LWH to advise of the proposal	Katie Bromley	12/05/25			
		Post Mitigation Risk Score	5	3	15

Summary

Decision made	Pre Mitigated Score	Mitigated score	Impact
Progress	16	16	Catastrophic
Not progress	6	4	Moderate
Score summary (add to front page)			
Negligible and Low risk	Moderate risk	Major risk	Catastrophic risk
1-3	4 - 7	8 - 12	13 - 25

- The 'progressed' risk scores are applicable if the 1 cycle option is approved. The 'not progressed' risk scores are applicable if the 2 cycle option is approved. In line with the ICB Risk Management Strategy, an ICB wide risk score for a risk-in-common should mirror that of the highest domain risk score.

Risk Impact Score Guidance

LEVEL	DESCRIPTOR	DESCRIPTION – ICB LEVEL
5	Catastrophic (>75%)	**Safety** - multiple deaths due to fault of ICB OR multiple permanent injuries or irreversible health effects OR an event affecting >50 people. **Quality** – totally unacceptable quality of clinical care OR gross failure to meet national standards. **Health Outcomes & Inequalities** – major reduction in health outcomes and/or life expectancy OR major increase in health inequality gap in deprived areas or socially excluded groups **Finance** – major financial loss - >1% of ICB budget OR 5% of delegated place budget **Reputation** – special measures, sustained adverse national media (3 days+), significant adverse public reaction / loss of public confidence major impact on trust and confidence of stakeholders
4	Major (50% > 75%)	**Safety** - individual death / permanent injury/ disability due to fault of ICB OR 14 days off work OR an event affecting 16 – 50 people. **Quality** – major effect on quality of clinical care OR non-compliance with national standards posing significant risk to patients.

		Health Outcomes & Inequalities – significant reduction in health outcomes and/or life expectancy OR significant increase in health inequality gap in deprived areas or socially excluded groups **Finance** - significant financial loss of 0.5-1% of ICB budget OR 2.5-5% of delegated place budget **Reputation** - criticism or intervention by NHSE/I, litigation, adverse national media, adverse public significant impact on trust and confidence of stakeholders
3	**Moderate (25% > - 50%)**	**Safety** - moderate injury or illness, requiring medical treatment e.g., fracture due to fault of ICB. RIDDOR/Agency reportable incident (4-14 days lost). **Quality** – significant effect on quality of clinical care OR repeated failure to meet standards **Health Outcomes & Inequalities** – moderate reduction in health outcomes and/or life expectancy OR moderate increase in health inequality gap in deprived areas or socially excluded groups **Finance** - moderate financial loss - less than 0.5% of ICB budget OR less than 2.5% of delegated place budget **Reputation** - conditions imposed by NHSE/I, litigation, local media coverage, patient and partner complaints & dissatisfaction moderate impact on trust and confidence of stakeholders
2	**Minor (<25%)**	**Safety** - minor injury or illness requiring first aid treatment **Quality** – noticeable effect on quality of clinical care OR single failure to meet standards **Health Outcomes & Inequalities** – minor reduction in health outcomes and/or life expectancy OR minor increase in health inequality gap in deprived areas or socially excluded groups **Finance** - minor financial loss less than 0.2% of ICB budget OR less than 1% of delegated place budget **Reputation** - some criticism slight possibility of complaint or litigation but minimum impact on ICB minor impact on trust and confidence of stakeholders
1	**Negligible (<5%)**	**Safety** - none or insignificant injury due to fault of ICB **Quality** – negligible effect on quality of clinical care **Health Outcomes & Inequalities** – marginal reduction in health outcomes and/or life expectancy OR marginal increase in health inequality gap in deprived areas or socially excluded groups

	Finance - no financial or very minor loss **Reputation** - no impact or loss of external reputation

The likelihood of the risk occurring must then be measured. Table 2 below should be used to assess the likelihood and obtain a likelihood score. When assessing the likelihood, it is important to take into consideration the existing controls (i.e. mitigating factors that may prevent the risk occurring) already in place.

Table 2 - Risk Likelihood Score Guidance

1	2	3	4	5
Rare The event could only occur in exceptional circumstances (<5%)	**Unlikely** The event could occur at some time (<25%)	**Possible** The event may well occur at some time (25%> -50%)	**Likely** The event will occur in most circumstances (50% > 75%)	**Almost certain** The event is almost certain to occur (>75%)

The impact and likelihood scores must then be multiplied and plotted on table 3 to establish the overall level of risk and necessary action.

Table 3 - Risk Assessment Matrix (level of risk)

LIKELIHOOD of risk being realised	**IMPACT (severity)** of risk being realised				
	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)	1	2	3	4	5
Unlikely (2)	2	4	6	8	10
Possible (3)	3	6	9	12	15
Likely (4)	4	8	12	16	20
Almost Certain (5)	5	10	15	20	25

Low Risk	Moderate Risk	High Risk	Extreme Risk	Critical Risk

Risk Proximity

A further element to be considered in the risk assessment process is risk proximity. Risk proximity provides an estimate of the timescale as to when the risk is likely to materialise. It supports the ability to prioritise risks and informs the appropriate response in the monitoring of controls and development of actions.

A pragmatic approach to the use of risk proximity which supports leadership, decision making and reporting is used and is therefore determined to be applied to all Risks.

The proximity scale used is below:

Proximity and timescale for dealing with the risk	Within the current quarter	Within the financial year	Beyond the financial year
Rating	**A**	**B**	**C**

Likelihood, impact and proximity are dynamic elements and consequently all three must be reviewed and reassessed frequently in order to prioritise the response.

Sign off process			
Name	Role	Signature	Date
Olivia Billington	Project lead	Olivia Billington	06/05/25
Rowan Pritchard Jones	Clinical lead		
Katie Bromley	Programme manager	Katie Bromley	06/05/25
	PMO lead		
Once signed off by all above, then the QIA is submitted via qia@cheshireandmerseyside.nhs.uk **to QIA review group**			

PMO receipt					
Verto/PMO reference	N/A	Date QIA reviewed PMO		Reviewed by	

This section to be completed following review at the QIA review group				
Meeting Chair	Date of Meeting	Approved	Rejected	Comments/feedback
Chris Douglas	12.05.2025	14.05.25		Recommendations made for amendments to QIA for panel to be reconsidered at a later date: 1) Psychological impact to the patient to be articulated in patient safety domain 2) Negative impact on clinical effectiveness is to be reworded and centred on evidence 3) Further work to be undertaken on the system/workforce domain 4) Clarification of scores across all domains required

NHS
Cheshire and Merseyside

27 November 2025

ICB Board Meeting

Agenda item: ICB/11/25/16

APPENDIX FIVE

Joint Health Scrutiny Committee - Proposed Changes to NHS Fertility Treatment Policies Across Cheshire and Merseyside

Joint Health Scrutiny Committee - Proposed Changes to NHS Fertility Treatment Policies Across Cheshire and Merseyside

Date: 5 November 2025

To: Cheshire and Merseyside Integrated Care Board (ICB)

Subject: Concerns Regarding Proposed Changes to NHS Fertility Treatment Policies

I am writing to formally convey the Joint Health Scrutiny Committee's concerns regarding proposed changes to NHS-funded fertility treatment policies, as discussed at our Joint Health Scrutiny Committee meeting on 29 October 2025.

On behalf of the Committee, I would like to express our gratitude to the NHS Cheshire and Merseyside ICB officers who attended the meeting. The Committee found the session highly informative and appreciated the transparency shown by ICB officers.

We acknowledge the significant financial pressures currently facing NHS Cheshire and Merseyside ICB and appreciate the need to review service provision. However, Members have significant reservations about the proposed reduction in IVF cycles and the broader implications of this policy change. These concerns are outlined below:

Alignment with NICE Guidance and Clinical Evidence

National Institute for Health and Care Excellence (NICE) guidance recommends offering up to three cycles of IVF as a cost-effective treatment, while the ICB's clinical working group, and clinical and operational teams at Liverpool Women's Hospital favour offering two funded cycles. Members are concerned that reducing the number of funded IVF cycles to one lacks robust clinical justification and may undermine patient outcomes.

The Committee also notes that the ICB has described the current proposal as an interim policy, intended for review following the release of updated NICE fertility guidance expected in March 2026. However, Members are concerned that early indications suggest the forthcoming guidance is unlikely to revise existing recommendations on the number of IVF cycles. This raises questions about the purpose of the planned review, particularly given that current NICE guidance is already being set aside. Members find it unclear why a review would be triggered by new guidance if its recommendations are not expected to differ significantly from those already in place.

Joint Health Scrutiny Committee - Proposed Changes to NHS Fertility Treatment Policies Across Cheshire and Merseyside

Treatment Effectiveness and Value

Evidence suggests that the cumulative success rate increases with additional cycles, rising to approximately 66% after three cycles. Members question whether the proposed reduction to one funded cycle (below the average of 1.36 cycles received by patients) truly represents optimal care given that there are benefits in being able to take learnings from an unsuccessful first cycle to improve chances of success in a second cycle. Members are concerned that the policy risks offering treatment that is insufficiently effective for the sake of making savings.

Equity and Financial Burden on Patients

The shift in financial responsibility to patients for additional cycles raises serious concerns about equity of access. While some may choose to self-fund, others will be excluded from the opportunity to pursue treatment due to financial constraints. We request confirmation that an assessment has been conducted on the disproportionate impact this policy may have on lower-income groups.

Public and Stakeholder Feedback

Members note that 86% of consultation respondents opposed the proposed changes. We urge the ICB to give due weight to this feedback, including views from staff groups and advocacy organisations such as Fertility Action, alongside the views of this Joint Health Scrutiny Committee.

Unassessed Wider Impacts

Concerns were raised about the potential negative effects this policy may have, such as the impact on patient mental health and the potential impact on local birth rates. Members request information on how these impacts will be monitored and considered in future reviews.

Additional Pressures on NHS Services

There is concern that the proposed changes may lead to increased demand for other NHS services, including mental health support, GP appointments, and complaints handling. Members question whether the projected savings of £1.3 million annually adequately account for these potential costs.

Support for Patients with High BMI

Members seek clarification on whether any support will be offered to patients from deprived areas to help meet BMI requirements, given the known barriers this presents.

Equality Impact Assessments

We request access to the ICB's Equality Impact Assessments to understand how the proposed changes are expected to affect vulnerable groups, including post-cancer patients and others.

In summary, the Committee urges the ICB to reconsider the proposed changes in light of clinical evidence, equity concerns, and stakeholder feedback.

The Committee requests that officers from NHS Cheshire and Merseyside ICB attend a follow-up meeting to address the concerns raised, provide the additional information outlined above, and provide details of any mitigations that could be implemented as part of the proposed policy changes.

Members remain committed to working constructively with the ICB to support the development of fertility services that are equitable, clinically sound, and responsive to the needs of our communities.

Yours sincerely,

Councillor Gary Bennett

Chairperson

On behalf of the Joint Health Scrutiny Committee

NHS
Cheshire and Merseyside

12 November 2025

Dear Councillor Bennett

Re: Joint Health Scrutiny: NHS Cheshire and Merseyside subfertility policy proposal

Thank you for your letter in relation to proposed changes to local NHS Fertility Treatment Policies.

I am glad that you found the information we provided at the first meeting of the Joint Health Overview and Scrutiny Committee useful. My colleagues and I were grateful for the opportunity to discuss this important issue in more detail.

I note the committee's concerns about the proposal. Our response to the individual points your letter raises is as follows:

Alignment with NICE guidance and clinical evidence:

It is important to be clear that the proposal to offer a single IVF cycle to eligible people under 39 years is being put forward for financial rather than clinical reasons. We recognise that moving to a single cycle for this group is not in line with NICE guidelines, and does not reflect the view of our local fertility experts, who had recommended that we offer two cycles. It would however put NHS Cheshire and Merseyside in the same position as the 66% of other integrated care boards in England whose policies allow for one cycle. In the documentation produced to accompany the consultation on its updated guidance, NICE notes that very few areas of the country offer IVF according to its recommendations.

Unfortunately, due to the extremely challenging financial position the local NHS is facing, we must make some difficult decisions about how we spend our budget. The move to a single IVF cycle offers the best opportunity for the ICB to continue providing this service, while ensuring that it is affordable.

It is correct that the proposed policy would be an interim one, pending the review of revised NICE guidance, which we expect to be published early in 2026. We note the committee members' concerns that the local position on IVF cycles is unlikely to be changed by this review, however the number of IVF cycles recommended is only one element of the guidance NICE produces on the assessment and treatment of fertility problems. It is important that NHS Cheshire and Merseyside reviews its whole policy against the latest evidence.

We understand that the timing of this proposal means that there will potentially only be a short gap between the introduction of a new policy and the ICB being in a position to begin the second review. Although we had delayed our original policy review while we awaited updated NICE guidance, we made the decision in early 2025 that we needed to

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move ahead with our process, given the variation in access that existed as a result of having ten separate policies.

Treatment Effectiveness and Value:

We acknowledge that the proposal around IVF cycles has the potential to impact on successful outcomes, however it should again be stressed that this is being put forward for financial rather than clinical reasons, which is a reflection of the severity of the financial position we currently face.

Equity and Financial Burden on Patients:

It is challenging to accurately assess how the proposed policy might impact on people on the basis of socio-economic factors, as the NHS does not routinely collect data on the financial circumstances of individuals who access NHS fertility services, however the equality impact assessment does address this issue.

Public and stakeholder feedback:

We recognise the strength of feeling reflected in the response to our public consultation, and we are grateful to the many people who shared their views.

Public consultation is an opportunity to set out information about a proposal, so that people can share views and perspectives which can be used in decision-making. This process allows us to hear about any additional issues or impacts which might not have already been considered, so that extra mitigations or amendments can be put in place as required. However, it is important to stress that it is not a voting process whereby the strength of support alone is used to make a final decision.

The consultation feedback report will be presented to the Board of NHS Cheshire and Merseyside alongside the final proposal for the single policy, so that this will inform their decision-making.

Unassessed Wider Impacts and Additional Pressures on NHS Services:

We understand that fertility problems can be the cause of significant emotional stress, and have an impact on an individual's mental health. Indeed, this was something we heard repeatedly in the public consultation feedback.

The savings projected from the proposed change are only based on the cost of providing IVF cycles, rather than wider potential costs or savings in other health services. We acknowledge that the ultimate financial impact might therefore be different, but based on the data we have available – and the fact that individual impacts will vary – we are unable to model this accurately.

If the change to the number of IVF cycles goes ahead, we will work with our local provider to monitor the impact. This will include exploring how we can better record the relationship between the number of cycles and outcomes, and the number of people who would no longer receive a second cycle, but would have done so under previous

arrangements. Where it is possible to collect this data, it will be used as part of future review(s).

Support for Patients with High BMI:

It is important to note that NHS Cheshire and Merseyside is not proposing to add any additional criteria around BMI as part of the single subfertility policy. We are however proposing that the new policy would make it clearer that only a female partner's BMI would be considered when deciding on eligibility. This change would only impact on Wirral patients, as the current Wirral policy says that male partners should also meet BMI requirements in order for a couple to begin NHS fertility treatment. In this respect, the new policy would improve access to treatment.

The BMI guidelines in our new policy align with NICE guidance, which reflects the relationship between BMI and the clinical effectiveness of fertility treatments, rather than acting as a method to limit access to this treatment.

Weight loss support is available to all patients via their GP, and not linked to individual financial circumstances.

Equality Impact Assessments

NHS Cheshire and Merseyside's post-consultation equality impact assessment (EIA) is provided alongside this response.

I would like to take the opportunity to stress once again that the decision to put forward the proposal around IVF cycles has not been taken lightly, and reflects the severity of the financial challenge facing the local NHS. The Board of NHS Cheshire and Merseyside will be considering this matter carefully, including taking into account feedback from both the public consultation, the Equality Impact Assessment and the views of the Join Health Overview and Scrutiny Committee, before making a final decision about how to proceed.

I hope that this response addresses the points that members have raised. I look forward to the opportunity to discuss this at the second committee meeting.

Yours sincerely

Dr Fiona Lemmens
Associate Medical Director for Transformation and Deputy Medical Director
NHS Cheshire and Merseyside ICB

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 November 2025

Safeguarding Our Workforce: Sexual Misconduct Policy

Agenda Item No: ICB/11/25/17

Responsible Director: Mike Gibney, Chief People Officer

Safeguarding Our Workforce: Sexual Misconduct Policy

1. Purpose of the Report

1.1 To provide an update on progress in implementing the NHS Sexual Safety Charter[1] and the organisation's Sexual Misconduct Policy. The report also sets out the next steps required to embed sexual safety across NHS Cheshire and Merseyside.

2. Executive Summary

2.1 The NHS Sexual Safety Charter, launched in 2023, sets national expectations for promoting dignity and safety in the workplace. NHS Cheshire and Merseyside has ratified its Sexual Misconduct Policy (Appendix One), implemented initial training programmes and established governance with assurance reported through the People Committee, to support a cohesive, trauma-informed approach. Significant actions have already been completed, including establishing trained Allies, introducing an e-learning offer and developing communications to build awareness.

3. Ask of the Board/Committee and Recommendations

3.1 The Board is asked to:

- endorse the governance and rollout plan for the Sexual Safety Charter
- support leadership sponsorship and engagement
- approve the integration of the Sexual Safety Policy into ongoing safeguarding and HR frameworks.

4. Reasons for Recommendations

4.1 Approval will ensure the organisation meets its responsibilities under the Sexual Safety Charter, the Worker Protection Act 2023 and the National Sexual Misconduct Policy Framework.

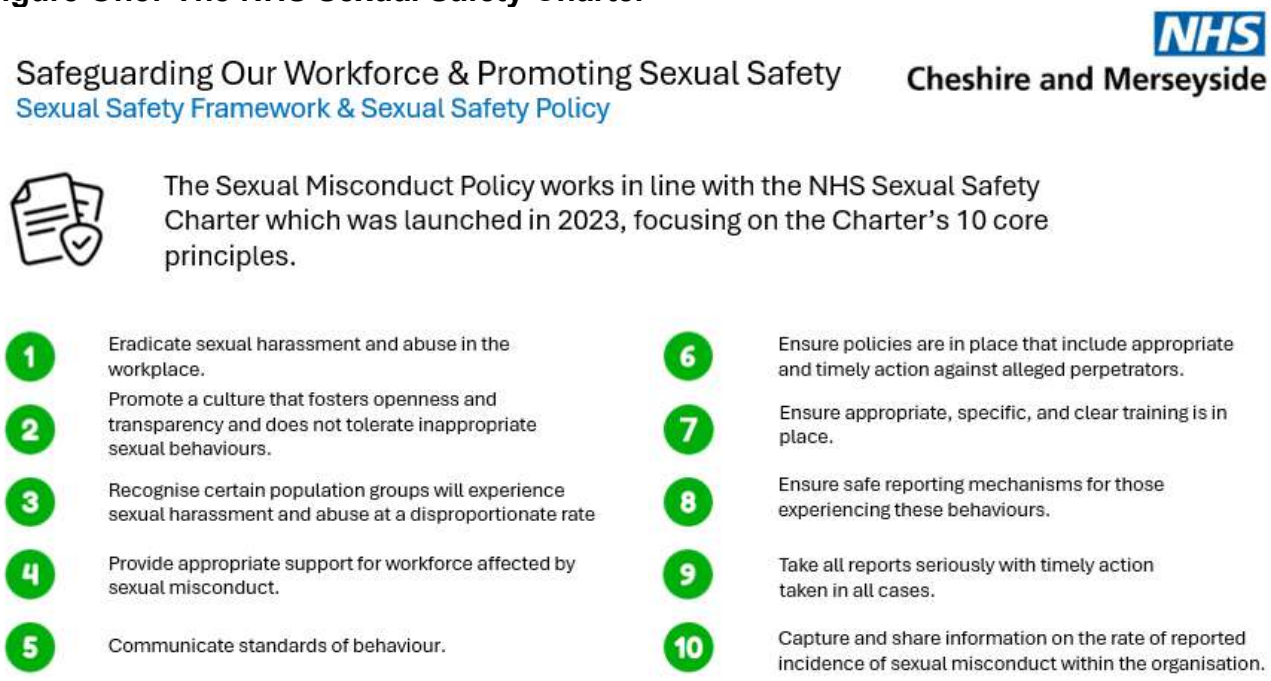
5. Background

5.1 The NHS Sexual Safety Charter was launched by NHS England in September 2023 (*See Figure One*). To support its implementation, the Sexual Safety Charter Assurance Framework and the National Sexual Misconduct Policy Framework were published in October 2024. NHS Cheshire and Merseyside is

[1] https://www.england.nhs.uk/publication/sexual-safety-in-healthcare-organisational-charter/

committed to the charter and is working to embed sexual safety across the organisation. Its Sexual Safety Policy (approved July 2025) brings together safeguarding, HR and Freedom to Speak Up frameworks into a trauma-informed, legally compliant approach aligned with the Worker Protection Act 2023.

Figure One: The NHS Sexual Safety Charter



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

By addressing sexual misconduct, the policy reduces barriers to employment and wellbeing for affected staff, supporting equitable access to safe working environments.

Objective Two: Improving Population Health and Healthcare

A workforce that feels safe, supported, and valued is better able to deliver compassionate, high-quality care, enhancing patient outcomes and experience.

Objective Three: Enhancing Productivity and Value for Money

Reducing harassment and improving culture decreases staff turnover and sickness absence, supporting retention and workforce stability.

Objective Four: Helping to support broader social and economic development

Through leadership in trauma-informed practice and safe employment culture, NHS Cheshire and Merseyside sets a positive example to local partners, influencing wider community wellbeing.

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

7.1 The Sexual Misconduct Policy supports the Annual Delivery plan by strengthening an inclusive workforce culture, developing leadership capabilities and improving the safety and wellbeing of our staff.

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety

- *Provides structured, accessible mechanisms for reporting and support.*

Theme Two: Integration

- *Embeds training and evidence-based interventions to prevent harm.*
- *Promotes compassion, dignity, and respect at all levels.*

Theme Three: Leadership

- *Establishes clear governance, leadership accountability, and a culture of openness.*

9. Risks

9.1 The key risks are as follows:

- staff reluctance to report issues related to sexual misconduct to be addressed through stronger confidential reporting routes, visible support and clear leadership messaging to increase staff confidence.
- inconsistent application of procedures and responses to disclosures creating inequity and potential legal challenges mitigated through standardised training, clear escalation pathways and HR oversight
- data handling and confidentiality concerns causing risk of breaches or loss in trust and confidence; mitigated by secure systems and confidentiality protocols to reduce the risk of breaches.
- perceived inaction may damage organisational reputation; transparent processes, timely action and clear support and communications are essential to mitigate this.

10. Finance

10.1 Actions stemming from the policy to be delivered within existing budgets. Training and communications will be absorbed through workforce and organisational development resources.

11. Communication and Engagement

11.1 A comprehensive communications plan underpins this programme. Early engagement has focused on creating awareness among senior leaders and staff networks, using consistent messaging across newsletters, briefings, and the staff hub.

11.2 Future phases will introduce visual campaigns, promotional materials, and digital resources, including, staff stories, dedicated ally profiles and clear guidance for managers. Engagement will continue with Freedom to Speak Up Guardians, HR business partners, and EDI networks to ensure coherence across all communication channels.

12. Equality, Diversity and Inclusion

12.1 This work directly supports the Public Sector Equality Duty (PSED), promoting fairness, respect, and inclusion across all parts of the workforce. The policy actively addresses inequalities through targeted training, culturally competent communications, and diverse ally recruitment.

12.2 An Equality Impact Assessment was completed ahead of policy ratification to ensure compliance with the Equality Act 2010 and alignment with the ICB's broader equality and inclusion objectives.

13. Climate Change / Sustainability

13.1 No direct impact found

14. Next Steps

14.1 The programme will now move into its delivery phase. Board development and Charter training will be scheduled, followed by completion of the Train-the-Trainer programme and full e-learning rollout in January and February 2026. Monitoring and evaluation will begin in the first quarter of 2026 to assess impact and inform future improvements.

15. Officer contact details for more information

Katie Horan, Programme Manager Staff Experience and Retention
Paul Martin, Head of Workforce Programmes

16. Appendices

CLICK HERE to view the Appendix
Appendix One: NHS Cheshire and Merseyside Sexual Misconduct Policy

Sexual Misconduct Policy

Version 1, July 2025

The contents of this policy framework may be upsetting for some colleagues to read.

If you would prefer to discuss this policy or need support, please contact a manager, member of the HR team or the safeguarding team.

Document owner: MLCSU HR Team	Prepared by: MLCSU HR Team	First published: July 2025
Approval date: July 2025	Version number: 1.0	Next review date: July 2028

Contents

What is a people policy?

A people policy provides support, advice and guidance on how you can expect to be treated and what is expected from you.

Why we have this policy

We have signed the sexual safety in healthcare organisational charter. We are committed to a zero-tolerance approach to sexual misconduct in the workplace to create a workplace where everyone feels safe.

The Worker Protection (Amendment of Equality Act 2010) Act 2023 creates a duty on employers to take reasonable steps to stop sexual harassment from colleagues and third parties in the workplace. This includes protecting their employees and people employed by other organisations, such as suppliers or visitors, from sexual misconduct.

Sexual misconduct is unwanted behaviour of a sexual nature. It can happen to anyone, but it often happens where there is a power imbalance. People in some groups can be more vulnerable than others. For example, women, black, ethnic minority, disabled and LGBTQ+ people can be more at risk. Some people will also find it more difficult to report sexual misconduct.

This policy provides information about:

- how to recognise and report sexual misconduct
- our approach to taking actions when sexual misconduct is reported, including the other policies that might be used
- the support available to people involved or harmed. More information is on page 11 and in appendix 4

What this policy covers

This policy covers sexual misconduct connected to work or the workplace. Sexual misconduct can include many things, such as:

- sexual comments or jokes
- unwanted touching or kissing
- showing sexual pictures
- staring at someone in a sexual way
- asking personal questions about someone's sex life
- sexual assault or rape

Appendix 3 provides more examples and should be read alongside this section.

Sexual misconduct can take place at any time and any place; for example, at social or learning events or while travelling for work. It can take place in person or online (for example, through chat messages, phone calls, voice messages, or social media).

All NHS employees, non-executive directors, volunteers, agency and bank workers, students and learners, contractors, secondees and interns can use this policy to report sexual misconduct.

This policy provides information about the support available and about the process used to keep people safe and manage concerns and reports.

It provides advice about what to do when someone makes a disclosure about sexual misconduct to you, and a checklist of information you need to collect when someone wants to report this to the organisation.

How this policy promotes a kind and caring culture

We want NHS Cheshire and Merseyside ICB to be a place where everyone feels safe to work, and where actions are taken to stop sexual misconduct.

This policy commits the organisation and everyone working within it to take all reports of sexual misconduct seriously and to act on all reports. A zero-tolerance approach to sexual misconduct in the workplace is crucial to promoting a kind and caring culture.

How do we know this policy treats people fairly?

Whenever we write a policy, we do an 'equality impact assessment' (EIA) to ensure it treats everyone fairly, and it does not disadvantage or discriminate against anyone or any protected group.

We also review our policies regularly to see how we are doing. This includes listening to colleagues' views and reviewing information about how the policy works in practice.

Appendix 7 outlines how this policy will be monitored to ensure it treats everyone fairly.

Language used in this policy

A disclosure

If you experience or witness sexual misconduct you may choose to tell someone at work about your experience. This might be your manager, supervisor, a colleague or anyone else you trust including a freedom to speak up guardian, a colleague from the safeguarding team, or a trade union representative.

It is important that the person who receives a disclosure uses the guidance in this policy on page 8 and in appendix 11.

If you make a disclosure to someone this does not mean that you have made or must make a report.

Report

A report is different to a disclosure. A report involves telling someone who is in a position of responsibility or authority in the organisation about sexual misconduct that has happened to you or that you have witnessed.

A report means you are requesting that the organisation makes decisions and takes actions to stop it from happening again.

Page 9 provides information about how to report sexual misconduct.

Review group

A review group is responsible for using the information provided by you in your report to agree what to do about sexual misconduct. Page 12 provides more information about a review group.

Advice and support

If you experience sexual misconduct, it is likely to be a distressing and isolating experience and you might not know what to do next.

Sexual misconduct can take place when there are no other witnesses. This does not change the response you should receive. You will be believed and supported.

If you can, write down what happened as soon as you can. Include dates and the order that events took place, and how they made you feel. This will help you to remember the details.

It's important you speak to someone you trust, to get support and to decide what to do. This is often called a 'disclosure'.

When speaking with others, it's important that you are given the time to clearly express:

- what you need, including support
- what you want to happen next
- what you expect them to do

For example, you might discuss:

- getting help or advice from a manager or someone else
- this policy to decide how to report what happened
- that you need more time before you decide what to do

You can also get advice and support from an external organisation (listed in appendix 4).

If you decide and are ready to make a report, page 9 provides information about how to do this. Every report will be taken seriously and there is no time limit – you can make a report at any time.

People who aren't employed by the organisation

If your report is about the behaviour of someone at work, but they are not employed by the organisation, you should make a report using this policy.

The review group will liaise with the employer of the individual and will agree on the actions to support you and to prevent it from happening again.

Patients and service users

If your report is about the behaviour of a service user, patient, or a member of the public, you should speak to your manager or the person in charge as soon as possible after the event happens, if you can.

This will allow them to take actions as soon as possible, for example, this could include warning a patient or service user about their behaviour or reporting a criminal act to the police.

Incidents unrelated to work

If you have been affected by a sexual safety incident, including domestic violence, that is not connected with work, the reporting process in this policy is not likely to apply. However, the impact of the incident might affect you at work. If you need support, speak to your manager or a person you trust.

Appendix 4 provides information about support, including specialist organisations you can contact to get help.

Witnessing behaviour

We all see things happening around us every day that we do not agree with. These things might not be happening to us, but we can choose to do something about them. This is often called being an 'active bystander'.

We can show others that we feel a behaviour is unacceptable. This will also give a voice to groups and individuals who may not feel able to challenge what is happening.

There may not always be a need to say something, and it may not always be safe to do so, but there are other actions we can take. These might include:

- asking someone to stop and being clear that the behaviour is inappropriate or unacceptable
- interrupting, diverting or distracting to allow someone to move away
- letting someone know you do not agree with what they are saying
- giving a disapproving look or not laughing at inappropriate jokes or comments
- asking someone else to help (for example, another colleague or security)
- seeking emergency help (call 999 if necessary)
- writing down what happened as a reminder for later action

You should speak to the person the behaviour was aimed at as soon as you can to give your support and to let them know that what you witnessed was unacceptable. Make sure you have a quiet and safe place to have this conversation and you have enough time to talk fully.

Appendix 4 provides information about the support available to those involved.

Talk to them about what happened. Ensure they understand the reasons for reporting and ask if they agree with reporting their experience.

If they do not agree and you are worried about them or others, you should not put their name in your report. Speak to a member of the HR team or the safeguarding team to get advice.

Supporting a colleague

When someone talks to you about what they have seen or experienced, it is called a disclosure. You need to be supportive and sensitive. Appendix 11 provides advice about what to do when a colleague discloses their experience of sexual misconduct to you.

If you think urgent actions are required, it is important to be as open as possible with them about what urgent action you need to take and why.

If you believe that someone is in danger you should contact the police and report the incident to the HR and safeguarding teams.

How to make a report

It is important that sexual misconduct is reported so actions can be taken to keep people safe and to prevent it from happening again.

There isn't a time limit, but making a report as soon as possible will allow actions to be taken more quickly.

If you are reporting something you have witnessed, you should read page 8 and talk to the person the behaviour was aimed at before you make the report.

You can make a report yourself or you can ask the person you have disclosed to (for example, a colleague) to do this for you.

Reports may be made to:

- your manager or another manager, or a supervisor or educational supervisor if an apprentice or work experience placement. They will ask a member of the HR team for guidance
- a member of the HR team
- a freedom to speak up guardian (FTSU)

A trade union representative can support you to make a report.

Every report will be taken seriously.

Anonymous reports

If you give your name when you report sexual misconduct, the organisation will be able to complete a more in-depth investigation.

Providing your details can help the organisation to support you and signpost or refer you to further support.

All reports are taken seriously. If you do not feel you can provide your name, you can report anonymously.

Provide as much information as possible, including the times of events and the impact they are having on you and others. This will ensure the person reading your report can understand what happened.

The steps in this policy will be followed as closely as possible using the information you provide.

Listening to you

If you provide your name when you make a report, you will be given time to talk about what happened and discuss and agree what will happen next.

A suitable place to ensure you feel safe to talk will be agreed with you. You can bring a colleague, interpreter or a trade union representative to support you.

The person you speak to will:

- ask you for information about what happened using the questions in appendix 10
- use the advice in appendix 11 about how to respond to a disclosure or report

If you have any notes or evidence, it's a good idea to take them with you to the meeting. If you don't have evidence this won't mean your concern is not taken seriously. During the meeting, we will also:

- discuss and agree how to manage your report
- discuss your wellbeing and the support you need and agree how this will be provided. Appendix 4 provides information about support
- agree next steps and who you should contact if you have any questions

If you are not clear how you would like your report to be managed, you might find that taking time to think about it or talking to someone you trust about your options helps.

If you decide to stop your report, your wishes will be respected where possible. Page 16 provides information about when the organisation might be required to continue to take action.

If you change your mind, or the behaviour continues, you can use this policy later. There is no time limit.

Support

The person you give your report to will talk to you about the options for accessing help and support, including from the organisations listed in appendix 4.

If you are a member of a trade union, they can also provide advice and support.

Support for you to continue to work will be arranged where possible, based on advice from your organisation's occupational health team/service. This may involve using policies such as 'Flexible Working and Special leave' policy. Examples of support could include adjustments to your role, your working hours or location, or giving you time off to attend appointments to get help and support.

All support will be reviewed with you regularly to ensure it remains helpful and to identify any additional needs you may have.

If you can't attend work

If you don't feel able or well enough to attend work, you should let your manager or other person in a position of responsibility know. They will provide advice about the sickness absence policy. If it is reasonable, managers may agree to record the sickness, but not use the absence/s towards sickness triggers for any absences related to sexual misconduct. You & your manager should also discuss a referral to Occupational Health and whether you'd feel this would be supportive and beneficial. (Occupational Health details can be found via the staff intranet).

If your sickness absence is a result of the sexual misconduct you have experienced at work and your absence will not be paid, or if your sick pay is reduced, you could receive injury allowance. This tops up your income (including some welfare benefits) to 85% of your usual pay during the absence. Section 22 of the NHS Terms and Conditions Handbook provides more information about injury allowance.

A member of the HR team or your trade union representative can provide advice and information about injury allowance.

After you make a report

Our organisation has a duty to ensure all employees involved with sexual misconduct cases are supported. This includes employees who have concerns raised about them.

The person you made your report to will request support from a review group to decide what to do. This will be arranged as soon as possible to ensure the report is managed quickly and in line with policies and procedures.

Review group

The review group will include:

- the person you made your report to, if applicable/appropriate
- a member of the HR team

It might also include:

- a senior manager
- an expert, who could include:
  - a colleague from safeguarding
  - any other person who can provide advice that is needed

Appendix 5 provides more information about expert advice.

The review group will discuss the information provided, including the harm caused to you or others, and any other information available that is important to use alongside your report. For example, if there are aggravating factors, such as abuse of power over a more junior colleague.

The review group will review and make decisions about:

- actions that need to be taken quickly to prevent possible harm to you or others involved, using the template in appendix 8. For example, if the people involved work together, temporary changes to working arrangements may be needed
- assessments that might be needed to understand and mitigate against any further harm to you or others
- the immediate support you and others involved need
- which policies or procedure(s) are relevant to managing your report
- what communication is needed to protect you and others, and to notify the right people
- whether the police or other organisations need to be contacted
- who needs to be told about the actions that have been agreed
- how you and others involved will be updated about what will happen next

Read more about providing information and updates on page 15.

The review group will use the checklist in appendix 9 to ensure that the plans to manage the report are clear. They will also ensure a record is kept (anonymously if needed).

Outcomes

The review group will ensure your views are considered when making decisions about how to manage your report. One or more of these outcomes could be agreed:

- a request for more information from you or others about what happened
- using the disciplinary policy to manage your report
- using the bullying and harassment or grievance policy to manage your report (if it was raised as a grievance)
- using the relevant professional standards policy if the report is about a doctor or dentist
- a referral to NHS England's Regional Head of Professional Standards if the report is about a GP, general dental practitioner, optometrist or ophthalmic medical practitioner working in primary care and their name is included in one of the England Performers Lists
- using safeguarding policies to agree actions
- a report to the police
- a report to the employer of the person named in the report, if they are not employed by our organisation
- no further action

Investigations

If an investigation is needed, it will be completed using the policy agreed by the review group.

You can ask for adjustments if you need them, and they will be agreed if possible. Examples of possible adjustments include:

- a friend or family member attending meetings with you to support you, in addition to a trade union representative or colleague
- using an external investigator or an investigator with specific training, skills and experience
- using an expert(s) to support the investigation

Preventing victimisation

Victimisation is negative treatment because of being involved with a discrimination or harassment complaint. It is unlawful under the Equality Act.

Harassment or victimisation of anyone who has reported, or has helped someone else to report, sexual misconduct is unacceptable as is any attempt to persuade or force an employee to not raise their concerns.

Everyone will be supported when reporting sexual misconduct, whether their complaint is upheld or not.

If you believe you have been victimised, this will be taken seriously.

You should report victimisation to a manager, a member of the HR team, a freedom to speak up guardian or your trade union representative.

Providing information and updates

You will be given the name of the person you can go to with your questions and to get advice and support. You can also raise any concerns or discuss any further needs you have with them and they will keep you updated. This will usually be the person you report your concern to or a member of the HR team.

Due to confidentiality, not everything that happens can be shared with you, but you will receive regular updates.

The information that can be shared with you will be shared with you. You will not normally be told about personal or confidential outcomes or actions relating to another employee.

Confidentiality

The information you share when using this policy will be kept confidential where possible. Everyone involved in the process will be informed of their responsibilities to keep information confidential.

This means that only people who 'need to know' will receive the information because they are, or will be, involved in the process. You will be told who will receive the information, and why.

If there are safeguarding duties information may need to be shared to keep other people safe.

If you need advice or are concerned that confidentiality has not been kept you should speak to your manager, a member of the HR team or a trade union representative.

Confidentiality or non-disclosure agreements will not be used to stop reporting of sexual harassment or whistleblowing.

Telling your manager

You will be asked how you feel about telling your manager by the individual/s you reported concerns to.

If you haven't told your manager, it may be helpful to do so, so they can support you and others involved. If the concern is about your manager, another manager will be asked to support you.

When will the person the report is about be told it has been reported?

The person the report is about will often be told about some, or all, of the report to ensure they can take part in the investigation process.

This will always be done in a careful and planned way and will not happen without your knowledge.

Before the person is told, conversations will take place to agree how to support your wellbeing and safety and that of others.

Involving the police and other organisations

Sexual misconduct can be a criminal act. Normally, it will be your choice whether to report what happened to the police.

If your report includes information that suggests other people are at risk, including patients or colleagues, the review group will get advice from our safeguarding team.

They may need to share information with the police, the local authority designated officer (LADO) and / or the relevant local authority safeguarding team.

This might happen even if you do not wish to use this policy.

Where possible, you will be told before actions are taken and support will be provided to you throughout the process.

Police investigations

If a report has been made to the police, their investigation cannot be impacted by our organisation's own investigation process.

This may mean there are delays in our organisation completing an investigation process. You will be told as soon as possible if the police ask for the process to stop or be put on hold. You will be told how long this might be for and we can discuss the support you and others involved will need during this time.

Statutory regulators

Sometimes, there may be a requirement to report an employee holding a professional registration to their statutory regulator (for example, Nursing and Midwifery Council, General Medical Council, the Health and Care Professions Council, The Law Society) in line with their relevant professional code of conduct.

A member of the HR team or the 'responsible officer' for medical professionals will be responsible for reporting to professional bodies.

They may take advice from a range of individuals including the most senior person from the relevant profession within the organisation (for example, the chief nurse) before making a formal referral.

Preventing sexual misconduct

Our organisation will:

- review the likelihood and risks of sexual misconduct occurring at work from colleagues, volunteers, learners and others including patients, service users and visitors
- decide the actions that can be taken to reduce risks and prevent harm
- ensure the agreed actions are implemented and managed
- update policies and procedures to clarify the law, how everyone can expect to be treated and how to make a report
- review the effectiveness of policies and training
- communicate consistently about our values and expectations for behaviour and what actions may be taken when these are not met
- communicate with patients, service users and visitors about how we expect them to treat our staff and each other
- provide guidance and support to colleagues, helping them assist others if they witness sexual misconduct
- create a culture where people feel safe to talk about and report sexual misconduct
- ensure systems are in place to respond to reports and provide timely support to all employees impacted by sexual misconduct

Our organisation will use reports about sexual misconduct to prevent events from happening again, and to understand potential patterns and areas of concern and what is required to mitigate risks, take action, and improve the culture within teams and across the wider organisation.

Training

It is important that everyone understands:

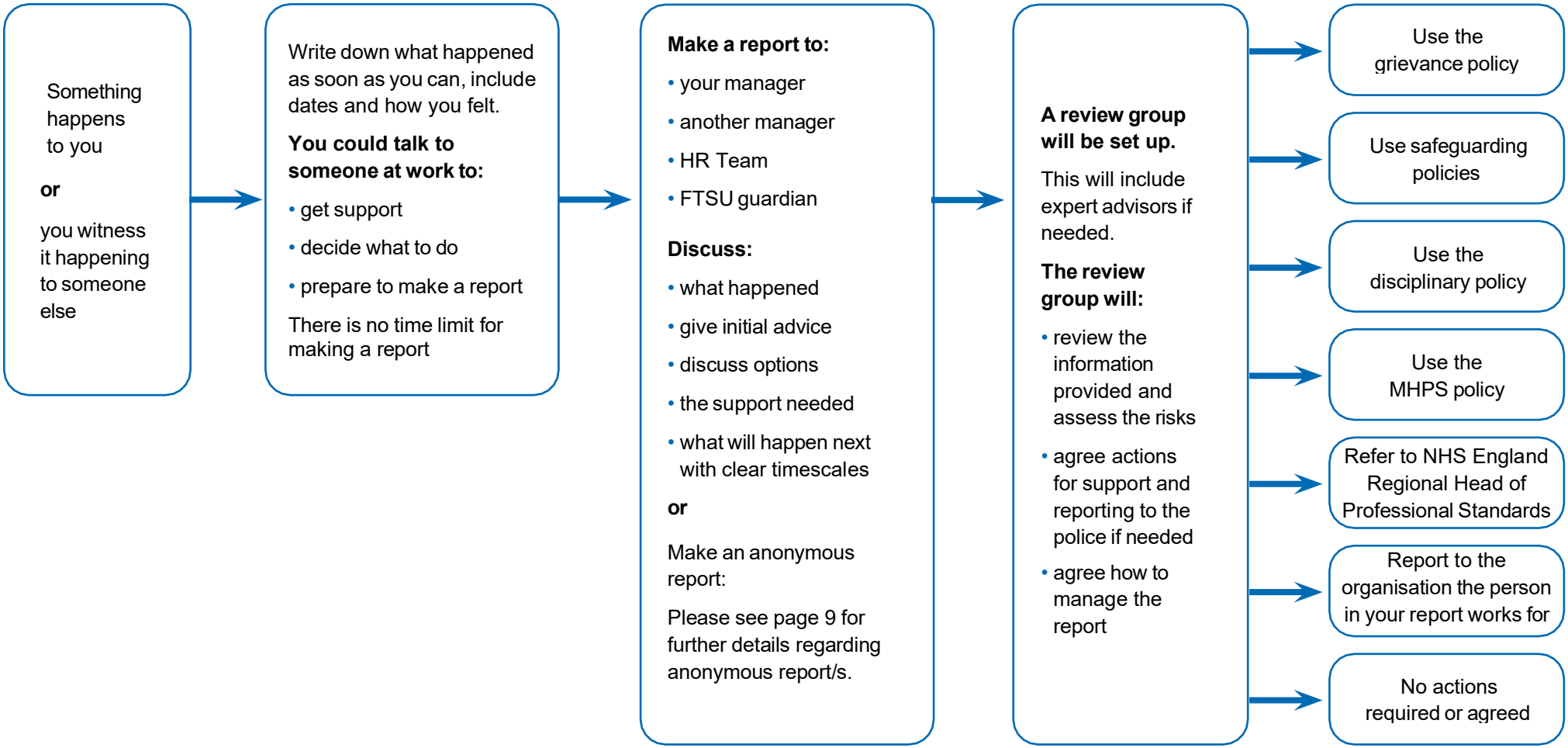
- what appropriate and inappropriate behaviours are
- how to use this policy
- what to do if they experience or witness inappropriate behaviours

Managers and members of the HR Team, freedom to speak up guardians (FTSU), wellbeing champions and colleagues from staff networks will receive training on this policy so they can offer support, advice and guidance to colleagues.

Feedback and experiences from those involved in using this policy will be used to create future training and ensure continuous reflection and learning across the organisation.

Appendix 1: Flowchart

This flowchart summarises the steps set out in this policy for reporting and determining how to handle cases of sexual misconduct.



Appendix 2: Responsibilities

The organisation's Board will:

- prioritise principles set out in this policy, and ensure they are followed by the organisation
- guide the organisational culture and set priorities relating to sexual safety
- take actions to ensure the organisation meets its legal duties to protect employees from sexual harm in the workplace. This will include actions to improve the environment and culture, and understanding and awareness among staff of sexual safety
- encourage, support and train managers and leaders to support the use of this policy, and to build a positive culture in their teams where people can talk openly
- regularly review data about sexual misconduct and use it to agree actions to prevent sexual misconduct and protect employees from it
- appoint an executive group member with responsibility for improving the sexual safety of employees
- appoint a lead for domestic abuse and sexual violence

Senior leaders will:

- create an environment that encourages and supports colleagues to discuss and report sexual harm, without fear of retaliation or victimisation
- provide leadership to support a positive and safe culture
- ensure all colleagues are aware of issues relating to sexual misconduct, the sexual misconduct policy and how to deal with disclosures appropriately

Everyone should:

- use this policy and get advice and support to report behaviour they have experienced or witnessed
- be respectful and maintain confidentiality when using this policy
- be clear that we do not accept any form of sexual behaviour described in appendix 3 at work or linked to work

The HR Team will:

- promote and provide support and guidance about using this policy and other people policies
- ensure that every report is managed compassionately and support is provided to everyone involved
- use specialist advice where needed and work closely with safeguarding teams, the police and other organisations where required
- provide advice and guidance to support learning and change where it is required
- ensure accurate records are made of concerns and manage information confidentially and in line with the policy for managing records

Managers, supervisors and educational supervisors will:

- take every conversation and report about sexual misconduct seriously
- use this policy to support everyone who is involved in a concern or report about sexual misconduct
- speak to a member of the HR team about all reports and concerns about sexual misconduct
- maintain confidentiality, unless there is a safeguarding concern that needs to be reported
- be clear about what is acceptable and unacceptable behaviour
- role model behaviours to create a culture where people feel safe to raise concerns and feel listened to
- attend training and development to ensure they have the required skills, knowledge and confidence to recognise sexual misconduct and take action
- ensure learning and change comes from using this policy, so that future misconduct is prevented and a positive culture is fostered
- be available to support an investigation if needed
- be proactive in putting in place any reasonable adjustments or safety actions if they are required

Safeguarding leads will:

- provide specialist advice and support about safeguarding
- advise on safeguarding training and support
- provide guidance and make referrals in confidence to a ‘person in position of trust’ (PIPOT) or local authority designated officer (LADO)

Freedom to speak up guardians will:

- provide appropriate support and signpost to further support to those who speak up about sexual misconduct
- assist employees to make a report where appropriate
- be responsible for creating a culture where employees feel safe to raise concerns and feel listened to

Trade union representatives will:

- influence and guide organisations about the preventative actions they can take to improve sexual safety
- signpost to this policy, explain the process for reporting and the possible routes and outcomes
- support and assist employees to report sexual misconduct, where appropriate
- explain the options for support and help with conversations about accessing support
- provide support to their members through informal and formal processes

Appendix 3: Language and definitions

Sexual safety: means being free from any unwanted sexual behaviour at work.

Sexual misconduct: describes a range of behaviours including sexual assault, sexual harassment, stalking, voyeurism and any other conduct of a sexual nature that is non-consensual or has the purpose or reasonable effect of threatening, intimidating, undermining, humiliating or coercing a person. Sexual misconduct can occur between people of the same or different sex and genders.

Sexual harassment: is unwanted behaviour of a sexual nature which has:

- violated someone's dignity, whether that was intended or not
- created an intimidating, hostile, degrading, humiliating or offensive environment for them, whether that was intended or not

Sexual harassment can be a one-off incident or an ongoing pattern of behaviour. It can happen in person or in other ways, for example online through email, social media or messaging tools.

Sexual violence: describes any sexual activity or act that happened without consent.

Sexual assault: is any sexual act that a person did not consent to or is forced into, against their will.

Examples

The following are examples that might be reported using this policy. They could take place at work, or in the course of your work, during online meetings or online chats, at a work event or a party:

- sexual comments or jokes, including what might be called 'banter'
- the sharing of sexual material online (for example, sharing sexual memes or, videos by email or platforms like WhatsApp)
- sexually inappropriate behaviour on social media where colleagues are involved
- displaying or sharing sexually graphic pictures, posters or photos (or other sexual content)
- suggestive looks, staring or leering
- using power, seniority to influence others for sexual favours
- intrusive questions about a person's private or sex life, or discussing your own sex life
- flirting, gesturing or making sexual remarks about someone's body, clothing or appearance
- making sexual comments or jokes about someone's sexual orientation or gender reassignment
- touching someone against their will
- sexual assault or rape

Appendix 4: Support provided by our organisation

Support available to all employees of the ICB include:

- employee assistance programmes
- wellbeing services
- health and wellbeing champions
- mental health first aiders

Members of the HR team

Can provide advice and guidance about this policy, and information about other services that can provide support via mlcsu.people@nhs.net

Safeguarding teams

Can provide advice and support to employees who disclose sexual misconduct and can signpost and refer staff to external support.

Trade union representatives

Can help and provide advice and support to their members about sexual misconduct at work.

They can provide advice, guidance and support, for example by attending meetings with you.

They will also help influence and guide organisations about preventative actions they can take to improve sexual safety.

Freedom to speak up guardians

Can offer a confidential and safe place to speak about sexual safety and provide guidance and information about how to resolve concerns. They can be contacted via FTSU@cheshireandmerseyside.nhs.uk

Appendix 4: External support

ACAS: helpline for anyone experiencing workplace related issues including sexual harassment.

Rights of Women: have free legal advice lines for women who have experienced domestic abuse, sexual violence and sexual harassment at work.

Surviving in scrubs: provide support, share survivor stories and campaign to end sexism, harassment, and sexual assault in the healthcare workforce.

General Medical Council: What to do if you think you have been subject to sexual misconduct by a doctor: a resource for patients and colleagues.

Health & Care Professions Council: sexual safety hub provides help and guidance about making a report to that organisation.

Protect: free, confidential whistleblowing advice.

Equality Advisory & Support Service: helpline to advise on issues related to equality and human rights.

Citizens Advice: provide information about your legal rights in the workplace if you are experiencing sexual harassment.

Samaritans: support for anyone who's struggling to cope, and who needs someone to listen without judgement or pressure

Getting help for domestic violence and abuse: NHS.uk provides practical advice and help to recognise the signs and where to get help.

Supporting a survivor of sexual violence: advice from Rape Crisis about how to support a survivor of sexual violence.

NHS help after rape and sexual assault: information on the NHS website about where to find support if you have been sexually assaulted, raped or abused.

Rape Crisis England and Wales: 24/7 helpline that can provide immediate support if you have experienced sexual misconduct.

Rape Crisis Scotland: 24/7 helpline that can provide immediate support if you have experienced sexual misconduct.

Sexual assault referral centres (SARCs): offer medical, practical and emotional support to anyone who has been raped, sexually assaulted or abused. SARCs have specially trained doctors, nurses and support workers.

Galop: support LGBT+ people who have experienced abuse and violence.

The Survivors Trust: The Survivors Trust has 120 member organisations based in the UK & Ireland which provide specialist support for women, men and children who have survived rape, sexual violence or childhood sexual abuse.

SurvivorsUK: provide support to male and non-binary survivors of sexual violence, providing counselling, practical help and community on your healing journey.

Victim Support: provide specialist help to support victims of crime to cope and move on to the point where they feel they are back on track with their lives.

A list of support services on the Government's website: for victims of sexual violence and abuse.

Appendix 5: Expert advice

An expert may be asked to support the review group and an investigation.

All reports will be different, so a range of expertise and experience could be needed. That knowledge and expertise may include:

Knowledge

- trauma informed interviewing and investigation techniques
- research led case reporting
- risk management
- understanding of issues impacting particularly vulnerable groups
- safeguarding

Skills

- ability to identify types of sexual misconduct
- ability to understand impacts on vulnerable groups
- ability to undertake extensive personal interviews to elicit better information and to reduce the potential for retraumatising
- ability to overcome barriers to disclosure while supporting employee wellbeing

Experience of

- undertaking or advising on trauma informed, employment led investigations
- supporting individuals or teams on a trauma-informed basis
- equality, diversity or inclusion implications within sexual misconduct reports and investigations, and understanding of the vulnerabilities of particular groups
- using subject matter expertise to aid investigations and improve decision making
- managing disclosures of sexual abuse and misconduct

Appendix 6: Links to more help and guidance

NHS England

Sexual safety in healthcare charter

Sexual safety charter assurance framework

E-learning on understanding sexual misconduct in the workplace

Guidance on the role of domestic abuse and sexual violence allies (on FutureNHS, registration required)

NHS Employers

NHS Terms and Conditions Handbook section 32 Dignity at Work

Equality and Human Rights Commission (EHRC) guidance

Preventing sexual harassment at work: a guide for employers

Employer 8-step guide: Preventing sexual harassment at work

Guidance on managing sexual misconduct

Advice about sexual harassment at work (ACAS)

Managing discrimination from patients and their guardians and relatives (BMA)

Managing concerns (Nursing and Midwifery Council)

Practitioner Performance Advice (PPA) (NHS Resolution)

Appendix 7: How will we know if this policy is effective?

We will monitor how effective this policy is by working in partnership with trade unions and other stakeholders to collect information. This information will be used regularly to review and understand the impact of the policy on our people and will help us understand how we can improve. This table sets out how we will monitor this policy:

What element of this policy will be monitored?	What is the method or information source, for example, audit or feedback?	Who will lead the monitoring?	When will the information be reviewed, by who or which group?	What are the arrangements for responding to issues and tracking delivery of planned actions?
How many individuals use this policy and how do they use it?	How many informal or formal processes are started each year? How many are completed?	The People/HR Function are responsible for monitoring compliance with this policy. The People/HR team will monitor the application of the policy and procedure through feedback from staff and managers. Feedback, legislature and changes to terms and conditions will be used to inform and improve policies, as well as provide recommendations for improving working practices. People/HR will provide relevant reports, based on this data, as required.	The information will be reviewed quarterly via People Committee and overseen by the board.	Upon receipt of a raised issue, the ICB will form a review group to oversee the complaint. They will be responsible for agreeing actions and ensuring these are implemented.
Does the extent of policy use vary across different staff or protected groups? Are there any differences in outcomes?	Using demographic, band and staff group data to analyse use of the policy.			
Feedback on advice, process, ease of use and internal and external support.	Feedback to the HR team from individuals, trade unions, freedom to speak up guardians and staff networks.			
What are the outcomes of using this policy? How much change or learning happens? What does this tell us about the culture?	How many concerns move to disciplinary? How many appeals are made each year, how are these resolved? What outcomes have come from anonymous reports?			

Appendix 8: Record of actions to support safety and wellbeing

Use this template to record risks to safety or wellbeing and decisions agreed to manage or provide support.

Anonymised details of people involved:	For example, refer to: the person who made the report and the person the report is about, rather than using names or initials.
Summary of the report:	
Expert advice provided by: **Details of the advice:**	
Has support been offered to everyone involved?	Yes or no – note response and actions
Are there safety risks? Who is impacted and how? (colleagues, service users, others) **What is the severity of impact?** **How likely is the impact to happen?**	
Decisions to support safety and wellbeing:	
Communication of decision to others that need to know: **Actions required to support the decision, for example, cover arrangements:**	

Appendix 9: Review group checklist

This checklist should be completed by the review group to ensure they have completed all the relevant actions.

Checklist:	Details:
Wellbeing and safety **1.** Has support been offered to the employee who made the report and others involved? **2.** Are those involved safe and are there any risks that need to be managed? **3.** Has a risk assessment been completed to review and take actions to support wellbeing and safety, including actions to ensure no further harm and risks to colleagues, patients, service users or other people. See more in appendix 8.	
Find the facts **1.** Do you have the facts from appendix 10 that you need? **2.** Has the employee who made the report discussed a preferred outcome? **3.** Do those involved work for the organisation? If not, which organisation do they work for? **4.** Are there any similar live cases on file relating to the person (or people) the report is about? **5.** Do other organisations have any information that is important to know, for example, another investigation. **6.** If further information is needed, gather this information **7.** Are there are aggravating factors, such as the abuse of power over a more junior colleague that need to be taken into account?	

Agree how to manage the report

1. Is there a requirement to get specialist advice? (for example, from safeguarding or legal). If so, record their advice
2. Following advice, is there a requirement to request advice or refer to another organisation, for example, the police, local authority designated officer (LADO), regulator?
3. Discuss and agree if another policy should be used.
4. Identify and agree who will take forward the management of the report, including how to refer to other organisations.
5. If a police report or LADO referral has or is being made, get advice about when the organisation can start to manage the report.

Appendix 9: Review group checklist

This checklist should be completed by the review group to ensure they have completed all the relevant actions.

Checklist:	Details:
Communication 1. Identify who 'needs to know' (for example, relevant managers, or other employers if one of the parties works for a different organisation) 2. Agree who will be the key point of contact for those involved and advise them of the arrangements 3. Agree regular review points (with everyone involved) 4. Have decisions and next steps been confirmed to those involved (including in writing if necessary)?	
Ensuring understanding **1**. Have you ensured the employee(s) understands the reasons for actions and for the approach to how the report will be managed? **2.** Have the next steps been discussed with the employee(s) involved (including a review of support)?	

Appendix 10: Questions to ask when you receive a report

Use this checklist to gather the information needed to understand what happened. If more than one incident took place, you may need to record each separately.

Before you begin, check:

- they do wish to make a report
- if they need or want anyone to support them during the conversation
- they are clear about confidentiality and safeguarding processes that mean you may need to share information (for example, if there is a safeguarding concern)

Personal details:

1. Name of the person making the report
2. Contact details and the best time to contact them

Who is reporting this?:

- someone who has experienced sexual misconduct
- a witness to sexual misconduct:
  - do they have consent of the person who was affected?
  - if yes, who did it happen to?
  - if no, do not ask or record information about the person affected
  - someone who has been disclosed to about sexual misconduct

About the incident:

1. Was it a single or multiple incidents?
2. Where did the incident(s) happen?
   - virtually using either work or non-work equipment and through any virtual platform including, social media, email and messaging services
   - NHS premises
   - offsite, in the course of work, at a non-work event or a work event
   - unsure or other
3. When did the incident(s) happen? If unsure, get rough dates or a range of dates
4. Do they want to name the person whose behaviour they are reporting?
5. Information about the behaviour(s) being reported (this doesn't need to be in lots of detail at this point)

Witnesses:

1. Did anyone witness this behaviour?
2. Do the witnesses know this report is being made?

Any further information the person wishes to provide? Check and discuss:

1. Do they have any notes or information to help them make their report?
2. Is anyone at immediate risk. Are any actions needed now?
3. What support is needed? (Refer to other policies such as flexible working or special leave)
4. Signpost to internal or external support (appendix 4)
5. Explain that more information will be needed if an investigation takes place
6. Explain the possible outcomes from the review group

Next steps:

1. Speak to a member of the HR team
2. Set up a review group

Notes:

Appendix 11: How to respond to a disclosure or report of sexual misconduct

It is important that everyone working in the NHS knows how to respond when someone makes a disclosure or report about sexual misconduct.

Each person will have different needs so you must ask how they want you or others to support them. Do not assume what they might need and do not dictate the process.

Many people feel a loss of control, so empowering them and validating their experience is vital to minimising trauma.

It is crucial to handle the conversation respectfully, sensitively and supportively. Your role is to listen to the person sharing their experience and agree on the next steps to take. Your role is not to provide counselling, clinical advice or offer retribution against the perpetrator.

Do:

- ensure they are safe
- actively listen (without having any distractions such as your phone)
- believe and validate them
- respect confidentiality but ensure they understand you may need to share information (for example if a safeguarding concern is outlined)
- safely signpost them to support (and reporting options if they haven't reported already)

Do not:

- push for details
- make assumptions
- ask why they did not say anything sooner
- be judgmental or criticise their choices
- express criticism or disbelief
- look disinterested (think about your body language)
- tell them what to do
- talk about your own experiences
- provide counselling yourself
- share their information with others unless they explicitly give you permission to do so, or there are safeguarding concerns
- ask why they did not run away or fight back
- play down or minimise their experience and the significance of what they are sharing

For more information complete the E-learning on understanding sexual misconduct in the workplace

Appendix 12: Additional guidance for managers

Promoting a positive culture

As a manager you have a key role in influencing the culture within your team. This begins with behaving in a way that lets your team see that you act and manage issues (not just those about sexual misconduct) fairly and with compassion. Your ability to recognise inappropriate behaviour and act as early as possible is important. It can help support people to speak up.

This means you need to challenge behaviours that are inappropriate and be aware of situations that might be harassment. Appendix 3 provides information and examples.

It may also involve identifying underlying tensions or information that suggests unreported events or behaviours within the team.

The grievance policy provides information about having early conversations to reach solutions between colleagues. It is important to consider whether this is appropriate before suggesting it. In some circumstances it will not be. You should never force someone to confront a colleague or try to resolve things together if they do not wish to. Ensure that you and your team attend the training to understand what sexual misconduct is and how to make a report.

Getting advice and support

Receiving information or a report about sexual misconduct can be worrying and you might not have experienced this before.

It's important to get advice from a member of the HR team, and the safeguarding team as soon as possible, especially if you are worried about safety.

You can do this without mentioning names in the first instance, to maintain confidentiality. It is important to remember that sometimes you may have a responsibility to escalate the report to ensure the safety of others.

If you are finding it difficult to support someone or to process information you have heard, speak to your manager or a member of the HR team who can provide advice and support.

Relationships at work

Relationships between work colleagues can happen. Sexual misconduct can happen within a range of relationships, and it is important that professional boundaries are maintained.

The relationship might not be appropriate where there is a power imbalance, when training and career progression opportunities of one party could be impacted, or when people work closely together.

To discuss a relationship between colleagues, speak to the HR Team.

Receiving a report about sexual misconduct

You have an important role to ensure reports are made effectively and dealt with. Your openness, ability to listen and take actions will show that sexual misconduct is taken seriously.

Try to remain calm and listen fully when someone reports a concern about sexual misconduct to you. This may have taken a lot of courage to raise with you and could be an emotional experience for them.

You should let them know you take their report seriously and you are there to help. Appendix 11 provides guidance about how to respond and provide initial support and appendix 10 provides a list of questions to ask and points to check and discuss.

Discuss and agree what will happen next. It is important that you understand their needs and expectations and are clear with them about the actions you are going to take. This might be difficult if they are feeling emotional or anxious and it might help to follow up later to check understanding.

If they are very upset, or they need more time to think about what to do, it might be helpful to give them some time and meet again at another time. Always check they have support and take actions to put support in place.

During the conversation, collect information about what happened and ensure they have time to discuss their views about what to do next, as it is important to respect their views.

Get advice from a member of the HR team or other professionals as soon as you can. They will support and help you to set up a review group.

Anonymous reports

Some people may prefer to report their concern anonymously. Anonymous reports will be recorded in one location and used to understand underlying concerns and trends.

It is important that anonymous reports are taken seriously. They can provide helpful information about patterns or areas of concern.

A member of the HR team will provide advice about managing anonymous reports.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 November 2025

Board Assurance Framework Strategic Risks 2025-2028

Agenda Item No: ICB/11/25/18

Responsible Director: Clare Watson
Assistant Chief Executive

Board Assurance Framework
Strategic Risks 2025-2028

1. Purpose of the Report

1.1 The purpose of the report is to present the proposed 2025-28 Board Assurance Framework (BAF) and strategic risks within for Board approval.

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 At the May 2025 Board meeting, it was agreed that the principal risks included in the 2024/25 Board Assurance Framework should be reviewed in light of new strategic challenges and, more specifically against a landscape of considerable change in terms of the future 'model ICB blueprint' and the publication of the government's 'Ten Year Health Plan for England'. Work commenced in July 2025 to re-assess the 2024/25 principal risks against the newly published Ten-Year Health Plan for England, the proposed transition of ICBs to 'strategic commissioners' and the shift from hospital-based care to community and the establishment of a neighborhood health service.

2.2 Following individual review meetings with risk leads / Executive Officers and discussions at Executive Committee meetings, it was agreed that a new set of strategic risks should be drawn up, taking into consideration the revised priorities within the Ten-Year Health Plan for England, the Cheshire and Merseyside Health Care Partnership Plan 'All Together Fairer' and the four core purposes of ICBs. The existing ICB BAF risk would either be encapsulated within the new BAF risks or closed down.

2.3 The proposed strategic risks were submitted to the Board at its September 2025 meeting where approval was sought and received to progress the development of the proposed strategic risks, and for the final drafts to be brought back to its November 2025 meeting for approval.

2.4 Additionally, support was received that the refreshed BAF runs for a three-year period (as opposed to the 12-month time frame usually adopted by NHS organisations). The rationale for this key change is to ensure a degree of consistency and 'future proofing' by aligning principal strategic risks against the four ICB 'core purposes; particularly given the scale of impending NHS reforms and the financial and economic challenges the ICB faces in the short to medium term.

2.5 The BAF in Appendix One therefore reflects these discussions and encompasses 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 proposed 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.

2.6 The BAF risks are also aligned to the proposed Cheshire and Merseyside key strategic themes and goals 2026-2031.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- **APPROVE** the Board Assurance Framework 2025-2028
- **CONSIDER** whether the ICBs current core appetite statement is still correct and should continue to be adopted or whether it should be reconsidered in light of the current environment the ICB is operating.

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 at place)
- 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[1] 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. 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

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		
0 – None*: avoidance of risk is a key organisational objective*	**1 – Minimal:** *preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential*	**2- Cautious:** *preference for safe delivery options that have a low degree of residual risk and only a limited reward potential*
3 – Open: *willing to consider all potential delivery options and choose while also providing an acceptable level of reward.*	**4 – Seek:** *eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)*	**5 – Significant:** *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.*

[1] https://www.cheshireandmerseyside.nhs.uk/media/ry3ab3cp/cheshire-and-merseyside-icb-risk-management-strategy-v21.pdf

The ICB has no tolerance for safety risks that could result in avoidable harm to patients.

Our ambitions to improve the health and wellbeing of our population and reduce inequalities can only be realised through an enduring collaborative effort 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 This ICBs Core appetite statement has not changed since 2023. **The ICB Board is asked to consider whether this core appetite statement is still correct and should continue to be adopted or whether it should be reconsidered in light of the current environment the ICB is operating in**. If the Board considers that it should be revisited then a further risk appetite session will be developed for the Board to consider this further.

6. Board Assurance Framework Risks 2025-2028

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 Since the September 2025 Board meeting the main change to the BAF risks that are being proposed is the combining of two risks around health inequalities and prevention/wider determinants into one risk (P12 and P18 combined). There have also been minor changes to the risk descriptions of each risk, however the risk titles/themes have remained the same.

6.3 Of the eight proposed risks, three are being identified as extreme risks (P4, P13, P14), four are being identified as high risk (P11, P12, P15, P16) and one is being 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, well as benchmarking against similar risks that feature on other ICB and provider BAFs.

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:

- BAF is updated and reported to Board on a quarterly basis
- reporting of assigned risks to each appropriate Committee – with reports to each Committee meeting as a standing 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 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

13.1 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

16. Appendices

Appendix One: Board Assurance Framework Risks 2025-2028

Draft Cheshire and Merseyside Integrated Care Board - Board Assurance Framework 2025-2028– Summary (v1.4 Nov 2025)

ICB Core Purpose	BAF ID	Strategic risk	Risk Appetite (draft)	Current score	*(proposed)* Target Score	Lead director(s) / board lead	Lead committee / board
Improve outcomes in population health	**P4**	**Quality & Safety failures in commissioned services:** 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	Exec Director of Nursing / Medical Director	Quality & Performance Committee
	P11	**Digital and Cyber Resilience Gaps:** 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	Medical Director	Executive Committee
Tackle inequalities in outcomes, experience and access	**P12**	**Failure to reduce health inequalities and improve population health:** Risk that 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	Assistant Chief Executive	Executive Committee
Enhance productivity and value for money	**P13**	**Inability to achieve financial sustainability and productivity:** 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 & Contracts	Finance, Investment and Resources Committee
	P14	**Failure to Recover Access and Performance Standards:** 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	Director of Performance & Planning	Quality & Performance Committee
	P15	**System Fragmentation and Provider Sustainability:** 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**	**Failure to Deliver the Shift to Neighbourhood and Community-Based Care:** 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	Assistant Chief Executive	Executive Committee
	P17	**Workforce Capacity, Capability, and Morale:** 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
	P18	**Failure to Embed Prevention and Address Wider Determinants:** There is a risk that the ICB will not embed prevention and action on wider determinants (housing, employment, environment) into commissioning and system leadership, limiting our impact on long-term health outcomes and economic prosperity. Decision made to combine with P12 (same risk)					

Risk Title	Quality and safety failures in commissioned services
Strategic Risk Ref: P4	**Risk Description**: 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.
ICB Core Purpose	Improve population health outcomes
ICB Strategic Goal	Reduce health inequalities
Directorate	Quality & Performance
Lead Director	Executive Director of Nursing / Medical Director
Lead Committee	Quality & Performance Committee
Risk Appetite	Minimal

Risk Scoring and Tolerance

	Inherent risk score	Q1	Q2	Q3	Q4	In-year Target Score	Long Term Target Score	Long Term Target Date
Likelihood	5	4	4			4	2	March 2028
Impact	5	5	5			5	5	
Risk Level	25	20	20			20	10	

Number of Linked Risks on Corporate Risk Register

Low (1 - 4)	Mod (6 – 12)	High (15 – 25)

Lines of Defence	Sources of Assurance	Assurance Level
1st Line	Reporting from Place ADQs; Quality Impact Assessment assurance reporting to Quality & Performance Committee; Nursing & Care Safeguarding Oversight Group reporting to Quality & Performance Committee;	Acceptable
2nd Line	Quality & Performance Committee - reporting to ICB Board; Regional Quality Group reporting.	Acceptable
3rd Line	Quality & Performance Committee - reporting to ICB Board; Regional Quality Group reporting. Assurance meetings with NHSE; Internal Audit reports / recommendations Regional SQG	Acceptable

Rationale for Risk Score and Progress made in the quarter

The increased focus on the challenging system financial position, availability of resources and our need to increase productivity in 2025-26 makes it imperative to mitigate any potential impact to the quality and safety of commissioned services. It is therefore anticipated that progress in further reducing this risk will be limited during the current financial year. There remains the potential for multiple deaths, permanent injuries or irreversible health effects, or harm to more than 50 people, totally unacceptable quality of clinical care, and gross failure to meet national standards. Good progress has been made in establishing the quality oversight framework providing a firm foundation for identifying emerging concerns and appropriate intervention.

Key Controls

1. Well established provider oversight processes / Quality Performance Dashboard
2. Quality Assurance Framework established and aligned with National Quality Board Standards
3. Quality Impact Assessment process established and embedded in ICB decision-making processes
4. Place-based Quality Schedules within NHS Contract / standardised C&M Quality Schedule
5. Place-based quality reporting
6. Rapid Quality Reviews, Independent Investigations & other reviews and responses to national enquiries and investigations

Gaps in Control or Assurance

Reduction in workforce capability and capacity due to organisational changes and organisational vacancies increases risk of gaps across central and place functions - gaps in assurance could increase whilst organisational structures are in transition (potential disruption to maintaining compliance of QA processes relating to safeguarding, AACHC and SEND)

Action

No	Action Required	Due Date	Update on Actions	BRAG RATING
1.	Development of Quality Statements to support 2025/26 Commissioning Intentions.	Mar 26		On track
2.	Develop BI capability to support intelligence led approach - Development of data and intelligence platforms to identify and triangulation	Mar 26		On track
3.	Strengthen use of patient experience, insight and feedback to ensure the early identification of negative impact on patient experience	Mar 26		On track
4.	Ensure ICB governance structure redesign aligns with statutory requirements and supports delivery	Mar 26		On track
5.				On track

Date of update: November 20205

Date next update due: January 2026

Risk Title	Quality and safety failures in commissioned services
Strategic Risk Ref: P4	**Risk Description:** 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.
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Risk Scoring and Tolerance

	Inherent risk score	Q1	Q2	Q3	Q4	In-year Target Score	Long Term Target Score	Long Term Target Date
Likelihood	5	4	4			4	2	March 2028
Impact	5	5	5			5	5	
Risk Level	25	20	20			20	10	

Number of Linked Risks on Corporate Risk Register

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5.				On track

Date of update: November 20205

Date next update due: January 2026

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Number of Linked Risks on Corporate Risk Register

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3rd Line	Quality & Performance Committee - reporting to ICB Board; Regional Quality Group reporting. Assurance meetings with NHSE; Internal Audit reports / recommendations Regional SQG	Acceptable

Rationale for Risk Score and Progress made in the quarter

The increased focus on the challenging system financial position, availability of resources and our need to increase productivity in 2025-26 makes it imperative to mitigate any potential impact to the quality and safety of commissioned services. It is therefore anticipated that progress in further reducing this risk will be limited during the current financial year. There remains the potential for multiple deaths, permanent injuries or irreversible health effects, or harm to more than 50 people, totally unacceptable quality of clinical care, and gross failure to meet national standards. Good progress has been made in establishing the quality oversight framework providing a firm foundation for identifying emerging concerns and appropriate intervention.

Key Controls

1. Well established provider oversight processes / Quality Performance Dashboard
2. Quality Assurance Framework established and aligned with National Quality Board Standards
3. Quality Impact Assessment process established and embedded in ICB decision-making processes
4. Place-based Quality Schedules within NHS Contract / standardised C&M Quality Schedule
5. Place-based quality reporting
6. Rapid Quality Reviews, Independent Investigations & other reviews and responses to national enquiries and investigations

Gaps in Control or Assurance

Reduction in workforce capability and capacity due to organisational changes and organisational vacancies increases risk of gaps across central and place functions - gaps in assurance could increase whilst organisational structures are in transition (potential disruption to maintaining compliance of QA processes relating to safeguarding, AACHC and SEND)

Action

No	Action Required	Due Date	Update on Actions	BRAG RATING
1.	Development of Quality Statements to support 2025/26 Commissioning Intentions.	Mar 26		On track
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4.	Ensure ICB governance structure redesign aligns with statutory requirements and supports delivery	Mar 26		On track
5.				On track

Date of update: November 20205

Date next update due: January 2026

NHS Cheshire and Merseyside

Risk Title	Quality and safety failures in commissioned services

Strategic Risk Ref: P4

Risk Description

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.

Risk Scoring and Tolerance

	Inherent risk score	Q1	Q2	Q3	Q4	In-year Target Score	Long Term Target Score	Long Term Target Date
Likelihood	5	4	4			4	2	March 2028
Impact	5	5	5			5	5	
Risk Level	25	20	20			20	10	

Number of Linked Risks on Corporate Risk Register

Low (1 - 4)	Mod (6 – 12)	High (15 – 25)

ICB Core Purpose	Improve population health outcomes
ICB Strategic Goal	Reduce health inequalities
Directorate	Quality & Performance
Lead Director	Executive Director of Nursing / Medical Director
Lead Committee	Quality & Performance Committee
Risk Appetite	Minimal

Rationale for Risk Score and Progress made in the quarter

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Date of update: November 20205

Date next update due: January 2026

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Strategic Risk Ref: P4	**Risk Description**: 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.
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Number of Linked Risks on Corporate Risk Register

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ICB Strategic Goal	Reduce health inequalities
Directorate	Quality & Performance
Lead Director	Executive Director of Nursing / Medical Director
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Risk Appetite	Minimal

Rationale for Risk Score and Progress made in the quarter

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5.				On track

Date of update: November 20205

Date next update due: January 2026

NHS Cheshire and Merseyside

Risk Title	**Workforce Capacity, Capability, and Morale**
Strategic Risk Ref	**P17**
Risk Description	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.
ICB Core Purpose	Enhance productivity and value for money
ICB Strategic Goal	Support workforce resilience
Directorate	Nursing & Care
Lead Director	Chief People Officer
Lead Committee	Executive Committee
Risk Appetite	Open

Risk Scoring and Tolerance

	Inherent risk score	Q1	Q2	Q3	Q4	In-year Target Score	Long Term Target Score	Long Term Target Date
Likelihood	4	4	4			4	2	March 2028
Impact	4	4	4			4	4	
Risk Level	16	16	16			16	8	

Number of Linked Risks on Corporate Risk Register

Low (1 - 4) | Mod (6 – 12) | High (15 – 25)

Lines of Defence	Sources of Assurance	Assurance Level
1st Line	Reporting of System Workforce Dashboard to ICB People Board. Reporting to Finance, Investment & Resources Committee (FIRC)	Acceptable
2nd Line	Reporting to ICB Board from FIRC/People's Board	Acceptable
3rd Line	Internal Audit Plans; NHSE Assurance Mechanisms	Acceptable

Rationale for Risk Score and Progress made in the quarter

The current risk score reflects both existing and emerging factors relating to NHS Reform / Model ICB Blueprint and continued uncertainty of future workforce needs. C&M ICB has a number of challenges relating to ongoing workforce gaps (much of which the ICB is unable to influence due to financial position and decreasing workforce due to leavers / long term sickness challenges in key functions), reduced staff wellbeing, lower morale and inequality of opportunity, which is likely to further impact on delivery of priorities and leadership capacity to manage change.

Key Controls

1. Management of Organisational Change Policy; Grievance & Disputes Policy; Pay Protection Policy
2. People's Operation Group (staff engagement forum); staff engagement forums at 'Place' level
3. Health & Wellbeing support available to all staff
4. System Workforce Dashboard
5. Series of workshops arranged for staff to increase resilience and support wellbeing (mindfulness, self care, CV writing and reflective practice)
6. All staff briefings (We Are One) conducted on fortnightly basis or where key updates require communication.
7. Equality Impact Assessments form integral part of ICB's decision-making processes.
8. Redirection of staff capacity/resources to priority recovery areas

Gaps in Control or Assurance

Majority of factors influencing this risk are outside of C&M ICB's controls (e.g. HR team capacity to deliver change programme, uncertainty of national timelines and of funding for compulsory/voluntary redundancy schemes).

Action

No	Action Required	Due Date	Update on Actions	BRAG RATING
1.	Continued, proactive engagement with staff groups to resolve current and emerging workforce concerns	Jan 26		On track
2.	Development of a transitional plan for the organisation between now and April 2026.	Nov 25		On track
3.	Mobilisation and engagement plan	Apr 26		On track
4.	Develop a robust organisational change plan that will be delivered in phases starting with the senior leadership team restructure.	Nov 25		On track
5.	Organisational development plan/process for the 6 identified 'do once services'	Apr 27		On track

Date of update: November 2025

Date next update due: January 2026

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

Cheshire and Merseyside ICS – Urgent Emergency Care strategy for 2025/26

Agenda Item No: ICB/11/25/19

Responsible Director: Mandy Nagra
Chief System Improvement and Delivery Officer

Cheshire and Merseyside ICS – Urgent Emergency Care strategy for 2025/26

1. Purpose of the Report

1.1 This paper and supporting presentation sets out the processes being taken across Cheshire and Merseyside in order to improve Urgent Emergency Care (UEC) delivery via standardisation and consolidation and a particular focus on equitable access to all patients.

1.2 This is being shared for Board approval so it can be progressed through individual Cheshire and Merseyside Trust and system governance. It has already been approved through the ICS UEC Board.

2. Executive Summary

2.1 The UEC Strategic Plan for 2025/26 sets the direction for system-wide improvement across Cheshire and Merseyside.

2.2 The plan responds to national asks and local priorities, focusing on shifting care from hospital to community, improving patient flow, reducing delays, and standardising pathways.

2.3 It is underpinned by principles of clinical leadership, data-driven decision-making, inclusivity, and collaboration across acute, community, primary, social care, and voluntary sectors.

2.4 The strategy is designed to deliver better patient outcomes, improved health equity, and greater system efficiency, directly supporting the ICB's strategic objectives for integrated, high-quality, and sustainable care

3. Background and key areas to note

3.1 Cheshire and Merseyside is a complicated system but to add to this complication, 9 places have made 9 local models for managing UEC across C&M. This has now resulted to unaffordability and inequitable access to services. Some basic processes are not in place across UEC and these include standardisation for Mental health support for UEC pathway, different discharge processes, the system does not work towards improving discharge processes (D2A) and hence we continue to delay patients waiting to be discharged. Additionally, response from Social Care varies across the system.

3.2 Considerable investment has been made in the system, over the past few years, through a number of funding streams (including Better Care Fund (BCF), Discharge funds and additional NHS investment) and yet the system continues to under deliver in a number of key areas such as 4-hour performance, Non-

Criteria To Reside (NCTR), and 12 hours delays in Emergency Departments (ED).

3.3 The accompanying presentation (Appendix One) now sets out the focus areas for the system that the Cheshire and Merseyside UEC Board believe will have the greatest impact for improving UEC across Cheshire and Merseyside. In summary, key areas of note are:

- **System-wide Standardisation and Integration:** The plan emphasises standardising urgent community response, frailty, mental health, and children and young people (CYP) pathways, while maintaining local flexibility. A single point of access and care coordination is being implemented to streamline referrals and reduce unnecessary hospital conveyance.
- **Digital Transformation and Data Utilisation:** Investment in digital tools and data platforms (e.g., SCC, Cipha, Shrewd) is central to improving patient flow, monitoring performance, and enabling real-time decision-making.
- **Workforce and Collaboration:** The strategy relies on multi-disciplinary teams, collaboration with local authorities, and engagement with the voluntary sector. Workforce sustainability and capacity are recognised as critical enablers.
- **Performance Improvement:** Key targets include reducing ambulance handover times, ending 12-hour corridor waits, increasing community-based care, and improving discharge processes (D2A).
- **Focus on Health Inequalities:** The plan aims to improve health equity by ensuring consistent access to UEC services across the region and addressing the “postcode lottery” in service provision.

3.4 There are a number of key risks to note:

- **Variation in Service Delivery:** There remains considerable variation in access and delivery of UEC services across Cheshire and Merseyside, risking inequitable outcomes.
- **Workforce Capacity and Sustainability:** The ability of locality teams to absorb new initiatives and maintain service standards is a key risk. Workforce shortages, particularly in frailty and CYP pathways, may impact delivery.
- **Integration with Local Authorities:** Effective alignment of NHS and social care, especially for winter planning and discharge, requires further improvement. Governance and impact of Better Care Fund (BCF) investments need clarification.
- **Digital and Data Challenges:** Ensuring all providers are equipped and trained to use digital platforms, and that data is consistently shared and acted upon, is essential for success.

3.5 The UEC strategy directly supports the ICB’s strategic objectives by:

- **Promoting integrated care** through system-wide collaboration and shared pathways.
- **Improving quality and safety** by reducing delays, standardising care, and focusing on both physical and mental health.
- **Enhancing sustainability** by shifting care closer to home, optimising resource use, and leveraging digital transformation.

- **Reducing health inequalities** by addressing variation and ensuring equitable access to urgent and emergency care services.

4. Ask of the Board and Recommendations

4.1 **The Board is asked to:**

- **approve** the Cheshire and Merseyside Urgent Emergency Care Strategy for 2025-26.

5. Reasons for Recommendations

5.1 To support this agenda to now progress at pace required and get all Providers to progress through local governance.

6. Next Steps, key actions and key timelines

6.1 Subject to the approval of the Strategy, the approval of the Strategy will need to be progressed with all NHS Trust provider Boards. There are a number of key actions that will need to be progressed:

- **Standardise and Implement Pathways**
  - Roll out standardised urgent community response (UCR), frailty, mental health, and children & young people (CYP) urgent and emergency care (UEC) pathways across Cheshire & Merseyside.
  - Embed Discharge to Assess (D2A) processes and single point of access/care coordination.

- **Governance and Partnership**
  - Strengthen collaboration with local authorities, especially for winter planning, discharge, and Better Care Fund (BCF) governance.
  - Establish clear processes for reviewing and endorsing BCF investments.

- **Address Health Inequalities**
  - Ensure equitable access to UEC services and reduce postcode lottery effects.

7. Officer contact details for more information

Mandy Nagra
Chief System Improvement and Delivery Officer – Leading system Recovery
mandy.nagra@cheshireandmerseyside.nhs.uk

8. Appendices

CLICK HERE to access the Appendix
Appendix One: Cheshire and Merseyside ICS UEC Strategy 2025-26

- Cheshire and Merseyside Integrated Care System – Urgent and Emergency Care strategy 25/26 – setting strategic direction and improvement for the system

C&M Urgent & Emergency Care Strategic Plan on a Page

Enablers

- Estates utilisation
- Digital transformation
- People - Workforce
- Communication
- Connecting the whole programme

Acute, Community, Primary & Social Care Teams with support from VCSFE & Local participation groups

One version of the truth; SCC, Cipha, Shrewd

A single team driven by opportunities to innovate & improve

Principles

- Driving standardisation and consistency by working together at scale where it makes sense.
- Doesn't replace what individual organisations should do, or the role of Place or localities.
- System designed, locally driven
- Clinically led
- Data & Intelligence led; go where the data leads us
- Inclusivity not exclusivity
- Physical and mental health focus

Scheme 1: HISU ownership at neighbourhood MDT level

Scheme 2: Single Point Of Access & Care Co-ordination

Scheme 3: Urgent Community Response standardisation

Scheme 4: Embed D2A across physical and Mental Health

Scheme 5: Agree Frailty model and standardise

Scheme 6: Standardise CYP UEC pathways

Scheme 7: UTC and WIC standardisation

Scheme 8: Mental Health UEC Plan

NHSE UEC Plan 25/26 ' Delivering the Asks'

1. From treatment to prevention: taking steps now to reduce demand for urgent care later this year
2. From hospital to community: increasing the number of patients receiving care in community settings
3. High-quality emergency care: meeting the maximum 45-minute ambulance handover
4. Improving flow through hospitals
5. Ending 12-hour waits in corridors for a bed
6. Collaboration of delivery between mental health and acute teams
7. A whole-system approach to improving patient discharge
8. From analogue to digital: using data and digital investment to improve flow

Quicker Recovery | Improved well-being & independence | Better Patient Experience | Improved Health equality | Happier workforce | Additional efficiencies

Scheme Name: (1) High intensity users

Lead: Fiona Lemmens

Key Objectives – what would success look like if the scheme works?

- Every locality has a core offer to support High intensity users that is adapted to meet the specific challenges of the locality.E.g. Some Localities may have HIUs predominantly with drug and alcohol issues, others may have multimorbid frail HIUs
- The offer is embedded into Neighbourhood teams.
- Outcome: patients receive proactive, personalised care, closer to home that reduces their attendance at GP practices, urgent care services and emergency departments.

Key Stakeholders:

- Emerging neighbourhood teams and those leading the development of the NH model
- PCNs and GPs
- NWAS
- Acute Providers
- SPOA /UCR providers

Key milestones/ next steps to take the scheme forward:

- Agree definition of HIU
- Agree scope of project
- Map current HIU schemes
- Identify gaps

Potential risks, issues to delivery and mitigation:

Potential risks/ issue	Mitigation
Variable stages of development of NHTs	Work to align with NHT programme
Capacity of locality teams to take on another project	Additional programme support identified

Scheme Name: (2) Single Point of Access / Care Coordination

Lead: Jenny Wood / Emma Danton

Key Objectives – what would success look like if the scheme works?

- UCRs will receive ~116 additional referrals per week from NWAS, via digital ITK link
- There will be ~49 fewer ambulances per week arriving at EDs across C&M

Key Stakeholders:

- SPOA providers: COCH/CWP; Wirral; East Cheshire; Mid Cheshire; MWL, Mersey Care, WHH/Bridgewater
- NWAS
- ED leads

Key milestones/ next steps to take the scheme forward:

- 27th Oct – 26th Nov: all SPOA providers to be set up with access to digital referrals from ambulance stack
- Nov – Dec: PDSA approach to monitoring impact and reviewing clinical safety
- Jan – Mar: Expand single telephone number to other HCPs

Potential risks, issues to delivery and mitigation:

Potential risks/ issue	Mitigation
Risk that SPOAs (mostly tagged onto UCR teams) become overwhelmed because they have essentially taken on the hear and treat function from NWAS	Processes have been built in to allow the teams to “switch off” referrals. Use of the function to be monitored closely
There is a risk that the benefits will not be felt immediately as providing a CAS via UCRs is untested	Close monitoring of data and feel of new pathway in a PDSA cycle approach to continuous improvement

Scheme Name: (3) Urgent Community Response Standardisation

Lead: Ian Moston / Emma Danton

Key Objectives – what would success look like if the scheme works?

- We will see an increase in UCR accepted referrals from ~39k (24/25) to ~54k (25/26), with a consistent spread of referrals per population
- There will be a correlating impact on ED attendances, proving that the additional UCR activity was admission avoidance

Key Stakeholders:

- UCR providers: COCH/CWP; Wirral; East Cheshire; Mid Cheshire; MWL, Mersey Care, WHH/Bridgewater
- Place commissioning teams

Key milestones/ next steps to take the scheme forward:

- Nov - Dec: providers to agree action plans with commissioners re closing gaps against standard spec
- Dec – Mar: activity increases expected to be delivered

Potential risks, issues to delivery and mitigation:

Potential risks/ issue	Mitigation
Risk that delivering additional elements of the spec will require additional funding	Place commissioners to work directly with UCR providers to address this within total funding envelope
Risk that delivering additional activity will result in a deterioration in the 2hr standard performance	System is asked to tolerate this risk, as long as there is a measurable impact on overall UEC performance and evidence that more patients are seen in the right place at the right time

Scheme Name: (4) Embed D2A

Lead: Alan Butler

Key Objectives – what would success look like if the scheme works?

- Pathway 1 patients are discharged within 48hrs of becoming medically fit for discharge in 90% of cases
- Pathway 2 patients are discharged within 72 hrs in 90% of cases
- Pathway 3 patients are discharged within 7 days in 90% of cases
- Pathway 3 will account for no more than 1.0% of all discharges for patients and only used in 'rare circumstances' as per national D2A guidance

Key Stakeholders:

- All Cheshire and Merseyside Local Authorities
- All NHS acute trusts
- Mersey Care NHS Foundation Trust
- North West Ambulance Service NHS Trust
- Independent sector domiciliary care providers
- Independent sector care home providers

Key milestones/ next steps to take the scheme forward:

- Draft a single framework for pre -discharge assessment to be used across all Trust sites, based on the principle full assessment should take place in the community.
- Work with Local Authorities and the independent sector to rollout trusted assessment in the domiciliary care and care home market
- Confirm capacity to support community assessment across
  - P1
  - P2
- Set out a proposal to 'right size' and reset P1 and P2 capacity and criteria based on capacity and demand

Potential risks/ issue	Mitigation
Getting agreement across all Trusts and LA's to a standard D2A assessment framework	Use best practice from other areas, and local learning to inform the development.
Type and volume of P1 and P2 capacity to enable an effective D2A approach	Capacity and demand work to ensure the system maximises the use of available resource.

Scheme Name: (5) Frailty

Lead: Carl Marsh

To coordinate delivery of frailty priorities across Cheshire & Merseyside, ensuring safer care, improved outcomes, and reduced system pressures through structured programmes and collaborative working

Key Stakeholders:

- North and Mid Mersey Frailty Group
- Frailty in Cancer Programme (Cancer Alliance)
- Palliative and End of Life
- Community Programme (Provider Collaborative)
- North West UEC Learning Improvement Network
- Cheshire, Warrington and Wirral Frailty leads
- Meds Management leads

Key milestones/ next steps to take the scheme forward:

- C&M frailty group meetings now in the diary
- Frailty SRO has met with stakeholders and delivery plan to be agreed at next meeting including actions for winter
- Implement standardised frailty assessment across settings
- Establish front-door frailty in all acute hospitals; deliver CGA within 48hrs
- Utilise LIN Breakthrough collaborative to progress anticipatory care, polypharmacy falls prevention

Potential risks, issues to delivery and mitigation:

Potential risks/ issue	Mitigation
Variation of frailty services across C&M	C&M Frailty group to map existing frailty units; review capacity and workforce
Frailty sits across multiple programmes of work - risk of duplication	C&M Frailty group to support alignment of programmes

Scheme Name: (6) Standardise CYP UEC Pathways

Lead: Adam Bateman

Key Objectives – what would success look like if the scheme works?

- Standardisation of paediatric pathways for accessing UEC across Cheshire & Merseyside
- Harnessing digital technologies to support working across a large geographical footprint
- Paediatric specialists intervening at the earliest opportunity to provide specialised advice
- Increase in home management with a corresponding decrease in primary care reliance and ambulance conveyance

Key Stakeholders:

- All NHS Acute & Community trusts
- North West Ambulance Service NHS Trust
- C&M ICB commissioners
- Primary Care
- PC24

Key milestones/ next steps to take the scheme forward:

• October 2025: Commencement of PCAS for 8 hours per day across Merseyside
• October 2025: Confirmation if successful in bid for evaluation funding
• First Week of November: Expansion of PCAS to cover Cheshire
• November 2025-March 2026: Evaluation of service and plan to expand hours
• January 2026-March 2026: Scope options across the system to expand on the concept of PCAS to create a digital front door.
• April 2026 – Implement expanded hours as per original case of two overlapping 8-hour shifts

Potential Risks/Issue	Mitigation
Workforce – ensuring a sustainable workforce to consistently deliver throughout winter	Managing within existing contracts to mitigate
Demand management – insufficient capacity to manage demand within hours for pilot	Current service will still be accessible out of these hours
Benefits are not able to be captured/realised	Bid for additional funding for this to be able to provide the resource and capacity to

Scheme Name: (8) Mental Health UEC Plan

Lead: Simon Banks

Key Objectives – what would success look like if the scheme works?

- Attendance/Admission Avoidance – (i) 50% reduction in ED attendances from 2024/25 baseline, (ii) No more than 5 people per day waiting for admission from community
- Improving ED flow – (i) 50% reduction in >12 hour waits, (ii) 50% reduction in >24 hour waits
- Length of Stay/CRFD – (i) reduce (MH inpatient) LoS by 10 days from March 2025 baseline (62 to 52 days), (ii) reduction in % bed base occupied by CRFD, (iii) eliminate inappropriate out of area placements.

Key Stakeholders:

- Alder Hey Children's NHS Foundation Trust
- All Cheshire and Merseyside Local Authorities
- All NHS acute trusts
- Cheshire and Wirral Partnership NHS Foundation Trust
- Cheshire Police
- Mersey Care NHS Foundation Trust
- Merseyside Police
- North West Ambulance Service NHS Trust
- VCFSE Crisis Care Providers

Key milestones/ next steps to take the scheme forward:

- "Tactical" delivery plan being produced with stakeholders.
- Parallel assessments and Crisis Assessment Services being rolled out from 1/12/25.
- Increase utilisation of (i) MH Response Vehicles, (ii) crisis professional lines (iii) existing s136 capacity.
- Allocation of health-based places of safety process implemented and access enhanced – experiencing some obstacles.
- Enhance crisis alternative pathways and access via NHS 111 and professional lines.
- Length of Stay/CRFD – (i) purposeful admission (ii) care pathway optimisation (iii) medical optimisation of patients (iii) increase weekend discharges, (iv) optimise 72 hour follow up.
- Implement and embed MH action cards.

Potential risks/ issue	Mitigation
Delay in agreeing HBPOS process and enhancing access.	Direct conversations with acute trusts who (i) have not responded and/or (ii) do not accept s136 conveyances.
Under utilisation of MHRV.	Proposals agreed to increase utilisation.
Increased demand on crisis lines and limited capacity.	Options for alignment to physical health responses and increased access to professional's line.
Crisis text messaging implementation delayed.	Plan to implement from April 2026 rather than have in place in 2025/26.
Early identification of people with apparent mental health need in ED.	Improved protocols and communication between acute trust and MH provider.
Capacity to implement escalation protocols including action cards.	Phased implementation and adaptation following lessons learnt.

What is now working well for C&M ICS on UEC agenda

- Focus on physical Health, Mental Health, Adults and CYP
- Very good collaboration progressing across Merseycare and CWP
- Appreciation that there **must** be standardisation and equitable access
- Can't be working as 9 place and need UEC to be owned as a system – but with local variation where applicable
- System starting to come together – sharing learning across COOs, CMOs, CNOs
- Seen an improvement in some of the longest delays for NCTR across C&M but risk of this increasing again considerably
- Recognition that this is an agenda where we must now 'stop' initiatives where impact not being seen – a focus on decomplication & standardiation
- Progressed agendas such as PCAS, increased UCR and SPOA, starting to drive D2A
- UEC Board established for C&M ICS and CEOs presence, as well as operational and clinical – focus for 'now' but start to set strategy for system

What is not working well and requires further focus – why does focus need to be different

Effective working with Local Authorities, including improved alignment of social care and NHS winter planning and delivery.

Lots of investment through BCF – impact not positive – no clear governance in system for how BCF is 'agreed' with all Providers and endorsed through ICB – all agreed locally

No clear processes for reviewing BCF – Better Care Fund review in progress since September between the ICB and Local Authorities to review variation and more effective use of funding

Considerable variation in access of services across C&M – postcode lottery

Primary Care and Secondary Care connectivity and effective ways of work, particularly with no or little additionality for 25/26 Winter

9 different ways of delivering UEC and how patients are supported at point of discharge

UEC – greatest investment for past 5 years and yet seeing little benefit – overcomplication

Ongoing and sustained UEC performance improvement required in all NHS Trusts

Step down capacity varies across system as well as P3 e.g. No step down in some parts of Cheshire, EMI capacity huge challenge in Liverpool

Primary Care – why do changes always need to result in further investment? What does/ doesn't work and what gets re-invested?

P1 capacity – who delivers what? Why can't we discharge in 48 hours? Openness and transparency across H&C on capacity and utilisation

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 November 2025

Winter Planning 2025 - 2026

Agenda Item No: ICB/11/25/20

Responsible Director: Anthony Middleton, Director of Performance & Planning

Winter Planning 2025/26

1. Purpose of the Report

1.1 This paper provides an update to the Board following the Winter Planning 2025/26 paper discussed in September 2025. It summarises the continued development and assurance undertaken since the submission of winter plan board assurance statements by providers and the ICB to NHSE and provides the board with the areas of primary focus, and the systems oversight, escalation and intervention capability.

2. Executive Summary

2.1 The winter of 24/25 saw three declarations of critical incidents across Cheshire and Merseyside demonstrating a failure of the winter plans to provide adequate resilience to the additional seasonal demands.

2.2 An NHS critical incident is defined as a situation where significant disruption prevents an organisation from delivering its critical services, or where there is serious harm to patients or staff. This is most acutely represented in this context by the inability of a system to respond effectively to priority 999 calls, and overcrowded A&E departments.

2.3 The key learning from last winter demonstrated a clear link between the bed occupancy rate of the acute hospitals on the Friday before the festive holiday period and the declaration of critical incidents in the immediate days after New Year.

2.4 There was also strong linked evidence of lower staff vaccination, short term sickness, and the ability to implement winter plan responsive actions.

2.5 This paper sets out the current assessment of the system to avoid a recurrence based upon the learning of last year, the focus on occupancy and vaccination in the run up to the expected peak of winter pressures and the system's ability to mobilise additional capacity and action should they be required.

3. Ask of the Board and Recommendations

3.1 The Board is asked to:

- **Note:** Note the current position on winter planning, including:
  - provider trajectories for bed occupancy and associated risk mitigation.
  - progress and challenges in staff vaccination uptake.
  - enhanced escalation arrangements and system coordination plans

- **Endorse** the continued approach to:

- implementing oversight and assurance arrangements throughout the winter period
- driving improvement in vaccination uptake and discharge performance.
- maintaining system resilience through agreed surge and escalation protocols.

4. Background

4.1 **National Context and Priorities:** Noting that there is no additional revenue funding to support winter planning and response, the NHS is expected to deliver a significant improvement in urgent and emergency care performance during winter 2025/26 against the following priorities:

- **Ambulance Response Times**: Category 2 average response <30 minutes.
- **Ambulance Handover**: Meet the 45-minute handover target.
- **A&E Four-Hour Standard**: Achieve a minimum of 78%.
- **Eliminate Long Waits**: Reduce 12-hour waits, end corridor care.
- **Mental Health**: Reduce >24-hour waits for beds.
- **Discharge**: Reduction in 21+ day delayed discharges.
- **Children's UEC**: Improve timeliness of care in A&E.

5. Winter Plan Development

Bed Occupancy

5.1 Achievement of a bed occupancy rate in the acute hospital provider at or below 92% just prior to the festive holiday period was proven last year to be a direct link the declaration of a critical incident in the New Year.

5.2 Liverpool University Hospitals NHS FT, Mersey & West Lancashire NHS FT, and Wirral University Hospitals NHS Trust all reported occupancy levels between 94% and 96% on the 20 December 2024 which fluctuated, but ultimately increased over the festive holiday period to a position by the New Year where any bed capacity had been exhausted causing considerable overcrowding within Accident and Emergency departments, delays to ambulance handover and significant consequential impact on Ambulance response times.

5.3 Whilst focus and intervention in the new year across these three systems brought a closure to all incidents within 3-5 days, it was a position that could have been avoided had the system winter plan been more effective across all delivery points much earlier.

5.4 Based on the current development of system winter plans providers have been asked to provide a trajectory of bed occupancy through November and December (Table One) which, with the exception of the Countess of Chester, demonstrates achievement of the 92% objective.

Table One

	Target bed occupancy (%)						
Provider	**w/c 3 Nov**	**w/c 10 Nov**	**w/c 17 Nov**	**w/c 24 Nov**	**w/c 1 Dec**	**w/c 8 Dec**	**w/c 15 Dec**
Alder Hey Children's NHS Foundation Trust	71.0%	76.3%	78.7%	78.6%	83.2%	78.2%	**76.1%**
Countess of Chester NHS Foundation Trust	97.3%	97.2%	97.1%	97.0%	96.9%	96.8%	**95.8%**
East Cheshire NHS Trust	97.3%	97.0%	96.0%	95.0%	94.0%	93.0%	**92.0%**
Liverpool University Hospitals NHS Foundation Trust	94.5%	94.3%	93.2%	93.2%	93.2%	92.9%	**91.9%**
Mersey and West Lancashire Teaching Hospitals NHS Trust	97.7%	97.9%	97.0%	96.0%	95.0%	93.0%	**92.0%**
Mid Cheshire NHS Foundation Trust	92.7%	93.2%	93.2%	93.2%	92.0%	90.7%	**89.4%**
Warrington and Halton Teaching Hospitals NHS Foundation Trust	93.6%	93.7%	92.8%	92.7%	92.5%	92.3%	**92.0%**
Wirral University Teaching Hospital NHS Foundation Trust	92.1%	92.8%	93.8%	93.8%	94.2%	93.7%	**91.8%**

Staff Vaccination – Flu and / or Covid

5.5 There has been a decline in the staff vaccination rate for several years with last year showing the lowest level of vaccination since reporting was introduced. There are a range of causal factors with the pandemic period significantly impacting on uptake which has been recognised in both staff and public alike.

5.6 The recommended improvement level of a 5% uptake by NHS England has been discussed by the board previously and it was agreed that that ambition fell short of what we should aspire to.

5.7 Table Two demonstrates the higher ambition that has been agreed locally – that being the best of the past 5 years in each organisation, as well as the minimum expectation as per national guidance:

Table Two

Provider	Uptake last year 2024/25	Target agreed for 2025/26	*Best uptake in last 5 years*	% vaccinated
Alder Hey Children's NHS Foundation Trust	41.3%	50%	*80.40%*	**44%**
Bridgewater Community Healthcare NHS Foundation Trust	51.9%	58%	*70.10%*	**44%**
Cheshire and Wirral Partnership NHS Foundation Trust	40.4%	50%	*71.00%*	**32%**
Countess of Chester Hospital NHS Foundation Trust	43.6%	50%	*83.40%*	**44%**
East Cheshire NHS Trust	54.6%	61%	*83.00%*	**37%**
Liverpool Heart and Chest Hospital NHS Foundation Trust	36.3%	50%	*80.80%*	**35%**
Liverpool University Hospitals NHS Foundation Trust	34.5%	50%	*80.20%*	**33%**
Liverpool Women's NHS Foundation Trust	32.6%	50%	*81.50%*	**27%**
Mersey and West Lancashire Teaching Hospital NHS Trust	41.5%	50%	*92.45%*	**39%**
Mersey Care NHS Foundation Trust	32.8%	50%	*82.10%*	**33%**
Mid Cheshire Hospitals NHS Foundation Trust	45.7%	60%	*81.30%*	**44%**
The Clatterbridge Cancer Centre NHS Foundation Trust	34.3%	75%	*82.00%*	**44%**
The Walton Centre NHS Foundation Trust	45.5%	52%	*80.30%*	**38%**
Warrington and Halton Teaching Hospitals NHS Foundation Trust	44.1%	65%	*87.00%*	**40%**
Wirral Community Health and Care NHS Foundation Trust	46.7%	52%	*71.60%*	**40%**
Wirral University Teaching Hospital NHS Foundation Trust	48.9%	55%	*82.80%*	**41%**
TOTAL	**40.2%**	**50%**		**37.1%**

5.8 After 7 weeks of the vaccination programme and with 6 weeks remaining there is still much focus needed with the ICB public health team and provider Chief Nurses working closely on attaining the objective.

Escalated Interventions – Additional Capacity

5.9 Within each winter plan there is now a clearer understanding of what additional capacity could be mobilised should the demands dictate that intervention. Systems are poised to deploy that capacity during the winter period in the absolute interest of patient safety and quality, but it is recognised that in most cases there is no financial reserve set aside (Table Three).

Site	Hospital Beds	Temporary Escalation Spaces	Community spot purchase	Virtual ward	Reablement hours
Countess of Chester Hospital NHS Foundation Trust	35	14	6		
East Cheshire NHS Trust	6		16		100
Liverpool University Hospitals NHS Foundation Trust - Aintree	38			53	
Liverpool University Hospitals NHS Foundation Trust - Royal	30				
Mersey and West Lancashire Teaching Hospital NHS Trust - Whiston	20		30		
Mersey and West Lancashire Teaching Hospital NHS Trust - Southport	16				
Mid Cheshire Hospitals NHS Foundation Trust	42				
Warrington and Halton Teaching Hospitals NHS Foundation Trust	6				
Wirral University Teaching Hospital NHS Foundation Trust	16				

Enhanced Escalation

5.10 Following discussion with local authority chief executive officers the ICB has been provided with a winter rota where a lead director of adult social services will be available throughout the festive and new year period. This lead can only make decisions on behalf of their home local authority however they will be able to access local authority leads throughout Cheshire and Merseyside where escalation and intervention is required. A similar arrangement is in place for local authority chief executives and will be available to NHS partners through the ICB system coordination centre.

Exercising

5.11 The ICB, NHSE, NHS providers and Local authorities have worked collectively on continued development of the plans and a series of stress testing exercises have taken place across the system or are planned to assess the preparation for the winter period and oversight arrangements throughout, as per the Table Four.

Table Four

Site	Date
Liverpool University Hospitals NHS Foundation Trust - Aintree	11th November
Countess of Chester Hospital NHS Foundation Trust	13th November
Mersey and West Lancashire Teaching Hospital NHS Trust - Southport	21st November
Mersey and West Lancashire Teaching Hospital NHS Trust - Whiston	26th November
Wirral University Teaching Hospital NHS Foundation Trust	27th November
East Cheshire NHS Trust	2nd December
Mid Cheshire Hospitals NHS Foundation Trust	2nd December
Liverpool University Hospitals NHS Foundation Trust - Royal	3rd December
Warrington and Halton Teaching Hospitals NHS Foundation Trust	5th December

5.12 Feedback from the early visits have demonstrated strong leadership, visibility, and staff awareness of escalation pathways and communications but also where further progress needs to be made in terms of partner inclusion such as primary care.

6. Link to ICB Strategic Objectives and Cheshire & Merseyside Priorities

6.1 Winter planning and response align primarily with:

- Objective One: Health Inequalities
- Objective Two: Improving Population Health and Healthcare.

7. Link to Annual Delivery Plan Objectives

7.1 Urgent Care Improvement is a top priority for 2025/26, winter planning directly underpins delivery of this objective.

8. Link to CQC ICS Themes and Quality Statements

8.1 NHS England's UEC Plan 2025/26 metrics underpin quality and safety across the UEC pathway. Winter planning focuses on leadership and integration to deliver these standards.

8.2 **Patient Experience:** Locality SROs have embedded patient feedback, including Healthwatch and voluntary sector insights, into plans.

8.3 **Quality Impact Assessment:** In line with the winter guidance under ICB policy, a QEIA has been completed and reviewed by the QIA panel on 19 September.

8.4 The winter plan mitigates risk and optimises performance within existing resources, with detailed actions aligned to CQC ICS themes:

- **Quality and Safety:** Patient Safety & Risk, Infection Prevention & Control, vaccination and prevention, support for at risk groups.
- **Integration:** Plans span acute, community, mental health, primary care.
- **Leadership:** System leadership, EPRR.

9. Risks

9.1 Winter planning addresses Board Assurance Framework Risk P14: **Failure to Recover Access and Performance Standards:** 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.

9.2 The winter plan is a key control alongside the UEC Programme, supported by locality checklists, Exercise Aegis, and the ICB BAS for assurance.

9.3 Notably, no additional revenue funding is available; plans rely on optimal use of existing resources and UEC improvement initiatives.

10. Finance

10.1 As above, there is no additional revenue funding outside of normal allocations to support winter preparations and the winter response.

11. Communication and Engagement

11.1 Locality SROs will have continued to engage and work with providers and system partners to strengthen the winter plans.

11.2 Robust public communications activity will be in place, including clear public messaging on accessing health services across the Christmas period, including out of hours, and all relevant providers will be informed of arrangements to ensure effective signposting.

12. Equality, Diversity and Inclusion

12.1 The planning team assessed winter plans for EDI as part of the QEIA. The plans aim to mitigate risks with a strong focus on reducing health inequalities, as follows:

- Older adults: Flu, RSV, frailty pathways
- Children & young people: School immunisations
- Pregnant women: RSV and flu vaccination
- People with SMI, LD, autism: Health checks, housing support
- Ethnic minorities & migrant communities: Interpretation and cultural support
- Use of CORE20PLUS5 to identify and address inequalities.

13. Officer contact details for more information

Anthony Middleton, Director of Performance & Planning

Claire Sanders; Associate Director of Urgent & Emergency Care Operations and Improvement

Meeting of the Board of NHS Cheshire and Merseyside

27 November 2025

CONSENT ITEMS

All these items have been read by Board members and the minutes of the November 2025 Board meeting will reflect any recommendations and decisions within, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.			
AGENDA NO	**ITEM**	**Reason for presenting**	**Page No**
ICB/11/25/24	Board Decision Log **(CLICK HERE)**	For information	-
ICB/11/25/25	**Confirmed Minutes of ICB Committees** **Click on the links below to access the minutes:** • Children and Young People Committee – August 2025 **(CLICK HERE)** • Finance, Investment and Our Resources Committee – Sept 2025 **(CLICK HERE)** • Quality and Performance Committee – September 2025 **(CLICK HERE)** • Quality and Performance Committee – October 2025 **(CLICK HERE)** • System Primary Care Committee – August 2025 **(CLICK HERE)** • Women's Hospital Services in Liverpool Committee – July 2025 **(CLICK HERE)**	For assurance	Page 287