

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

28 May 2026

13:00pm

Liverpool Suite,
Holiday Inn, Lime Street,
Liverpool, L1 1NQ



Public Notice:

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

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

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

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

Raising Questions:

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

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

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

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

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

Further details can be found at:

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

Agenda

| AGENDA NO & TIME | ITEM | Format | Lead or Presenter | Action / Purpose | Page No |
|--------------------------------|---|--------|--|---------------------|-------------------------|
| 13:00pm | Preliminary Business | | | | |
| ICB/05/26/01 | Welcome, Apologies and confirmation of quoracy | Verbal | Sir David Henshaw <i>ICB Chair</i> | For information | - |
| ICB/05/26/02 | Declarations of Interest <i>(Board members are asked to declare if there are any declarations in relation to the agenda items or if there are any changes to those published on the ICB website)</i> | Verbal | | For assurance | - |
| ICB/05/26/03 | Minutes of the previous meeting: • 26 March 2026. | Paper | | For approval | Page 6 |
| ICB/05/26/04 | Board Action Log | Paper | | For approval | Page 21 |
| ICB/05/26/05 | Key issues – significant items to raise | Verbal | | For discussion | - |
| ICB/05/26/06 | Chairs announcements | Verbal | | For information | - |
| ICB/05/26/07 | Questions received from members of the public | Verbal | | For information | - |
| ICB/05/26/08 | Experience / achievement story | Film | | For information | - |
| 13:20pm | ICB Business Items | | | | |
| ICB/05/26/09 | Proposed changes to complex and high-risk maternity and gynaecology care in Liverpool – a public engagement approach | Paper | Dr Fiona Lemmens <i>Executive Clinical Director</i> | For approval | Page 22 |
| ICB/05/26/10 13:35pm | Governing the NHS Cheshire and Merseyside Single Improvement Plan - Terms of Reference for ICB Task and Finish Committee | Paper | Ben Vinter <i>Executive Director of Corporate Services and Governance</i> | For approval | Page 48 |
| ICB/05/26/11 13:45pm | Cheshire and Merseyside Cyber Security Improvement Programme Update | Paper | John Llewellyn <i>Chief Digital Information Officer</i> | For endorsement | Page 60 |
| ICB/05/26/12 14:00pm | NHS Cheshire & Merseyside Antimicrobial Resistance and Infection Prevention & Control Update | Paper | Dr Fiona Lemmens <i>Executive Clinical Director</i> | For endorsement | Page 72 |

| AGENDA NO & TIME | ITEM | Format | Lead or Presenter | Action / Purpose | Page No |
|-------------------------|--|----------------------|---|---------------------|--------------------------|
| ICB/05/26/13 14:10pm | NHS Cheshire and Merseyside Freedom to Speak Up Annual Report | Paper | Ben Vinter <i>Executive Director of Corporate Services and Governance</i> Temitayo Roberts <i>Freedom to Speak Up Guardian</i> | For endorsement | Page 88 |
| ICB/05/26/14 14:25pm | NHS Cheshire and Merseyside NHS Staff Survey Results 2025-26 and next steps | Paper & Presentation | Katie Horan <i>Programme Manager – Staff Experience and Retention</i> | For endorsement | Page 105 |
| ICB/05/26/15 14:40pm | Delegation of Specialised Services Update | Paper & Presentation | Clare Watson <i>Executive Director of Health and Integrated Care Commissioning</i> | For assurance | Page 121 |
| 14:55pm | Break | | | | |
| 15:10pm | Leadership Reports | | | | |
| ICB/05/26/16 | Report of the ICB Chief Executive | Paper | Liz Bishop <i>Chief Executive</i> | For assurance | Page 147 |
| ICB/05/26/17 15:20pm | Cheshire and Merseyside ICB and System Finance Report – Month One | Paper | Andrea McGee <i>Executive Director of Finance and Contracting</i> | For assurance | Page 212 |
| ICB/05/26/18 15:30pm | Highlight report of the Chair of ICB Finance, Investment and Contracting Committee | Paper | Sue Lorimer <i>Non-Executive Member</i> | For assurance | Page 217 |
| ICB/05/26/19 15:35pm | NHS Cheshire and Merseyside Integrated Performance Report | Paper | Jude Adams <i>Interim Executive Director of Transformation & Strategy (Turnaround)</i> | For assurance | Page 224 |
| ICB/05/26/20 15:50pm | Highlight report of the Chair of ICB Quality and Performance Committee | Paper | Tony Foy <i>Non-Executive Member</i> | For approval | Page 268 |
| ICB/05/26/21 15:55pm | Highlight report of the Chair of the Audit Committee | Paper | Mike Burrows <i>Non-Executive Member</i> | For approval | Page 281 |
| ICB/05/26/22 16:00pm | Highlight report of the Chair of the Remuneration Committee | Paper | Tony Foy <i>Non-Executive Member</i> | For assurance | Page 302 |
| ICB/05/26/23 16:05pm | Highlight report of the Chair of System Primary Care Committee | Paper | Tony Foy <i>Non-Executive Member</i> | For assurance | Page 305 |

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| 16:10pm | Closing Business | | | | |
| ICB/05/26/24 | Closing remarks and review/reflections of the meeting | Verbal | Sir David Henshaw <i>ICB Chair</i> | For information | - |
| ICB/05/26/25 | Any Other Business | Verbal | | For information | - |
| 16:15pm | CLOSE OF MEETING | | | | |

Consent items

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

| AGENDA NO | ITEM | Reason for presenting | Page No |
|--------------|--|-----------------------|--------------------------------------|
| ICB/05/26/26 | Confirmed Minutes of meetings of the ICB Committees: <ul style="list-style-type: none"> Audit Committee - March 2026 Finance, Investment and Contracting Committee - March & April 2026 Quality and Performance Committee - March & April 2026 System Primary Care Committee - Feb 2026 | For assurance | CLICK HERE TO ACCESS |

Date and start time of future meetings

- 18 June 2026, 09:00am** – online meeting to consider the ICB Annual Report and Accounts 2025-26. Joining details on the ICB website
- 30 July 2026, 14:00pm**, Conference Suite, Riverside Innovation Centre, 1 Castle Drive, Chester, CH1 1SL

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

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

Thursday 26th March 2026, 1:00pm – 4:30pm

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

Unconfirmed Minutes

| ATTENDANCE | |
|-----------------------------|---|
| Name | Role |
| Members | |
| Sir David Henshaw | Chair, Cheshire & Merseyside ICB (voting member) |
| Liz Bishop | Chief Executive, Cheshire & Merseyside ICB (voting member) |
| Tony Foy | Non-Executive Member, Cheshire & Merseyside ICB (voting member) |
| Dr Ruth Hussey, CB, OBE, DL | Non-Executive Member, Cheshire & Merseyside ICB (voting member) |
| Prof Hilary Garratt, CBE | Non-Executive Member, Cheshire & Merseyside ICB (voting member) |
| Warren Escalade | Partner Member (VCFSE) (Voting Member) |
| Adam Irvine | Partner Member (Primary Care), Cheshire & Merseyside ICB, (voting member) |
| Dr Fiona Lemmens | Executive Clinical Director, Cheshire & Merseyside ICB (voting member) |
| Dr Naomi Rankin | Partner Member (Primary Care) (voting member) |
| Clare Watson | Executive Director of Health and Integrated Care Commissioning, Cheshire & Merseyside ICB (regular participant) |
| Janelle Holmes | Partner Member (NHS Trust), Cheshire & Merseyside ICB (voting member) |
| Sue Lorrimer | Non-Executive Member, Cheshire & Merseyside ICB (voting member) |
| Mike Burrows | Non-Executive Member, Cheshire & Merseyside ICB (voting member) |
| Trish Bennett MBE | Partner Member (NHS Trust), Cheshire & Merseyside ICB (voting member) |
| Delyth Curtis | Partner member (Local Authority) (voting member) |
| Andrew Lewis | Partner Member, (Local Authority) (Voting Member) |
| Erica Morriss | Non-Executive Member, Cheshire & Merseyside ICB (voting member) |
| Ben Vinter | Executive Director of Corporate Services and Governance, Cheshire and Merseyside ICB (voting member) |
| In Attendance | |
| Prof. Paul Kingston | Chair of ICB Research and Innovation Committee, (regular |

| | |
|--------------------|---|
| | participant) |
| Prof. Ian Ashworth | Director of Population Health, Cheshire & Merseyside ICB (regular participant) |
| Jude Adams | Interim Executive Director of Strategy and Transformation, Cheshire and Merseyside ICB |
| Rebecca Tunstall | Associate Director of Finance – Planning & Reporting, Cheshire & Merseyside ICB (attending on behalf of Andrea McGee) |
| Paul Mavers | Manager, Healthwatch Sefton |
| Jennie Williams | Senior Executive Assistant (Note Taker), Cheshire and Merseyside ICB |

Apologies

| Name | Role |
|---------------|--|
| Louise Robson | Chair, Health Innovation North West Coast (regular participant) |
| Andrea McGee | Executive Director of Finance and Contracting, Cheshire and Merseyside ICB (voting member) |

Agenda Item, Discussion, Outcomes and Action Points

Preliminary Business

ICB/03/26/01 Welcome, Apologies and Confirmation of Quoracy

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

ICB/03/26/02 Declarations of Interest

None.

ICB/03/26/03 Minutes of the previous meeting of 26th January 2026

The minutes of the previous meeting held on 26th January 2026 were accepted and recorded as a true and accurate reflection of the meeting.

ICB/03/26/04 Board Action Log

The Board agreed the actions as listed.

ICB/03/26/05 Key Issues – Significant Issues to Raise

There were no key issues raised by Board members.

ICB/03/26/06 Chairs Announcements

It was noted that Cathy Cowell has been appointed as the new Chair for NHSE, North West region and has been warmly welcomed into the role. The Board looks forward to meeting with her at a future point.

ICB/03/26/07 Questions Received from Members of the Public

The Board discussed questions received from members of the public, full responses will be

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available on the ICB website from 30th March 2026.

Billinge Medical Practice

A number of queries have been raised in relation to the lease arrangements and landlord issues, it was agreed that a formal response to one of the questions would be provided for the record, with all questions and responses being shared on the ICB website. It was noted that local MPs have shown a strong interest in this estates matters. The St Helens Place team is working collaboratively with the practice, the local Estates team, and NHS England Estates leads to review all viable long-term estate options. The priority remains to retain a local solution that best meets the needs of the population served by the practice.

Due diligence is underway to assess the full range of estate options. Relocation of patients is not currently being considered; the immediate focus is on identifying a feasible and mutually agreeable estate solution for the practice. Regular meetings are taking place with the practice and system partners.

The Board was advised that minutes from the enhanced surveillance group cannot be shared publicly due to the nature of the forum, however, an update is available on the organisation's website, and further information can be provided via the St Helens Place team if required.

Liverpool Women's Hospital

The Board received a question relating to page 61 of the Board papers, which notes that the cost of delivering the current model of maternity and neonatal services contributes to wider system financial pressures. The question asked whether this reflects inadequate funding for maternity and neonatal care, as referenced in the Ockenden and interim AMOS report and whether relocating services to the Royal Liverpool Hospital would reduce costs given that staffing is the largest expenditure. A further query was raised regarding the timeline for publication of the Women's Services business case and associated consultation.

In response, it was clarified that the section on page 61 refers to the strategic planning of maternity and neonatal services across Cheshire and Merseyside, as part of the medium-term strategy, rather than solely the Liverpool configuration. The position of maternity and neonatal services in Liverpool remains complex, with the maternity tariff being only one of several contributing financial factors. Full costing of the proposed reconfiguration of maternity and gynaecology services in Liverpool, as previously outlined in the options appraisal, has not yet been completed. While staffing costs are significant, a range of other considerations, including quality and safety must also be assessed before a final financial position can be determined.

The Board was advised that development of the draft business case is underway. Subject to completion of the necessary governance steps, the Board will be asked to approve the public engagement plan, with the intention of commencing engagement in early June. The engagement period is expected to run for six weeks. Feedback from this process will inform the final business case, which is anticipated to be presented to the Board for decision-making in autumn 2026, following completion of all required governance processes.

Winter Pressures

The Board received a series of questions relating to winter pressures, specifically acute bed

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occupancy levels, which had reached 96%, and the subsequent reduction in pressures over the Christmas period.

It was emphasised that corridor care is unacceptable and reflects system challenges both in managing demand into emergency departments and in maintaining patient flow. Work is underway with providers across the system to implement actions aimed at improving flow and reducing reliance on corridor care. While the national aspiration for bed occupancy is 85%, most providers, including those in Cheshire and Merseyside, operate closer to 95%. Evidence from winter demonstrated that reducing occupancy to around 92% significantly improves flow and reduces corridor care, and this will be set as an ambition for the coming year.

It was noted that reduced planned care activity over Christmas contributed to improved occupancy, but the primary driver was the collective effort across the health and care system. Questions were raised about whether occupancy figures include corridor care; it was confirmed that corridor care is captured separately, including patients in temporary escalation spaces, reflecting wider unmet demand for beds.

Further questions related to the age profile of patients in corridor care. While the ICB does not routinely collect this data, operational experience indicates that many are frail older people. Work within neighbourhood models will focus on improving urgent and emergency care for this group. It was also confirmed that children are not placed in corridor care, with a zero-tolerance approach in paediatric emergency departments. Alder Hey was specifically noted as having no corridor care for children.

Additional questions concerned infection prevention and control (IPC), hospital-acquired infections and falls. While corridor care is never considered acceptable, the system has developed a set of quality standards, the Red Lines Toolkit, to support safe care in these circumstances. This toolkit has been adopted nationally through GIRFT guidance. A second version is being developed to include staff wellbeing considerations. Healthwatch has been involved in its development and uses it during Emergency Department visits. Assurance on these standards is sought through the NHS Standard Contract and reported quarterly to the Quality and Performance Committee. Although it is difficult to isolate IPC or falls data specific to corridor areas, providers continue to address safety concerns proactively.

Subject Access Request

The Board received a question from a resident regarding delays experienced in receiving Subject Access Request (SAR) responses from three local trusts. The resident asked whether such delays were considered acceptable by the ICB and what powers the ICB holds in relation to enforcing compliance.

It was confirmed that, like the ICB, all NHS trusts are legally required to comply with SAR's under GDPR and the Data Protection Act. However, the ICB does not have the authority to compel or enforce disclosures. Following receipt of the inquiry, the ICB contacted the relevant partner organisations, who advised that the delays were linked to complexities within the individual SAR's. Assurance was provided that the resident has now received all requested information.

Five-year Strategic Commissioning Plan

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The Board received a question relating to the Five-Year Strategic Clinical and Commissioning Plan. The question commended the plan but highlighted the significant financial and workforce constraints facing the system, asking whether the plan should more explicitly warn residents and stakeholders that delivery and sustainability are subject to severe internal and external resource pressures.

In response, it was acknowledged that the risks identified are valid. The Board noted that the plan sets out a series of actions designed to mitigate these risks, including working differently with partners and residents, and focusing efforts on priorities identified through the Joint Strategic Needs Assessment (referenced on pages 6–8 and 12–17 of the plan). It was further noted that the role of the ICB is evolving, requiring development of organisational skills and new ways of working with system partners, as outlined on pages 9–10. The plan also reflects the need to shift expenditure in line with national policy, recognising that this will take time. Initial steps are described in the commissioning plan (page 32) and in the Population Health Improvement Plan (pages 7–8), including applying a population health approach to target resources towards high-need groups where the greatest impact can be achieved. The Board reaffirmed its commitment to the 'shift left' agenda and to increasing investment in population health.

ICB/03/26/08 Experience / Achievement Story

The Board received an experience story film – Cervical Screening on the Living Well Bus which showed how cervical screening is being made available in underserved areas across Cheshire and Merseyside.

The Board received an update from Fiona Lemmens noting that the mobile health service has recently delivered its 2000th cervical screening. The service originated during COVID-19 as a mobile vaccination model and has since expanded to support a wide range of community health interventions, including migrant health checks and childhood immunisations. Cheshire and Wirral Partnership NHS Foundation Trust (CWP) has led the service, demonstrating significant flexibility and innovation. Cervical screening activity initially focused in Sefton due to low uptake rates, and the service now operates across Cheshire and Merseyside.

ICB Business Items

ICB/03/26/09 NHS Cheshire and Merseyside Annual EPRR Assurance Report 2025 – 26

The Board received the annual assurance report from Jude Adams, outlining the ICB's responsibilities under the Civil Contingencies Act as a category one responder. The report highlighted continued improvement in compliance with core standards, with the team achieving substantial compliance overall. It was noted that ongoing work is required each year to maintain and strengthen this position.

The ICB is working with provider organisations to ensure system-wide substantial compliance, with particular focus on areas such as shelter and evacuation. NHS England will be supporting this through forthcoming national workshops. A work plan is in place and will be delivered through the Local Health Resilience Partnerships (LHRPs) for both Cheshire and Liverpool, with the aim of sustaining and further improving compliance across the system.

The Board discussed forthcoming changes under the new ICB operating model, noting that certain Emergency Preparedness, Resilience and Response (EPRR) functions are expected to transfer to

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NHS England. Clarification is still required, as current national guidance does not fully set out how responsibilities and accountabilities, particularly those of the Accountable Emergency Officer (AEO) will operate within a shared regional model.

It was reported that regional discussions are ongoing, including a meeting scheduled for 27th March 2026. While the proposals present opportunities for greater standardisation of policies, procedures and practices across the North West, concerns were raised about ensuring that local support and resilience are not diluted. The Board noted that there is variability in EPRR capacity across ICB's, and a collaborative approach could strengthen system wide arrangements. It was acknowledged that the model is still being developed and may not ultimately reflect the original proposals.

The Board -

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

ICB/03/26/10 5-year Clinical and Strategy Commissioning Plan 2026-31 – incorporating the ICB Population health Improvement Plan

The Board received an update on the Five-Year Strategic Clinical and Strategic Commissioning Plan, along with the Population Health Improvement Plan from Clare Watson and Fiona Lemmens. Documents set out the ICB's commissioning ambitions and priorities for the next five years and align with NHS England's medium-term planning requirements. The plans describe how the ICB will work differently with partners, strengthen its strategic commissioning capability, and base priorities on the integrated needs assessment and the 'Altogether Fairer' framework.

Seven key priorities have been identified through the needs assessment, reflecting areas of significant clinical need and system challenge. The strategic commissioning plan incorporates the clinical strategy, reflecting the ICB's integrated approach and commitment to avoiding siloed working. The plans have been developed with extensive engagement from partners, local authorities and providers, and feedback received since February 2026 has been incorporated.

A detailed Population Health Improvement Plan outlines commissioning intentions across the life course, with greater detail for years one and two. A draft outcomes framework has been produced to support performance oversight of the seven priorities. Governance arrangements for delivery and implementation are being finalised and will align with the forthcoming single improvement plan.

The Board noted thanks to Neil Evans and Stephen Woods who led the development of the plans.

The Board Discussed –

- How the Board will be assured of delivery against the Five-Year Strategic Clinical and Commissioning Plan, including progress on priorities over the next year and the monitoring of KPI's. It was confirmed that an integrated outcomes framework is included at Appendix 3, and detailed implementation plans are being developed for each priority, incorporating specific metrics and outcomes. Delivery and assurance will be overseen through the Strategic

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Commissioning Programme Board, with regular reporting to the Board.

- Highlighting the importance of the workforce plan as a key enabler of the strategy, and emphasising the need for a more intentional anti-racist approach across the organisation. The point stressed the importance of cultural diversity, including stronger representation in decision-making forums at Board and sub-Board level, and the need for clear outcomes and accountability. In response, it was noted that a Quality Impact Assessment (QIA) and Equality Impact Assessment (EQIA) have been completed for the plan, and the feedback regarding intentionality and accountability in outcomes will be taken on board. The plan was welcomed as a strong foundation for this work.

The Board

Approved the publication of both the 5-Year Clinical and Strategic Commissioning Plan 2026/2031 (Appendix One) and the associated Population Health Improvement Plan (PHIP) (Appendix Two) on 31 March 2026.

ICB/03/26/11 NHS Cheshire and Merseyside Single Improvement Plan

The Board received an update on the Single Improvement Plan from Ben Vinter, which has been developed in response to the undertakings issued to the ICB. The plan sets out how the organisation will structure and organise itself to address the required improvements. The paper outlines the methodology used in developing the plan and invites Board feedback on the proposed approach.

It was noted that the plan aligns closely with the Five-Year Strategic Commissioning Plan, with several shared themes. The document will be subject to ongoing dialogue with NHS England to ensure appropriate framing of actions and system assurance. The plan will continue to evolve over the coming year.

Six key domains have been identified: quality; governance; system recovery, financial planning and sustainability; commissioning strategy and intentions; leadership, organisational development and communications; and turnaround. Executive leads have been assigned to each domain. The Board was advised that a mechanism for ongoing oversight outside formal Board meetings will be established, with further detail to be brought to the next public meeting. Board support for the plan was sought.

The Board discussed the financial planning and sustainability element of the Single Improvement Plan, while recognising the need to address immediate efficiency requirements, it was suggested that the plan should also reflect medium-term financial development, including zero-based budgeting and future resource allocation, to avoid an exclusive focus on short-term pressures. It was noted that the Single Improvement Plan will address the immediate undertakings over the next year, while the Strategic Commissioning Group will lead the broader developmental work referenced. Governance arrangements for how these elements will align and report to the Board are being finalised and will be brought back for consideration.

The Board -

Approved the Single Improvement Plan noting the plan will continue to iterate and as the ICB responds to anticipated and expected feedback from NHSE.

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ICB/03/26/12 NHS Cheshire and Merseyside Board Assurance Framework and High Scoring Corporate Risks

The Board received an update on the outputs arising from the strategic review undertaken in November 2025 from Ben Vinter. The revised Board Assurance Framework (BAF) priorities broadly reflect the ICB's strategic themes and purpose, however, it was acknowledged that further alignment is required to fully incorporate the Strategic Commissioning Plan and the Single Improvement Plan (SIP).

The Board was asked to review whether the current risk scores, controls and assurances are accurately reflected. Feedback from committees indicates that additional refinement is needed to ensure controls and trajectories are clearly articulated and that risks are being managed safely over the agreed three-year horizon.

Eight BAF priorities are currently presented, with the expectation that these may evolve as governance arrangements for the SIP and strategic commissioning mature. High-scoring risks reflect system concerns over the past year, including infrastructure and service fragility, capital and financial pressures, quality and safety, statutory duties, all-age continuing care, and specific risks relating to East Cheshire.

The Board noted that further 'housekeeping' work will be undertaken as the organisation transitions to the new arrangements. Thanks were recorded to Gavin Wraige and Stephen Wood who led the development of the updated BAF.

The Board Discussed -

- The risk appetite has remained unchanged, despite previous discussions about whether it should evolve. The current position continues to provide a strong foundation for the Board Assurance Framework, confirming that the ICB has zero tolerance for safety risks that could lead to avoidable patient harm and will not accept risks that compromise its core responsibilities to patients and partners. The underlying principles of the BAF were reaffirmed as robust.
- The clinical risk assessment for the Liverpool Women's Hospital programme should be reviewed in the wider context of clinical risks across the region. It was suggested that the current assessment may not fully reflect relative risks and may be influenced by historic approaches and siloed risk development. It was confirmed that the programme-specific risk assessment is based on earlier work undertaken through the Liverpool Clinical Services Review, which pre-dated the ICB and identified the programme as a high-risk area. As that programme has now concluded, a refreshed assessment is required. The Executive Team will review the clinical risks collectively, with Fiona Lemmens and colleagues taking this forward as part of a broader regional clinical risk assessment.
- The segmentation of risks associated with All-Age Continuing Care (AACC). It was noted that current risks are split across workforce, finance and outcomes, including concerns about the impact on individuals waiting longer than appropriate for assessments. It was suggested that these issues are interconnected and would benefit from being considered as a single, holistic risk rather than separate, siloed risks. The Quality Committee may therefore need to review the position in the round, including risks linked to individualised care packages outside AACC. FL acknowledged that All-Age Continuing Care (AACC) has become a significant area of concern within the portfolio. It was highlighted that while a CRES plan exists, there is currently no

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equivalent workforce or quality improvement plan. Work is now underway to bring these elements together into a single, comprehensive improvement plan. This integrated approach will also support the development of a more coherent and holistic risk profile for AACC

Actions

- **Risk team to support clinical services to formalise and consolidate the relevant AACC risks into a more rounded, holistic risk entry for future review.**
- **Executive team to review risks for Liverpool Women's programme.**

The Board:

- **Considered the current scores for the Board Assurance Framework 2025- 2028 and scores relating to the High Scoring Corporate Risk.**
- **Considered if it felt suitably assured by the Controls and Assurances on each risk detailed in Appendix One.**
- **Considered whether this core appetite statement is still relevant and should continue to be adopted, or whether it should be reconsidered with reference to the current environment the ICB is operating in.**
- **Further iteration to be brought back to a future meeting.**

ICB/03/26/13 Amendments to the NHS Cheshire and Merseyside Scheme of Reservation and Delegation (SORD) and Operational SORD

The Board received an update from Ben Vinter on the amendments to the NHS Cheshire and Merseyside Scheme of Reservation and Delegation and Operational SORD, outlining proposed amendments to the NHS Cheshire and Merseyside Scheme of Reservation and Delegation. The changes reflect the new Executive Director structure and the recent streamlining of several committees, as previously agreed by the Board. It was noted that these updates effectively formalise decisions already taken.

The Board was reminded that, as part of the Single Improvement Plan, the organisation has committed to a wider governance review. Accordingly, further updates to the scheme are expected in the next financial year to ensure alignment with the evolving governance framework.

The Board –

Approved the proposed changes to the SORD and OSORD.

Leadership Reports

ICB/03/26/14 Report of the ICB Chief Executive

Liz Bishop provided an update to the Board noting the first phase of the workforce change programme, which included a voluntary redundancy scheme, has now concluded. By the end of the month, 150 colleagues will leave the ICB following acceptance of voluntary redundancy. The Board formally recorded its thanks for their contribution and service.

Rising demand for adult ADHD assessments and support remains a significant risk on the corporate risk register. Work is progressing on a needs-led model of care that shifts focus from diagnosis alone toward earlier, more equitable access to practical support. Further clarity will be provided on associated actions to strengthen risk mitigation.

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The strategic outline case for the Health of the Future, New Leighton Hospital has been formally approved by the Department of Health and Social Care. Funding has also been secured for a transformation business case to support delivery in 2026–27. This will enable Mid Cheshire Hospitals and system partners to accelerate transformation, particularly in out-of-hospital care, to support the success of the new hospital programme.

The Board noted the outcomes of the recent staff survey. Positive feedback was received on equality, diversity and inclusion, and flexible working. Areas requiring improvement include learning and development, appraisals, and core management practices, which are essential to ensuring a workforce aligned to the future operating model currently under consultation.

Updates were provided on prevention programmes, including smoke-free initiatives delivered through CHAMPS, which continue to progress well.

The Board received an update on the joint work between Mersey Care and Cheshire and Wirral Partnership NHS Foundation Trust on intensive and assertive outreach within community mental health services. Progress against the previously agreed action plan was noted, with supporting appendices provided for information.

The Board Discussed progress on the intensive and assertive outreach community mental health action plan, noting that several key actions, such as ensuring all “did not attend” (DNA) events are recorded, flagged, and followed up—remain incomplete despite the time elapsed since the previous update. Assurance was sought on when the outstanding actions will be fully implemented, given the scrutiny following earlier service failures. The Board was informed that policy changes have now been embedded within the service. DNA’s are treated as a red-flag event, triggering a full multidisciplinary team discussion for any missed appointment, including for depot medication. This revised approach is now operational across the organisation.

The Board Noted -

- **Progress against the agreed action plan (detailed in the appended report and RAG-rated appendix).**
- **The risks identified and proposed mitigations.**
- **The intention to work with the ICB digital programme to explore opportunities to improve interoperability and develop cross-agency alerting systems.**
- **The Board noted receipt of updates and issues considered by the Executive Committee during the preceding period.**

ICB/03/26/15 Cheshire and Merseyside ICB and System Finance Report – Month 11

The Board received an update on the financial position from Rebecca Tunstall. At Month 9, the system was forecasting a mid-case deficit of £335m and a best-case deficit of £240m against a control total of £178m. Following discussions with NHS England under the forecast change protocol, a revised year-end system control total of £290m was agreed.

At Month 11, the ICB reported a £16m surplus and remains on track to deliver its breakeven control total. System-wide pressures continue in prescribing, ADHD services, acute activity and all-age continuing care. The overall system deficit at Month 11 was £271m, consistent with

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delivering the agreed £290m control total.

A significant change since Month 9 relates to deficit support funding. NHS England confirmed that providers able to deliver their original 2025/26 control totals and submit compliant plans for 2026/27 would be eligible to earn back deficit support funding. Three providers met these criteria as at month 11. Provider requests for distressed cash totalled approximately £350m, with the final confirmed requirement reduced to £231m.

The Board –

Noted the financial position and metrics reported at Month 11 and the risks to delivery of the financial plan.

ICB/03/26/16 Highlight report of the Chair of the ICB Finance, Investment and Our Resources Committee

The Board received an update from the Chair of the Finance, Investment and Our Resources Committee on recent work focused on developing the financial plan and CRES for the new financial year, alongside ongoing changes to strengthen the organisation's approach to identifying and managing cost-saving programmes. Recommendations from external support provided by PWC have been incorporated into revised business processes.

The committee met again on 18th March 2026 and approved a significant number of contracts, with an intention to explore future opportunities for rationalisation. Among the approvals were contracts for non-emergency ambulance services with West Midlands Ambulance Service and North West Ambulance Service, following delays to the wider re-tendering process.

The committee also approved £7.5m of financial support for nine providers to implement MARS and voluntary redundancy schemes within the revised year-end forecast. These schemes are expected to deliver recurring annual savings of £9.6m.

The Board

Approved the recommendation of the Committee to approve amendments to the Committees TOR.

ICB/03/26/17 NHS Cheshire and Merseyside Integrated Performance Report

The Board received an update on the Integrated Performance Report (IPR) from Jude Adams. Permission was requested to undertake a review of the IPR document, noting that while it contains extensive information, it does not always clearly highlight priority areas. The proposed review would involve interested Non-Executive Directors and would align the IPR more closely with the emerging five-year plan, including agreement on the key KPIs to be tracked throughout the year.

It was highlighted that workforce metrics require greater prominence within future reporting, particularly in relation to equity, diversity and inclusion, and the development of community services to support the neighbourhood model and left shift. Current IPR's contain limited community and neighbourhood-level indicators, and work is needed to define and incorporate these as part of five-year plan delivery.

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The current report was described as an end-of-year “report card”, showing areas of improvement over time but also metrics that continue to lag or show normal variation, noting the need to ensure that priorities, ambitions and BAF risks are aligned with the actions required to shift performance indicators.

Updates were provided on nationally mandated standards. The urgent and emergency care sprint continues, focusing on whole-system performance rather than solely acute providers.

Performance from February 26 to March 26 has improved, though variation remains across providers, particularly those furthest from plan. Targeted work is underway with these organisations to address known barriers.

In planned care, providers have delivered strong performance through the recent sprint. The system is expected to report approximately seven patients waiting over 65 weeks at year-end, with a potential risk of up to fifteen, some due to patient choice. The likely March 26 position is around 62% RTT performance against a plan of 63.9%, placing the system as the best-performing in the North West this week.

Early indications suggest that the system will deliver the statutory cancer standards for the year, with strong performance reported across providers.

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

ICB/03/26/18 Highlight Report of the Chair of ICB Quality and Performance Committee

The Chair of the Quality and Performance Committee provided an update to the Board highlighting significant operational pressures, workforce challenges and ongoing reform activity. All-Age Continuing Care (AACC) continues to experience very high demand and a deterioration in performance, driven primarily by delays in assessment timelines and the emergence of case review backlogs. Sickness absence remains high at over 10%, although whole-time equivalent staffing has increased by around 10% during the financial year. Fragmented data systems continue to hinder efficiency, however, seven of the nine place-based teams are progressing towards a single system to improve data quality and consistency.

While recognising the need for continued financial control, the committee emphasised the importance of more patient-centred reporting, including a clearer focus on outcomes and on improving the experience of individuals awaiting assessment.

A priority decision was taken to implement a temporary six-month pause on routine Funded Nursing Care reviews to relieve workforce capacity pressures. The committee noted concerns and stressed that urgent and demand-driven reviews must continue, with close monitoring of emerging risks throughout the pause period.

The committee endorsed a range of improvement plans, including prioritised organisational development support for AACC staff and work to understand the causes of variation and outlier status to inform future service restructuring.

The committee also reviewed the Mental Health Improvement Plan, significant progress was

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noted, and the joint work between Mersey Care and Cheshire and Wirral Partnership was commended.

The Board noted the contents of the report.

ICB/03/26/19 Highlight report of the Chair of the Audit Committee

The Chair of the Audit Committee provided an update on to the Board on matters discussed at committees throughout the year relating to the impact of organisational change and reduced capacity. This has been reflected in challenges around the timetable for producing the Annual Report and Accounts. As of the committee meeting on 3rd March 26, no national timetable had yet been issued, creating a continuing risk that audit committee scheduling, and potentially Board meeting dates, may need to change once national guidance is received. This risk has also been highlighted within the Finance and Investment Committee.

The Board was also updated on the Financial Governance Review, an interim report was received, Non-Executive Members reflected on the ongoing challenge of balancing the need for timely decision making with ensuring appropriate levels of scrutiny and assurance.

The Board noted the contents of the report.

ICB/03/26/20 Highlight report of the Chair of the System Primary Care Committee

The Chair of the Quality and Performance Committee provided an update on the collaborative work taking place to strengthen GP prescribing oversight and wider primary care governance. Assurance was provided that the multidisciplinary forum, bringing together the Head of Pharmacy, Medicines Management, contractor groups and the LMC, continues to operate as a productive space focused on relationships, problem-solving and addressing current challenges in prescribing. It was emphasised that this work is a priority and that pace is important to ensure the system remains ahead of emerging pressures. An interim governance arrangement has been established between the Primary Care Committee and the Finance Committee, ensuring that all primary care decisions with revenue or capital implications are routed directly into the Finance Committee for oversight.

The Board noted the contents of the report.

ICB/03/26/21 Highlight report of the Chair of Shaping Care Together Joint Committee

The Chair of the Shaping Care Together Joint Committee provided an update highlighting that a Joint Committee meeting was held on 13 March 2026, at which approval was given for the business case to progress the option to co-locate adult and children's A&E services at Southport and Formby District General Hospital. The meeting was held in public, with significant attendance from local residents, elected members and the press. The committee acknowledged the sensitivities surrounding the proposed relocation of children's A&E from Ormskirk but welcomed the scrutiny and recommendations provided by the Joint Overview and Scrutiny Committee, these were fully considered during the meeting, and the formal response is available within the Shaping Care Together committee papers.

The programme board will now advance the business case through the required NHS England processes, with the intention of ultimately seeking approval from the Department of Health and

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Social Care. In parallel, both ICB's will continue work to strengthen urgent and emergency care services within their planning processes, ensuring neighbourhood-level provision remains central. The committee was assured that engagement with the public, stakeholders and the Joint Scrutiny Committee will continue throughout the next phase, including work on the recommendations and mitigations arising from both scrutiny and public consultation.

The Board recorded its thanks to Cheshire and Merseyside's ICB executive lead and programme team for their extensive work in bringing together both ICBs and progressing this complex programme.

The Board noted the contents of the report.

ICB/03/26/22 Highlight report of the Chair of North West Specialised Commissioning Services Joint Committee

The Chair of the North West Specialised Commissioning Services Joint Committee provided a verbal update from the specialised commissioning joint committee, which covers services commissioned across the three ICB footprint. The committee noted several quality-of-care incidents relating to infection control and renal dialysis, none of which occurred in Cheshire and Merseyside. Workforce and business-continuity risks remain significant due to vacancy freezes and organisational change within the specialised commissioning function. The ongoing issue regarding procurement of the adult critical care transport service was highlighted, including an unresolved capital funding gap.

The committee reported active progress on establishing the Office for Pan-ICB Commissioning (OPIC). Funding envelopes and structural proposals have been identified, with a wider remit expected to include criminal justice, vaccination and immunisation. The Board was advised that this will change the role of the North West Joint Committee, with proposals expected by summer and a transition to an OPIC governing board in shadow form from October 2026 ahead of full implementation in April 2027.

A health inequalities strategy for specialised commissioning was approved. The neonatal critical care service review is progressing, with staff, parent and carer engagement underway and a long list of options being developed. The committee also discussed risks associated with highly specialised "niche" services dependent on very small patient numbers, and a deep-dive review is being undertaken.

Specialised commissioning remains on track to deliver a financial surplus for 2025/26 and has submitted a balanced plan for 2026/27, subject to final negotiations. Assurance was provided that quality oversight processes remain robust during the transition period. A new mental health assurance report covering secure services, CAMHS and prison transfers has been received, with detailed oversight to be managed by individual ICBs.

An internal audit report on specialised commissioning provided substantial assurance, with actions to be incorporated into the emerging OPIC governance model.

The Board noted that a more detailed report on specialised commissioning and OPIC developments will be brought to the May meeting. The committee chair confirmed that the rotation of chairing responsibilities will pass to Lancashire and South Cumbria at the end of the month.

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The Board noted the contents of the report.

Closing Business

ICB/03/26/23 Closing Remarks and Review / Reflections of the Meeting

The Chair thanked all members for their contributions and reflected on the constructive and insightful discussions held throughout the meeting. The importance of maintaining focus on the major strategic issues highlighted earlier in the session was emphasised. The Chair expressed appreciation for the engagement and commitment shown by all present.

ICB/03/26/24 Any Other Business

None.

CONSENT ITEMS

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

Date and start time of future meetings

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

ICB Board Meeting Action Log

Updated: 13.05.26

| Action Log No. | Original Meeting Date | Description | Action Requirements from the Meetings | By Whom | By When | Comments/ Updates Outside of the Meetings | Status | Recommendation to Board |
|----------------|-----------------------|---|--|---------------|------------|--|---------|---|
| ICB-AC-104 | 27/11/2025 | Safeguarding Our Workforce – NHS Cheshire and Merseyside Sexual Misconduct Policy | ICB Sexual Misconduct Policy to be shared with higher education institutions through the deanery | Mike Gibney | | | ONGOING | |
| ICB-AC-105 | 27/11/2025 | Board Assurance Framework | Board risk appetite session to be developed | Clare Watson | Q1 2026-25 | To be incorporated as part of Board Development Programme in 2026 and as part of single improvement plan | ONGOING | Board is asked to approve removal of action |
| ICB-AC-108 | 29/01/2026 | Women's Hospital Services in Liverpool – Options Appraisal and Next Steps | ICB Finance Leads will need to be involved with the business case to understand the financial impact of the options. Andrea McGee will become involved and will support. | Andrea McGee | 01/03/2026 | | ONGOING | |
| ICB-AC-112 | 26/03/2026 | ICB/03/26/12 NHS Cheshire and Merseyside Board Assurance Framework and High Scoring Corporate Risks | Risk team to support clinical services to formalise and consolidate the relevant AACC risks into a more rounded, holistic risk entry for future review. | Ben Vinter | 28/05/2026 | | ONGOING | |
| ICB-AC-113 | 26/03/2026 | ICB/03/26/12 NHS Cheshire and Merseyside Board Assurance Framework and High Scoring Corporate Risks | Executive team to review risks for Liverpool Women's programme. | Fiona Lemmens | 28/05/2026 | | ONGOING | |

Meeting of the Board of NHS Cheshire and Merseyside

28 May 2026

Proposed changes to where high risk and complex
gynaecology and maternity care takes place in
Liverpool – a public engagement approach

Agenda Item No: ICB/05/26/09

Proposed changes to where high risk and complex gynaecology and maternity care takes place in Liverpool – a public engagement approach

1. Purpose of the Report

- 1.1 The purpose of this paper is to present plans and seek approval for progressing with the delivery of a public engagement process on proposed changes to complex and high-risk maternity and gynaecology care in Liverpool, provisionally planned to take place during June and July 2026.

2. Background

- 2.1 On 29 January 2026, the Board of NHS Cheshire and Merseyside ICB agreed to progress with a medium-term service development proposal to improve hospital gynaecology and maternity services in Liverpool.
- 2.2 This proposal ('Option 2' in the appraisal process) involves changes to where complex and high-risk gynaecology and maternity care takes place, with a view to moving it from Liverpool Women's Hospital to the Royal Liverpool Hospital to improve the safety and quality of this care.
- 2.3 During this meeting, the Board asked the provider Trust (University of Liverpool Hospitals Group) to begin to develop a business case for this option, and signaled that further public engagement would be held on this proposal over summer, to help inform this process.
- 2.4 Further details from this previous meeting, including a fuller history and background on this programme of work, can be found in [previous Board Papers from January 2026](#).

3. Ask of the Board and Recommendations

- 3.1 **The Board is now asked to:**
- **Consider** the proposed approach to holding a public engagement on proposed changes to where high risk and complex gynaecology and maternity care takes place in Liverpool, presented in this paper
 - **Review** the formal communication and engagement plan (included as an Appendix One)
 - **Provide approval** to progress with the launch the proposed six week public engagement period, running from 2 June – 14 July 2026, based on these plans.

3. Reasons for Recommendations

- 3.1 Legal context** - both integrated care boards (ICBs) and NHS trusts have a legal duty to involve the public. These duties are set out in the National Health Services Act 2006, as amended by the Health and Care Act 2022: section 14Z45 for ICBs, and section 242(1B) for NHS trusts and NHS foundation trusts. NHS England's *Working in partnership with people and communities: statutory guidance*¹, provides further information about how organisations should approach these duties.
- 3.2 Other factors** - Statutory guidance is clear about the need to involve people, but it is not prescriptive about the form that involvement should take, and it does not provide a set threshold for full public consultation. The number of patients potentially impacted by the proposed medium-term service improvements in gynaecology and maternity services is likely to be relatively low, which might in other circumstances indicate a smaller scale, targeted approach.
- 3.3** However, other factors can form part of the decision-making around levels of involvement, and because of the level of interest in women's hospital services in Liverpool, a wider, more formal public involvement process will be undertaken to demonstrate our continued commitment to transparency and ongoing engagement with the local population.
- 3.4** This is also in line with legal advice taken regarding public involvement in the programme, and the Board's previous commitment to doing so.

4. Communication and engagement

- 4.1 Summary of engagement approach** - A summary of our proposed engagement approach is provided below, but described in more detail in the supporting communication and engagement plan (Appendix One):
- to hold **a six-week engagement period (provisionally 2 June to 14 July 2026)** entitled: 'Improving hospital gynaecology and maternity services in Liverpool: Proposed changes to where high risk and complex care takes place'.
 - feedback will be collated through **an online questionnaire** containing a series of both quantitative and qualitative questions – paper copies/other formats will be available on request.
 - a **series of 1:1 in depth conversations/interviews** will be undertaken with identified individuals who have lived experience of receiving the complex/high risk care that is the focus of the proposal.
 - **3 x public in-person information events** will be held (one each for Knowsley, Liverpool and Sefton). Each session will include a presentation on the proposal (led by a clinician), answer additional questions, and provide support to any members of the public who need extra help to participate.

¹ <https://www.england.nhs.uk/publication/working-in-partnership-with-people-and-communities-statutory-guidance/>

- local community organisations will be offered an opportunity to invite members of the programme to their **existing meetings, networks and groups** to share information about the engagement.
- a **Lived Experience Panel** made up of individuals with personal experience of using these services will be consulted to ensure that patient voice is reflected in the development of all engagement activity and patient materials.

4.2 **Delivery of communication and engagement** - NHS Cheshire and Merseyside's communication and engagement team are leading this public engagement process, working closely with the communications, engagement and patient experience colleagues at University Hospitals of Liverpool Group (UHLG).

4.3 Two key communications and engagement groups have been mobilised to support engagement planning, including a delivery group of ICB and UHLG communications and engagement staff, and a wider reference group for communications and engagement colleagues from other local trusts (Alder Hey, Clatterbridge Cancer Centre), local authorities, Healthwatch organisations, and the Maternity and Neonatal Voices Partnership (MNVP).

4.4 The ICB communications and engagement team is convening and overseeing each of these groups.

5. Risks and mitigations

5.1 A list of specific risks related to the communication and engagement delivery in this phase of the programme is detailed in the communication and engagement plan (appendix 1), alongside mitigations being built into this work.

5.2 The single biggest risk to this process is that the engagement fails to effectively meet our engagement duties around involvement, which can lead to legal challenge. Ensuring that our planning is comprehensive, and seeking early input from a range of key partners in this planning phase, is a key part of ensuring a successful process.

6. Finance and costs

6.1 **Rationale for outsourcing elements of delivery** - External specialist agencies will be appointed to provide support for the delivery of specialist elements of this project, including: graphic design and print services, translation services, and independent feedback analysis and report writing.

6.2 The rationale for this outsourcing is in part due to what is practicable, since not all of these services are deliverable in-house – e.g. print services, translation services, but it also about ensuring we deliver a robust and comprehensive engagement, and it is widely considered to be best practice that analysis and

reporting of feedback data collected during a public engagement on NHS service change is undertaken by a separate organisation with specialist research skills.

6.3 **Associated costs** - The associated costs related to this are detailed below:

| Item | Details | Estimated costs |
|--|---|---|
| Design and print | Graphic design, artworking, production of all printed materials | 7-10k (dependent on final print quantities required by partners) |
| Accessible formats and translated materials | Translation into Easy Read and BSL formats, and any other languages upon request only | 2-3k (dependent on quantity of requests made) |
| Public event venue costs | Venue/room hire, resources and basic refreshments | Up to 2k |
| Independent data collection, analysis and report writing | Collection of all qualitative and quantitative feedback Full technical analysis of data Production of findings into a summary report to be used in decision-making. | 50-60K (dependent on final quantity of responses provided for analysis) |

7. Equality, Diversity and Inclusion

7.1 **Commitment to supporting these standards** - Alongside our statutory public involvement duties, the NHS is expected to meet the Public Sector Equality Duty, and the Accessible Information Standard. This means the engagement will be actively designed so that those voices are less often heard, are able to understand the proposal and take part in a meaningful way.

7.2 As part of planning work, a high-level equalities report was prepared which highlights a variety of equalities considerations. This engagement plan has been developed to reflect and respond to those considerations, and will support these requirements by:

- utilising a variety of different communication and engagement mechanisms to ensure that a wide range of voices and experiences can be heard
- providing paper-based copies of the questionnaire to ensure online access is not a barrier to participation.
- providing Easy Read version and BSL translation of key information, and a clear route to request other languages/formats.
- partnering with local community organisations to maximise our reach into a wide range of different communities.

- building equalities monitoring questions into the engagement and using continuous real-time data monitoring to identify/address any gaps in our reach.

8. Sustainability and social value considerations

- 8.1 This engagement approach has been developed with due consideration to the ambitions of the ICB regarding the delivery of its Green Plan and Net Zero obligations, and ensure social value in each of the following ways:
- taking a 'digital first' approach to our engagement delivery – while also balancing this with ensuring that accessibility also remains a priority.
 - applying a 'light touch' approach to print and production requirements, and using recycled/recyclable products wherever possible.
 - partnering with local community organisations to source event venues, demonstrating our commitment to support VCSFE/public sector partners over corporate interests.

9. Next Steps and Responsibilities

- 9.1 **Timescales and next steps** - Subject to final approval from the Board to progress with proposed engagement plans, the timescales for delivery and next steps will be as follows:

| | |
|--|--------------------|
| Launch of six-week public engagement | 2 June 2026 |
| Close of public engagement | 14 July 2026 |
| Analysis of feedback and report writing | July - August 2026 |
| Report finalised and ready for sharing | Autumn 2026 |

- 9.2 **Key roles and responsibilities** - The following staff will be acting as the organisational named communications and engagement leads, with responsibility for the delivery of this work:

| Organisation | Named lead |
|---|-------------------|
| NHS Cheshire and Merseyside (ICB) | Anna Kettle |
| University of Liverpool Hospitals Group | Andrew Duggan |

10. Officer contact details for more information

Anna Kettle, Senior Communications and Engagement Manager, NHS Cheshire and Merseyside (ICB): anna.kettle@cheshireandmerseyside.nhs.uk

11. Appendices

Appendix 1: Full communication and engagement plan



Women's Hospital Services in Liverpool

Communication and Engagement Plan

For a public engagement on proposed changes where high risk and complex gynaecology and maternity care takes place

Summer 2026

Version control

| Date | Version | Reviewed by | Updates |
|----------|---------|---|------------------------------------|
| 09/03/26 | 1.0 | Anna Kettle, ICB Comms & engagement team | Authored |
| 17/03/26 | 2.0 | Helen Johnson, ICB Comms & engagement team | Peer reviewed |
| 14/4/26 | 3.0 | Communications & Engagement Delivery Group (UHLG comms) | Reviewed & amended |
| 16/4/26 | 4.0 | Andy Woods, ICB Equalities lead | Reviewed & amended |
| 27/4/26 | 4.0 | ICB Exec Team – led by Fiona Lemmens | Discussed & reviewed |
| 5/5/26 | 4.0 | Communications & Engagement Reference Group | Discussed & reviewed |
| 6/5/26 | 4.0 | Lived Experience Panel | Discussed & reviewed |
| 18/5/26 | 5.0 | Anna Kettle, ICB Comms & engagement team | Final amends collated & signed off |

1. Introduction

The Women's Hospital Services in Liverpool programme was established to look at some long-standing issues facing hospital maternity and gynaecology services in the city.

It was established by NHS Cheshire and Merseyside Integrated Care Board (ICB), with close involvement from NHS University Hospitals of Liverpool Group (UHLG) which operates Liverpool Women's Hospital and the Royal Liverpool University Hospital, as well as Alder Hey Children's NHS Foundation Trust, and The Clatterbridge Cancer Centre NHS Foundation Trust.

Currently, in Liverpool these services are mainly delivered at Liverpool Women's Hospital, meaning that they are separate from other acute and specialist adult hospital services. This arrangement presents significant clinical risks and challenges for providing care to women and their families, and Liverpool is the only city in the country where services are arranged in this way.

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

Although this would not solve all of the wider problems that come from having gynaecology and maternity in a separate hospital to other adult services, it would help us to provide better, safer care for women who are at the highest risk.

We have committed to holding a six-week public engagement process to give people an opportunity to share their views on the proposed changes, in order to help shape the next steps for this improvement work.

This plan provides an overview of the approach we intend to take for that public engagement process.

2. Scope of this document, roles and responsibilities

This plan covers the delivery of a six-week public engagement on proposed changes, and the analysis and reporting of engagement findings.

Its focuses on communications and engagement activity to support public involvement during this phase of the programme only.

As such, this plan should be read alongside the equality and health inequalities analysis, prevention and equity population profile, stakeholder map, staff engagement arrangements, local authority scrutiny arrangements and final engagement evaluation framework for wider context.

This plan has been developed by NHS Cheshire and Merseyside's communications and engagement team, will input from colleagues at UHLG and other partners.

Following discussion and refinement with a range of partners, it will be presented to NHS Cheshire and Merseyside's Executive Committee and the Trust's executive team, before being recommended to the ICB board for final approval.

3. Key communications and engagement objectives

The communications and engagement objectives are as follows:

- To communicate the proposed changes, and reasons for them, to a wide audience, in a clear and easy to understand way
- To effectively publicise the engagement period, and maximise opportunities for participation
- To utilise a variety of methods of engagement and promotion, reflecting different needs and preferences (including accessible formats and translations), and helping ensure that a wide range of voices and experiences are heard
- To monitor participation and involvement on an ongoing basis, and where possible take corrective action to help ensure that specific places or protected groups are not under-represented
- To ensure that feedback received is effectively analysed and reported, including clear disaggregation of data by demographic groups/protected characteristics
- To clearly communicate the findings from the engagement, and how any decision making that follows from it will be taken forward.

4. Understanding the context for public engagement

NHS legal duties

Both integrated care boards (ICBs) and NHS trusts have a legal duty to involve the public. These duties are set out in the National Health Services Act 2006, as amended by the Health and Care Act 2022: section 14Z45 for ICBs, and section 242(1B) for NHS trusts and NHS foundation trusts.

NHS England's *Working in partnership with people and communities: statutory guidance*¹, provides further information about how organisations should approach these duties. While both commissioners and providers are subject to public involvement duties, they can work together to discharge these requirements.

¹ <https://www.england.nhs.uk/publication/working-in-partnership-with-people-and-communities-statutory-guidance/>

Statutory guidance is clear about the need to involve people, but it is not prescriptive about the form that involvement should take, and it does not provide a set threshold for full public consultation.

Other considerations

The number of patients potentially impacted by the proposed medium-term service improvements in gynaecology and maternity services is likely to be relatively low, which might in other circumstances indicate a smaller scale, targeted approach.

However, other factors can also form part of the decision-making around levels of involvement, and because of the level of interest in women's hospital services in Liverpool, a wider, more formal public involvement process is therefore being undertaken.

Given that the future of women's services in Liverpool is a long-standing issue, attracting significant interest, this approach will help demonstrate a commitment to transparency and ongoing engagement with the local population. This course is also in line with legal advice taken regarding public involvement in the programme.

Public Sector Equality Duty

Alongside our statutory public involvement duties, the NHS is expected to meet the Public Sector Equality Duty, which is the duty to have regard to reducing inequalities in access to and outcomes from health services, and the Accessible Information Standard.

This means the engagement will not only be open to all, but actively designed so that people with information and communication needs, people facing language barriers, people affected by digital exclusion, people with protected characteristics, and people whose voices are less often heard through standard channels are able to understand the proposal and take part in a meaningful way.

5. Equality, diversity and inclusion

As part of this work, a high-level equalities report was prepared, highlighting a variety of equalities considerations for the programme, including the option we're now planning to consult on.

This communication and engagement plan has been developed to reflect and respond to the considerations set out in that report. We'll also continue to review and refer back to it as we move forward.

In practical terms, our engagement process will support these requirements by:

- Utilising a variety of different communication and engagement mechanisms to help ensure that a wide range of voices and experiences are able to be heard and that not

one is excluded from participation – including a mix of online, print based, face to face channels.

- Providing an Easy Read version and a BSL translation of key information materials, and signposting people to a single point of contact (via telephone and email) for requesting this information in other languages or formats. These contacts will be very visible across all materials.
- Although we will take a ‘digital first’ approach in this engagement, we will also provide paper-based copies of the questionnaire so that online access is not a barrier to participation.
- Partnering with a range of local community organisations and groups to help us maximise our reach into a wide range of different communities throughout this engagement process.
- Making reasonable adjustments to help remove any barriers to participation, including ensuring that information is accessible in a range of formats, and providing additional support to help people participate in the engagement, where required – for example, collating feedback over telephone discussion, and offering 1:1 support face to face support at the public information events.
- Building equalities monitoring questions into the engagement questionnaire, and any other information we capture during the process. Collecting this information will help us build a detailed picture of who has engaged, help highlight any differences in responses from specific groups; and understand whether any patterns or themes emerge.

Continuous real-time monitoring of this data will also help us to identify any gaps in our reach, so that we can take rapid corrective action in response to ensure that our engagement reaches a diverse range of people.

6. Summary of engagement approach

A six-week engagement period is provisionally slated to run between 2 June until 14 July 2026, subject to receiving final Board approval being given to proceed.

During this engagement process, the following mechanisms/channels will be utilised:

- **Questionnaire:** Containing a series of both quantitative and qualitative questions – available online, and with paper copies/other formats available on request.
- **Public Events:** 3 x public in-person information events will be held, one each for Knowsley, Liverpool and Sefton. These events will provide a presentation on the proposal, and allow space for answering any additional questions. Time would also be allocated for participants to be supported to complete questionnaires at this session, if they require this.

- **Individual 1:1 interviews:** We will also run a series of individual 1:1 interview conversations with those with lived experience of complex/high risk care, in order to maximise opportunities for qualitative insights from those directly impacted by these proposals. However, achieving this will be dependent on being able to identify previous patients or carers with relevant experience, and their availability/willingness to take part.
- **Phone line, email and text message contact points:** People will be able to make contact by phone and email, both to provide feedback or request alternative formats and versions of the questionnaire/materials. The phone line will be supported by the PALs team at Liverpool Women's.
- **Lived Experience Panel:** A panel has been established to help inform the programme, including communications and engagement planning and delivery. This is made up of individuals with direct experience of using services – either as a patient, carer, or family member. As well as seeking the panel's input on the materials we are developing for patients/public for accessibility, we will ask them to consider participating in interviews where relevant.
- **Virtual Reference Group:** We have also established a Virtual Reference Group for this work (people have signed up via email for ongoing updates on the programme). This database is hosted by NHS Cheshire and Merseyside and will be used to help support participation and feedback.
- **Patient support groups and networks:** A mapping exercise will identify other relevant local support networks and groups which we can share information and materials with – and ask them to share this with their members and contacts.
- **Presentations at community group settings:** Groups will also be invited to request a presentation from a programme representative at their existing meetings/events during the engagement period.

7. Data collection, analysis and reporting

Specialist independent support will be commissioned to collect and analyse data, and produce a final independent report setting out findings, which will be used to inform a final decision. It is crucial that feedback collected during the engagement period is safely and securely handled, according to NHS data security and GDPR standards.

It is equally important any feedback gathered during the engagement process is comprehensively analysed, and using an independent, external organisation to undertake this work is widely recognised as best practice in NHS service change process.

Once the analysis and reporting has been completed, the report will progress through programme governance, then published (and shared with key stakeholders) to help inform how this service improvement work moves forwards.

8. Timescales and key communication milestones

Proposed timescales are as follows (but may be subject to some slippage), and this will create a number of key milestones on which communications will be focused as follows:

| Milestone | Date | Comms activity |
|---|--------------------------------------|--|
| Plan presented to Board of NHS Cheshire and Merseyside for approval | 28 May 2026 | Stakeholder briefing and media release to confirm decision |
| Launch of six-week public engagement (subject to Board approval) | 2 June 2026 | Follow up stakeholder briefing and media release about how to take part Questionnaire and website information live Print/ display materials used Comms toolkit issued to key partners |
| Midpoint review | Late June | Equalities analysis to see if any gaps in who is being reached – and consider corrective action if needed Follow up media release to promote/remind people to participate Additional targeted comms to be considered |
| Close of public engagement | 14 July 2026 | Post-engagement stakeholder briefing and media to explain next steps |
| Analysis and report writing | July - August 2026 | N/a |
| Final engagement report due to be published | Likely to be ready by September 2026 | Stakeholder briefing and media release to be issued |
| Decision-making on how proposal moves forwards | Later in Autumn 2026 | Stakeholder briefing and media release to be issued |

9. Communication and engagement delivery

Partnership working

NHS Cheshire and Merseyside's communications and engagement team will lead the public engagement, working alongside communications, engagement and patient experience colleagues at NHS University Hospitals of Liverpool Group (UHLG) and others.

Two key communications and engagement groups will be mobilised to support this work: a delivery group made up of ICB and UHLG communications and engagement staff, and a wider reference group for communications and engagement colleagues from Alder Hey Children's NHS FT and Clatterbridge Cancer Centre NHS FT, Healthwatch and local authorities. The ICB will convene and oversee both groups.

In addition to this, external specialist agencies will be appointed to provide support for the delivery of the following elements: graphic design and print services, and independent feedback analysis and report writing.

Key areas of delivery will include:

- Developing all written information materials about the engagement e.g. summary engagement booklet, website content, promotional print materials such as posters, leaflets etc.
- Planning and delivering the engagement process and materials, including questionnaire, interview materials, and public events planning and management
- Promotion of the engagement period – developing a toolkit of communication resources for the ICB and key partners to use
- Stakeholder mapping and engagement – keeping all stakeholder regularly briefed and updated on the process
- Proactive and reactive media activity and supporting reputation management – proactive press releases, reactive media handling
- Overseeing political briefing arrangements
- Oversight of data handling, feedback analysis and report writing on engagement findings.

10. Identifying key stakeholders

Keeping all key stakeholders informed and updated will be critical to the success of this work.

The table below provides an overview of some of key stakeholder groups for the programme, and details of how we will communicate with them / keep them informed at each key milestone during this phase of the programme:

| Audience | Proposed channel/method of communication |
|---|---|
| Internal | |
| NHS Cheshire and Merseyside Integrated Care Board (ICB) | <ul style="list-style-type: none"> Briefings to be shared via email |
| Transformation Committee (UHLG) | <ul style="list-style-type: none"> The Communications and Engagement Group provides an update report for each committee meeting |
| Liverpool Women's / UHLG Board | <ul style="list-style-type: none"> Briefings to be shared via email via trust comms team for onwards cascade. |
| Other trust boards in Cheshire and Merseyside | <ul style="list-style-type: none"> Briefings to be shared via email via trust comms teams for onwards cascade. |
| Staff working in maternity and gynaecology services | <ul style="list-style-type: none"> Briefings to be shared by LWH /UHLG comms team Wider staff engagement covered in a separate plan |
| GP practice staff | <ul style="list-style-type: none"> Briefings to be shared in fortnightly Cheshire and Merseyside email newsletter for general practice |
| Wider workforce across other trusts | <ul style="list-style-type: none"> Briefings about launch of engagement shared with all staff – via comms teams |
| NHS Cheshire and Merseyside staff | <ul style="list-style-type: none"> Briefings shared via existing internal communications routes, including weekly email newsletter and all-staff We Are One sessions |
| NHS England | <ul style="list-style-type: none"> Briefings/updates shared with NHSE communications team |
| External | |
| Current maternity and gynaecology patients and/or those with lived experience | <ul style="list-style-type: none"> Lived Experience Panel – online pre-briefing meeting Ongoing engagement in process |
| Liverpool Women's patient experience team | <ul style="list-style-type: none"> Represented on the Communications and Engagement Delivery Group |

| | |
|--|---|
| Current gynaecology and maternity patients | <ul style="list-style-type: none"> • Info to be shared on Trust and ICB websites • In hospital display materials – posters, leaflets, banner stands, display screens |
| Liverpool Maternity and Neonatal Voices Partnership (MNVP) | <ul style="list-style-type: none"> • Invited to comms reference group for input and pre-briefing • Comms toolkit to be shared for use/onwards cascade |
| Communications and engagement team across North Mersey local authorities | <ul style="list-style-type: none"> • Invited to Comms Reference Group for input and pre-briefing • Comms toolkit to be shared • Share stakeholder briefings |
| Local authority scrutiny and local councillors | <ul style="list-style-type: none"> • Subject to discussions with scrutiny officers • Stakeholder briefings will be shared for onwards cascade to local Councillors and HOSCs |
| Local authority executive teams | <ul style="list-style-type: none"> • Briefings to be shared via email |
| MPs in Liverpool, Sefton and Knowsley | <ul style="list-style-type: none"> • Offer of pre-briefing meeting • Stakeholder briefings also to be shared via email • Include info in regular MP briefings |
| Steve Rotheram, Mayor of the Liverpool City Region (combined authority) | <ul style="list-style-type: none"> • Stakeholder briefings to be shared via email |
| Local Healthwatch organisations – Liverpool, Knowsley, Sefton | <ul style="list-style-type: none"> • Invited to Comms Reference Group for input on plans and pre-briefing • Comms toolkit to be shared • Share stakeholder briefings |
| Local voluntary, community, faith and social enterprise organisations (VCFSEs) | <ul style="list-style-type: none"> • Comms toolkit to be shared • Offer of meetings / presentations to groups and networks • Share stakeholder briefings |
| Media | <ul style="list-style-type: none"> • Press releases for publication • Follow-up activity e.g. proactive interviews to be considered to promote participation |
| General public | <ul style="list-style-type: none"> • Non-direct engagement via partner promotion • Media coverage • Social media reach • Public information events • Dedicated Virtual Reference Group to receive ongoing updates on email |

11. Key messages

This phase of public engagement will be underpinned by the following key messages:

- The NHS has been looking at how to improve hospital gynaecology and maternity services in Liverpool for a number of years.
- Most of these services happen at Liverpool Women's Hospital, which means they are separate from other adult hospital services, including critical care and other specialist teams. This can delay care and create problems getting women the treatment they need, particularly very seriously ill patients.
- A case for change document was published in September 2024, which describes the issues currently affecting these services in more detail, and during summer 2025 we held a number of workshops as part of an 'options process' to think about how services could look in the future (supported by a range of stakeholder groups).
- This process came to the conclusion that the only options which would resolve the clinical risks for most women who use Liverpool Women's would mean having inpatient gynaecology and maternity services located next to other adult acute hospital services. However, doing this would need significant financial investment.
- For now, we are proposing to move to treating a small number of the most complex and high-risk gynaecology and maternity cases at the Royal Liverpool University Hospital, rather than Liverpool Women's Hospital.
- If it went ahead, this proposal would only improve care for a very small number of women – doctors estimate that overall this would impact about 1% (which is approximately 150 women) accessing gynaecology and/or maternity care each year.
- Although making this change would not solve all of the wider problems that come from having gynaecology and maternity in a separate hospital to other services, it would help us to provide better, safer care for women who are at the highest risk.
- The NHS is still committed to finding a long-term solution that will improve quality and safety for everyone who uses gynaecology and maternity services in Liverpool. Discussions about how we can do this will continue as we move ahead with this smaller proposal.
- Between 2 June and 14 July 2026, we are asking people to let us know what they think about this proposal. We'll use the feedback we receive to help inform the next steps.
- People can find out more about the issues and take part in the engagement by visiting: www.GynaeandMaternityLiverpool.nhs.uk

12. Media briefing and engagement

Key outlets

A number of key media outlets covering the North Mersey footprint will be proactively offered the opportunity for an interview with key spokespeople from each organisation (ICB and UHLG) identified for quotes, and to support media with interview requests in advance.

Offer of media interviews with key clinicians to be made to:

- Broadcast – BBC NWT
- Broadcast – ITV Granada Reports
- Regional radio - BBC Radio Merseyside
- Regional print - Liverpool Echo

Media spokespeople

We recognise that this engagement process is ICB/commissioner led, but is being delivered in partnership with the Trust, and the communications arrangements should reflect this.

Key spokespeople have already been identified as follows, selected for their knowledge of the programme and previous experience in handling media, as follows:

- NHS Cheshire and Merseyside – Dr Fiona Lemmens (Medical Director) or Kerry Lloyd (Deputising), as well as Dr Jonathan Griffiths or Dr Sinead Clarke (if required).
- Liverpool University Hospitals Group – Dr Oliver Zuzan / Peter Hampshire (ICU Consultants), Heledd Jones (Director of Midwifery), Jen Deeney (Divisional Director for Nursing at LWH)

All of these individuals will be fully prepared for any media interviews in advance, including being provided with a pre-briefing with key information, figures/stats, and key messages/lines to take.

They will also be used to support clinical presentations and support questions and answers, during any public engagement events.

Reactive handling

NHS Cheshire and Merseyside will lead on the media briefing and handling – and provide a single co-ordination point for inbound media enquiries – but drawing on Trust partners for support as required.

To support the readiness of communications teams for handling any media interest and potentially minimising any negative or misleading coverage of the issues, a series of key media lines to take will be developed based on some of the key media questions/enquiries that are likely to emerge, and some pre-agreed responses.

Filming / access requests

Often media outlets request on site access and filming at the hospitals (Liverpool Women's and/or the Royal). We recognise that the ability to fulfil these proactive media requests/bids where we can is an important part of getting accurate information about this process out to the public, however there will also be a need to balance this against operational pressures for services and staff.

As such, we will keep any filming access limited to standard interview settings in a non-clinical area such as outside the entrance or on a corridor at most. (i.e. no filming around clinical areas as this time since there is nothing 'new' to show at this time).

Social media handling

Social media will also be a key channel used to engage with audiences, but it's really important that our information is clear and factual. As such, all posts will focus on signposting back to the programme website as a single source of trusted online information at: www.GynaeAndMaternityLiverpool.nhs.uk

A key principle of public engagement is that our intention is always to inform, not to persuade or unduly influence. This will guide how we manage online engagements, including any instances where individuals/groups challenge our narrative, or intentionally or unintentionally spread online information which is incorrect, misleading or potentially harmful for patients.

13. Political briefings and engagement

NHS Cheshire and Merseyside communications and engagement team already produces a regular MP briefing, and a monthly update which goes to wider stakeholders, including MPs, local authority elected members, and other local authority colleagues.

These channels will continue to be utilised for sharing updates about the programme and engagement period, but will be supplemented with some additional direct activity to support awareness of the launch of public engagement.

This will include a proactive briefing session for all Liverpool, Sefton and Knowsley MPs, ahead of the engagement launch, in order to ensure that they feel fully informed and are able to signpost constituents accordingly.

14. Local authority scrutiny arrangements

NHS commissioners must also consult local authorities when considering any proposal for a substantial development or variation of the health service.

Since service change guidance strongly advises local authority scrutiny involvement throughout every stage of the process, regular briefings are already shared with local authority scrutiny teams and elected members in Liverpool, Sefton and Knowsley.

Ahead of the launch of this engagement process, we will also engage with each H/OSC to share further information about it, and to confirm their preferred scrutiny arrangements.

15. Key promotional materials to support engagement

Below is a list of key materials / deliverables that will need to be developed to support the engagement process:

| Item | Details |
|---|--|
| Branding, look and feel | We have an already established brand/style for this programme, developed for the previous stage engagement in Autumn 2024. Continuing to use these assets will ensure continuity of message, and help us to keep any marketing and design costs to the minimal. |
| Programme website updates GynaeAndMaternityLiverpool.nhs.uk | A dedicated, accessible programme website is already built and is hosted and managed by the ICB comms team. We will need to update all of its content to support the new engagement, but will continue to use it as a single, shared NHS information hub for the programme. Another key benefit of this approach aside from consistency of message is that Google Translate allows individuals to access all of this online content in other languages. |
| Questionnaire design and build | An online questionnaire will be developed and built to capture views. Printed versions and different formats/languages will also be made available on request (via the PALs team phonenumber and helpdesk at LWH) |
| Branded engagement information booklet (A4) | The booklet will outline the proposal and explain how people can participate in the engagement. It will be made available for download from the website, and as a printed version (on request) and at public information events. |
| Information Leaflet (A5) | For use in public-facing areas (i.e. in hospitals) to promote the pre-consultation engagement, and signpost people to further information (via QR code) about how to take part – as well as other ways to contact us. |

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| Easy Read summary | A summary version of key information and the questionnaire will be set out in an Easy Read format. |
| BSL (British Sign Language) video translation | BSL video explaining more about the engagement and how to take part. |
| Digital resources – including social media assets, web banners and digital display screens | <p>A series of social media tiles and reels will be developed to help promote the engagement for use across a wide range of system partner’s social media channels - including X, Facebook and Instagram. This will be supported by a comprehensive social media plan.</p> <p>We’ll also develop digital assets for website banners signposting to the engagement, and display screens for use in staff and patient areas.</p> |
| Communications toolkit – for partners to use | <p>Partner organisations, including local NHS Trusts, Healthwatch, local authorities, VCFSE organisations and other system partners – will be asked to support the engagement by sharing information about it via their own internal and external communications channels.</p> <p>We will make this as easy as possible by compiling content into a toolkit, pulling together web copy, social media assets and key links – all into one easy ‘package’.</p> |
| Presentation summary | A branded PowerPoint presentation – taking key points from the summary booklet mentioned above – will be developed for use at the public information events, and as part of any group sessions/meetings or other briefings. A copy of this can also be published online for those who can’t attend the event. |
| Pop up roller banners | Pop-up roller banners will be created for use in reception/waiting areas and hospital foyers to help promote the engagement and encourage participation, as well as used for signage during public information events. |
| Posters (A3 & A4) | A4 posters will be developed for display in hospitals, and provided digitally as part of the comms toolkit for wider partners to print off and use in their localities too. |
| Digital display assets | Graphics will also be developed for use on digital display screens in hospitals, and shared in the toolkit for other key partners to use. |

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| Media releases | Media releases will be prepared and issued to local / regional print online and broadcast media, at the point the engagement plan is published in the NHS Cheshire and Merseyside Board papers and also when the engagement launches, encouraging people to share their views, and signposting to further information. A further follow up / reminder release will be issued after the half-way point. |
| Media handling plan | A clear media handling plan will be developed to support reactive media enquiries – with key messages, briefing lines and key spokespeople identified for use as quotes, and for media interview requests. |
| Set of updated FAQs | Previous programme FAQs will need updating and agreeing for use of the website, and to support with potential media enquiries, political enquiries, patient/engagement enquiries and FOIs. |
| Stakeholder briefing/updates | As detailed above, regular stakeholder briefings about the programme will be issued to all key stakeholders at key milestones. These updates will also be published on the NHS Cheshire and Merseyside website and on partner Trust websites. |

16. Indicative delivery costs

Rationale for outsourcing elements of delivery

External specialist agencies and community organisations will be appointed to provide support for the delivery of the following specialist elements of this project: graphic design and print services, translation services, community event hosting, and independent feedback analysis and report writing.

The rationale for this outsourcing is in part due to what is practicable, since not all of these services are deliverable by in-house teams – e.g. print services, and translation services.

Part of this decision is also about ensuring that we deliver a robust and comprehensive engagement approach, and is reflective of the fact that it is widely considered to be best practice to contract data analysis and reporting of feedback during a public engagement on NHS service change to an independent organisation with specialist skills.

The associated costs for these elements are detailed below:

| Item | Details | Estimated costs (subject to quotes) |
|--|---|--|
| Design and print | Graphic design, artworking, production of all printed materials | 7-10k (dependent on sets of amends) |
| Accessible formats and translated materials | Translation into Easy Read and BSL formats, and other languages upon request only | 2-3k (dependent on requests made) |
| Public event venue costs | Venue/room hire, resources and basic refreshments | Up to 2k |
| Independent data collection, analysis and report writing | Collection of all qualitative and quantitative feedback received during public engagement; full technical analysis of data; production of findings into a summary report to be used in final decision-making. | 50-60K (dependent on number of responses to analyse) |

Please note: All of these costs are just indicative at this stage for planning purposes and will be finalised following supplier quotes being provided. In some instances, these services may be provided by our pre-approved preferred suppliers, but suppliers for larger contract sums will be selected via a formal NHS contracting process.

17. Sustainability and social value considerations

This engagement approach has been developed with due consideration to the ambitions of the ICB regarding the delivery of its Green Plan and Net Zero obligations, and in order to ensure social value in each of the following ways:

- Taking a 'digital first' approach to our engagement delivery – while also balancing this with ensuring that accessibility also remains a priority and that reasonable adjustment have been made for those who experience barriers to digital engagement
- Applying a 'light touch' approach to print and production requirements and showing due consideration to the cost and environmental impact by applying caution around the volume of paper-based units of materials (e.g. posters, flyers, booklets) and keep waste to a minimum. We will do this by carefully considering what is required with our Trust partners at a planning stage, limiting our print runs of larger documents, and working on a 'print more if needed' rule.
- Where print materials are deemed necessary, we will also endeavour to use recycled/recyclable products where possible.

- Ensuring a commitment to working with ethical external partners such as design and print agencies who understand and support our sustainability ambitions, and can demonstrate clear social value.
- Choosing to partner with local community venues in the delivery of any engagement events, demonstrating our commitment to support local VCSFE partners over corporate interests.

18. Identified risks and mitigations

A number of potential risks and issues have been identified, which could impact on our ability to successfully delivery this communication and engagement plan. These are outlined in brief below, alongside any pre-emptive actions we are taking to help mitigate these risks, where possible:

| Potential Risks | Mitigations |
|--|--|
| <p>Ineffective engagement process: Ineffective public and patient involvement in the women’s services programme could lead to legal challenge.</p> | <p>Ensuring that we develop a comprehensive engagement plan, seeking input from key partners, and fully evidence all of the work done to engage with different local communities and partner agencies will support this process.</p> |
| <p>Potential for lack of clarity or understanding: If communication is unclear, it could lead to a lack of sufficient public and/or stakeholder engagement with the process which will negatively impact on outcomes.</p> | <p>This plan has a strong focus on ensuring that complex information is conveyed in as simple a way as possible for a range of audiences, and includes a range of simple formats including a public summary, an easy read version, visual graphics, and video and power point content. Preparing a clear set of FAQs and lines to take will also help to support with this, by minimising the risk of misunderstandings.</p> |
| <p>Under representation of most disadvantaged communities: Engagement needs to hear from a broad range of people, and be as reflective of our communities as possible –</p> | <p>Ensuring that a digital first approach doesn’t disadvantage anyone from taking part by also retaining paper, phone, email, face to face event options will be important.</p> <p>Providing materials in a range of different accessible formats and translations, and signposting to how to get further support is also key.</p> <p>Working with our community partners to help extend our reach into different communities and groups will also help to address this challenge.</p> |

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| <p>Under representation of those most directly affected by the proposal: We also need ensure that we proactively listen to the views of patients, family members and carers who have direct, lived experience of high risk and complex maternity or gynaecology care</p> | <p>Two ways we will achieve this are via: 1:1 interviews, and our lived experience panel. We will work closely with Trust patient experience teams, the MNVP, Healthwatch and individual clinicians to help recruit service users with relevant experience.</p> |
| <p>Message fatigue and disengagement: The future of women’s hospital services in Liverpool has been a long-standing, issue, and some stakeholders and members of the public might experience message fatigue, or wrongly assume that decisions have already been made, which could lead to lower engagement levels.</p> | <p>Making sure that the key message that this is a new proposal, and that no decision has been made yet, is kept front and centre on all communications activity will help to offset this risk, as will ensuring that we engage with those most directly impacted by the proposal.</p> |
| <p>Alternative narratives: There has been an active campaign to retain all maternity and gynaecology services at the current site. The long-standing focus on potential changes to the location of services – and in some cases, the resistance to this in principle – might create additional challenges to clear communications, such as distraction from key messages and/or the spreading of misinformation.</p> | <p>Although having a well-planned and coordinated, proactive plan for communicating key messages can’t prevent misinformation, it will help to balance it and minimise the impact of this ensuring that factual information cuts through. Developing a robust media handling plan, with key lines to take, will also support with any challenges this brings.</p> |
| <p>Patient reassurance: Communicating the need for change to services means clearly articulating the real clinical risks that local services are currently managing. There is a need to provide reassurance about the steps that are being taken to make sure services are safe in their current form, while not downplaying the significance of the challenges.</p> | <p>These important key messages will need to be carefully woven through all materials prepared for the engagement process.</p> |
| <p>Wider questions: There are also likely to be wider questions/issues raised during the engagement period, including about funding and any potential longer-term</p> | <p>It will be important to reinforce the focus/scope of this engagement, as well as confirming a longer-term commitment to addressing outstanding issues. Having a strong set of FAQs pre-</p> |

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| solutions to address outstanding problems not resolved within the current proposal. | prepared, and clear lines to take, will be key to supporting this. |
|---|--|

19. Evaluation and measurement of communications and engagement process

The engagement process will offer a range of potential metrics for evaluation which will be useful information to help evidence the breadth of reach we have achieved, as well as the effectiveness of different activities undertaken, during the engagement process.

Some of the key metrics we can use during the evaluation phase include:

- Numbers of questionnaires completed – is it proportional to the change being proposed?
- Geographic and demographic breakdown of responses received – have we heard from a wide range of voices?
- Number of calls/emails/texts – was information clear enough, and offered in the right formats?
- Number of sign-ups to Virtual Reference Group – how engaged are people in the issues?
- Numbers of people attending engagement sessions – who do face to face events tend to capture, and are they enabling us to hear from different voices?
- Numbers of people taking part in 1:1 interviews – have we heard sufficiently from those most affected by the proposal?
- Number of community/voluntary sector partners taking up offer of an event, and/or sharing information with their own networks
- Equalities reach – have we heard from the priority groups outlined within the EIA report?
- Amount of media coverage generated – have we created enough general awareness?
- Website page views – where is online traffic coming from? QR codes, social media, website news articles etc?
- Social media impressions and level of engagements
- Uptake of accessible formats

To support our ongoing learning, wherever possible we will aim to understand more about how people became aware of the public engagement, and gather feedback about their preferences for further communication.

Any evaluation data gathered will also be used to inform our ongoing understanding of what works well, and help to shape the development of communication and engagement activities for future phases of this and other service change programmes.

ENDS

Meeting of the Board of NHS Cheshire and Merseyside

28 May 2026

Improvement and Development Oversight Committee –Terms of Reference for task and finish group

Agenda Item No: ICB/05/26/10

REPORT SUMMARY SNAPSHOT

| Required Information | Details | | | |
|--|--|-------------|--|-----|
| Responsible Executive Director | Liz Bishop | | | |
| Report approval | By | Liz Bishop | | |
| | Date | 19 May 2026 | | |
| Presented by | Ben Vinter, Executive Director of Corporate Services and Governance | | | |
| Ask of the Board | Approval | ✓ | Decision | |
| | Endorsement | | Ratification | |
| | Receive assurance | | Note | |
| Route to Board – where has this report been discussed | n/a | | | |
| ICB Strategic Objective(s) the report relates to | Tackling Health Inequalities in access, outcomes and experience | ✓ | Improving Population Health and Healthcare | ✓ |
| | Enhancing Productivity and Value for Money | ✓ | Helping to support broader social and economic development | ✓ |
| Board Assurance Framework Risk(s) the report relates to* | n/a | | | |
| Financial Implications* | Yes | | No | ✓ |
| | If Yes: | | | |
| | Have the financial implications been reviewed by the Director of Finance | | | n/a |
| | Has a budget been identified | | | n/a |
| Legal Implications* | n/a | | | |
| Conflicts of Interest associated with this report | n/a | | | |
| Impact assessments undertaken* | Equality | | | n/a |
| | Quality | | | n/a |
| | Data | | | n/a |
| | Sustainability | | | n/a |
| Public or Clinical engagement undertaken | n/a | | | |

Improvement and Development Oversight Committee –Terms of Reference for task and finish group

1. Purpose of the Report

- 1.1 This cover paper introduces the attached Terms of Reference (ToR) for the proposed establishment of an Improvement and Delivery Oversight Committee (IDOC) which will provide the Board with a task and finish capacity to enact oversight of the ICB's Single Improvement Plan.
- 1.2 The ToR have been developed to provide the Board and its representatives with designated space to consider progress and actions delivering against the Single Improvement Plan and to secure relevant assurance.
- 1.3 The described approach supports the ICB's response to its undertaking which in themselves contained areas of specific focus related to leadership and governance. As such these require clear and considered responses and underpinning governance for the Single Improvement Plan (SIP).

2. Executive Summary

- 2.1 The ToR document sets out:
 - Authority and scope
 - Membership, attendance, quorum and frequency
 - Duties
 - Reporting; and
 - Conduct.
- 2.2 The key points requiring consideration to support approval by the Board are as follows:

Agreement of membership composition

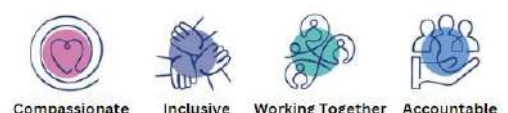
The membership has been developed to reflect the role, functions, operating model of the ICB and the breadth of the work associated with the SIP. It identifies the need for wide NED participation and proposes links to significant assurance committees.

Reporting and assurance

NHS Cheshire and Merseyside has accepted enforcement undertakings with NHS England our means of governing our response to the issues raised is through our Single Improvement Plan.

Our undertakings require us deliver rapid improvement work in a number of key areas, including:

- Financial planning



- Quality (with particular regard to mental health)
- Leadership
- Governance.

Our Single Improvement Plan provides:

- Established executive leadership for each domain
- Monthly RAG-rated reporting covering scope, milestones, risks and dependencies
- PMO-led synthesis supporting Executive oversight which will be governed and reported to the SIPG who will, in turn, provide assurance to the oversight committee from an action to a domain level.

3. Ask of the Board and Recommendations

3.1 The Board is asked to:

- **Agree** the ToR to establish and IDOC and enact this assurance structure from June
- **To note** that the majority of the business considered by the committee will be on an exception and headline basis with a significant amount of action assurance being conducted by SIPG

4. Reasons for Recommendations

4.1 The ToR have been developed to reflect the role, functions, operating model, and expectations of the NHS Cheshire and Merseyside Integrated Care Board in particular the need for oversight and assurance of delivery of actions associated with undertakings.

5. Background

5.1 Our undertakings require us deliver rapid improvement work in a number of key areas, including:

- Financial planning
- Quality (with particular regard to mental health)
- Leadership.

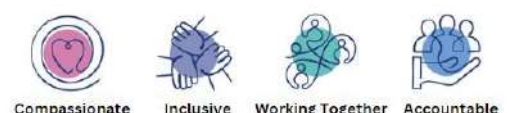
6. Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities

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

Objective Two: Improving Population Health and Healthcare

Objective Three: Enhancing Productivity and Value for Money

Objective Four: Helping to support broader social and economic development



- 6.1 Effective delivery of a single improvement plan and board oversight and assurance supports the achievement of the objectives and priorities of the ICB.

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

- 7.1 This Committee has a pivotal role in the monitoring and oversight of the ICB's Single Improvement Plan (SIP).

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety
Theme Two: Integration
Theme Three: Leadership

9. Risks

- 9.1 None identified as relevant to the governance of the SIP. SIP delivery risks will be reported as part of this process

10. Finance

- 10.1 Not applicable.

11. Communication and Engagement

- 11.1 The updated ToRs will be published on the ICB website, following approval by the Board.

12. Equality, Diversity and Inclusion

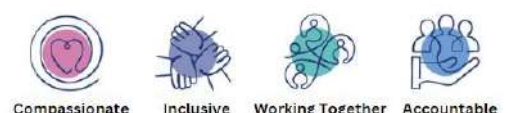
- 12.1 Not applicable.

13. Climate Change / Sustainability

- 13.1 Not applicable.

14. Next Steps and Responsible Person to take forward

- 14.1 ToRs are presented to the Board for approval. Enactment of SIP reporting is underway and will be taken forward by the Executive Director of Corporate Services and Governance



15. Officer contact details for more information

Ben Vinter, Executive Director of Corporate Services and Governance

16. Appendices

Appendix One: Improvement and Delivery Oversight Committee (IDOC), Terms of Reference



NHS Cheshire and Merseyside Integrated Care Board

Improvement and Delivery Oversight Committee (IDOC)

Terms of Reference (2026/27)

DRAFT

Document revision history

| Date Approved by Board | Version | Revision | Comment | Author / Editor |
|------------------------|---------|----------------|---------|-----------------|
| March 2026 | 1.0 | Initial | | Sam Proffitt |
| March | 2 | Considerations | | B Vinter |
| | | | | |
| add date | | | | |

Review due: **September 2026**

V1:XX approved by the ICB Board on add date

DRAFT

Improvement and Delivery Oversight Committee (IDOC)

1. Establishment and Authority

The IDOC is established by the ICB as a task and finish Committee of the Board to provide the Board with oversight of its single improvement plan. It can:-

- Request information, data and reports from any ICB directorate or partner organisation.
- Seek external advice where necessary.
- Escalate risks, delivery concerns or system barriers to the ICB Board.
- Provide formal assurance updates to relevant regulators.
- Approve the Terms of Reference of the Single Improvement Plan Delivery Group
- Approve decisions within the financial limits as set out in the ICB's Scheme of Reservation and Delegation (SoRD), operational SoRD (OSoRD) and Standing Financial Instructions (SFIs). Decisions exceeding those limits will be recommended to the Board.

Decision-making authority remains with the ICB Board unless explicitly delegated.

2. Purpose

The purpose of the Oversight Committee is to provide strategic oversight and an integrated view of Single Improvement Plan through 2026–2027.

The Committee will ensure delivery through agreed assurance reporting against agreed objectives, identify and mitigate risks, and maintain accountability for outcomes, timelines and performance.

3. Interfaces and Boundaries

The IDOC scope includes oversight, assurance, and system-wide stewardship of the Single Improvement Plan. It does not duplicate:

- Audit & Risk assurance over the adequacy/effectiveness of internal controls and internal audit (reports are received for information only);
- Finance, investment and Contracting Committee's role in financial oversight, assurance and risk management
- Quality & Performance Committee's role in clinical quality assurance and patient safety;
- System Primary Care Committee's commissioning of GP contracts and oversight of the delivery of delegated functions
- Executive Committee which has operational responsibility for day-day financial delivery, implementation of recovery actions, contract management, digital/cyber delivery, risk management and operational budget control.

It will similarly provide a holistic and integrated view rather than thematic review of the ICB's approach to commissioning development and delivery

4. Duties

The IDOC has the following duties

- Provide oversight of the Integrated Care Single Improvement Plan.
- Assess the capability and capacity to deliver the Improvement Plan.
- Monitor performance against milestones, metrics and agreed deliverables.
- Provide cyclical Alerts, Advice and Assurance (AAA) reports to the ICB Board.
- Provide regulatory update reports to relevant external regulators.
- Approve the Terms of Reference of the Single Improvement Plan Group
- Receive and review regular progress reports from the Single Improvement Plan Delivery Group.

5. Membership & Attendance

Chair: Chair of the ICB Board

Members:

- Chair of Audit Committee
- Chair of Finance Committee
- Chair of Quality Committee
- Another ICB NED
- Chief Executive
- Clinical Director
- Executive Director of Finance
- Executive Director of Strategy and Transformation Director
- Executive Director of Integrated Health and Care Commissioning
- Executive Director of Corporate Services and Governance
- HR Director.

6. Duration and Review

The Oversight Committee will operate for the 2026–2027 financial year. A formal review of effectiveness will take place at six months. At the conclusion of the financial year, the ICB Board will determine whether the group should be disbanded, extended or the alternative opportunities that might exist.

7. Decision Making and Voting

Decisions will be taken in accordance with the ICBs Standing Orders, SoRD, OSoRD and SFIs, and within the authority as delegated to the Committee. The IDOC will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

8. Frequency

The IDOC shall meet on a monthly basis through to September 2026 and at least on alternate months thereafter. Members of the Committee are expected to attend meetings wherever possible. The notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

The Board, ICB Chair or Chief Executive may ask the IDOC's advice.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

9. Meeting arrangements

The Committee is not a meeting held in public. If an agenda indicates the requirement for a 'Private and Confidential' session of the meeting (e.g., part two) usually as a result of an issue with potential conflict of interests for committee members or of a sensitive nature, then separate agendas and minutes will be produced.

Part of the justification for establishing a private and confidential agenda will be the identification of an appropriate Freedom of Information exemption together with, where required, an assessment of the public interest test on each agenda item.

10 Conflicts of interest management

The IDOC will apply and adhere to the ICB Conflicts of Interest Policy and NHS England good governance and collaboration guidance, where members with relevant interests will be excluded from discussion/vote and decisions will record how conflicts were managed.

11. Administrative Support

The IDOC shall be supported with a secretariat function which will include ensuring that:

- the agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead. Papers for the meeting will be issued ideally five working days in advance of the date the meeting is due to take place and no later than 4 working days
- attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements
- records of conflicts of interest, members' appointments and renewal dates. Provide prompts to renew membership and identify new members where necessary
- good quality minutes are taken in accordance with the ICBs standing orders and Corporate Standards Manual and agreed with the chair. Keep a record of matters arising, action points and issues to be carried forward
- the Chair is supported to prepare and deliver reports to the Board

- the IDOC is updated on pertinent issues/ areas of interest/ policy developments
- action points are taken forward between meetings and progress against those actions is monitored
- a risk register is maintained for the Committee.

12 Accountability and Reporting Arrangements

A Single Improvement Plan Group will operate beneath the Oversight Committee. The Single Improvement Plan Group will include key action owners responsible for implementing the Improvement Plan. The Group will be chaired by the Executive Director of Corporate Services and Governance, who will report on activity to Oversight Committee meetings. The IDOC will approve the Single Improvement Plan Group Terms of Reference.

The IDOC will meet at an appropriate frequency. A monthly AAA (Alerts, Advice and Assurance) report will be submitted to the ICB Board. A separate regulatory assurance report will be produced as required. Significant risks or delivery concerns will be escalated immediately.

13. Behaviours and Conduct

ICB values: Members will be expected to conduct business in line with and uphold the Nolan Principles, the ICB values and objectives. Members of, and those attending, the Committee shall behave in accordance with the ICB's Constitution, Standing Orders, and Standards of Business Conduct Policy.

Equality and diversity: Members must demonstrably consider the equality and diversity implications of decisions they make.

These Terms of Reference will be reviewed at least annually, and earlier if required. Any proposed amendments will be submitted to the ICB Board for approval.

Meeting of the Board of NHS Cheshire and Merseyside

28 May 2026

Cyber Security Improvement Programme Update

Agenda Item No: ICB/05/26/11



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REPORT SUMMARY SNAPSHOT

| Required Information | Details | | | |
|---|--|------------------|---|-----|
| Responsible Executive Director | Dr Fiona Lemmens, Executive Clinical Director NHS Cheshire and Merseyside ICB | | | |
| Report approval | By | Dr Fiona Lemmens | | |
| | Date | 19 May 2026 | | |
| Presented by | John Llewellyn, Chief Digital Information Officer | | | |
| Ask of the Board | Approval | | Decision | |
| | Endorsement | | Ratification | |
| | Receive assurance | ✓ | Note | ✓ |
| Route to Board – where has this report been discussed | n/a | | | |
| ICB Strategic Objective(s) the report relates to | Tackling Health Inequalities in access, outcomes and experience | | Improving Population Health and Healthcare | |
| | Enhancing Productivity and Value for Money | ✓ | Helping to support broader social and economic development | |
| Board Assurance Framework Risk(s) the report relates to* | | | | |
| Financial Implications* | Yes | | No | ✓ |
| | If Yes: | | | |
| | Have the financial implications been reviewed by the Director of Finance | | | n/a |
| | Has a budget been identified | | | n/a |
| Legal Implications* | n/a | | | |
| Conflicts of Interest associated with this report | n/a | | | |
| Impact assessments undertaken* | Equality | | | n/a |
| | Quality | | | n/a |
| | Data | | | n/a |
| | Sustainability | | | n/a |
| Public or Clinical engagement undertaken | n/a | | | |



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Cyber Security Improvement Programme Update

1. Purpose of the Report

- 1.1 This report provides the Board with an update on cyber security risk, assurance and improvement activity across Cheshire and Merseyside. It reflects the refreshed Cheshire and Merseyside Cyber Security Improvement Plans presented to Audit Chairs in April 2026.
- 1.2 The Integrated Care Board has two distinct but connected areas of focus around cyber security:
 - as an organisation, to protect the systems and services used by the ICB, maintain proportionate controls, assure key commissioned services and keep incident response arrangements current and tested.
 - as a system leader, to support a joined-up approach to cyber security across Cheshire and Merseyside, coordinate arrangements for multi-organisation incidents, promote secure design principles and support effective governance and board oversight.
- 1.3 The report summarises the current risk context, the rationale for refreshing the programme, the proposed assurance approach and the immediate next steps for the ICB and system partners.

2. Executive Summary

- 2.1 Cyber security remains a material risk for healthcare organisations and for the wider system. A significant incident could affect patient safety, service continuity, public confidence and data protection.
- 2.2 Cheshire and Merseyside (C&M) has established a strong foundation through a system-wide strategy, target operating model and roadmap, supported by incident response arrangements, exercises, policies, training and stakeholder engagement.
- 2.3 As organisations become more interconnected through shared platforms, collaborative delivery models and integrated pathways, the need for consistent standards, secure design and system-wide visibility has increased.
- 2.4 The programme is being refreshed to create a clearer line of sight between strategy, delivery, measurable outcomes and board assurance.
- 2.5 The proposed next phase will strengthen governance, improve consistency of reporting and support more effective non-executive oversight across the system.



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3. Background and Context

- 3.1 Cyber resilience is not solely a technical issue. It depends on effective leadership, robust governance and the consistent application of people, process and technical controls.
- 3.2 The NHS continues to operate in a challenging cyber environment. Recent national incidents have shown that disruption affecting key suppliers or shared services can quickly impact diagnostics, appointments, treatment pathways and access to information.
- 3.3 Local experience has reinforced the need for preparedness, consistent assurance and effective system coordination.
- 3.4 The implication is clear: cyber risk is a clinical, operational, financial and reputational risk. The system must be able to prevent, detect, respond to and recover from incidents at both organisational and system level.

4. Programme to Date

- 4.1 The C&M Cyber Programme has previously been regarded as an exemplar and cited nationally. Key achievements to date include:
- development and approval of an ICS-wide cyber strategy, target operating model and roadmap.
 - creation and maintenance of an ICS cyber incident response plan, with exercises delivered across the ICS.
 - development of template security policies for ICS adoption.
 - completion of skills surveys, with training and certifications delivered.
 - ongoing support to the regional cyber stakeholder group.
 - production of bi-weekly cyber bulletins and Cyber Savvy campaign materials.
- 4.2 The next phase should build on this foundation by moving from strategy and policy into a more measurable improvement and assurance programme, underpinned by consistent reporting, governance and escalation.

5. Cyber and Information Assurance Metrics

- 5.1 The programme will adopt a standards-based approach to assurance, using metrics that are meaningful to boards and capable of consistent application across the system. The core measures and assurance sources are set out in Table One.

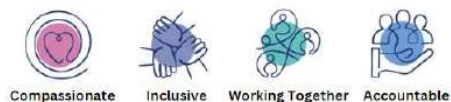


Table One

| Metric / framework | What it is | Board assurance purpose |
|--|---|---|
| Data Security Protection Toolkit (DSPT) and Cyber Assurance Framework (CAF) | DSPT is the NHS self-assessment used to demonstrate compliance with data security and information governance requirements. CAF provides a structured framework to assess cyber resilience outcomes and maturity across key domains. | Provide board-level assurance, highlight compliance gaps and evidence that controls are operating. |
| Microsoft Defender for Endpoint (MDE) scores | Microsoft Defender for Endpoint scores provide a security posture indicator drawn from telemetry and configuration, including onboarding coverage, recommended settings and exposure reduction actions. | Provide a measurable view of endpoint protection maturity and trends over time and help target practical hardening actions. |
| National Digital Maturity Assessment and Safe Practice | The Digital Maturity Assessment baselines organisational digital capability and maturity across areas including people, process, technology and data. Safe Practice includes clinical safety and assurance, cyber and network security, identity and access management and data governance. | Provide a baseline and target maturity position. Safe Practice scores support comparison and improvement planning. |
| Risk, controls and incident data | Local and system-level reporting on top cyber risks, control coverage, vulnerabilities, patching, incidents and training. | Enable consistent reporting, escalation and prioritisation across Trust, ICB and provider collaborative governance. |

5.2 These frameworks also provide assurance on whether cyber security is embedded in strategy, board oversight, workforce capability, clinical and operational engagement and organisational learning. Future planning will also include a trajectory to securing accreditation including potential for Cyber Security, Cyber Security + and Information Security accreditation standards (ISO27001).

6. Relaunch of the C&M Cyber Programme

- 6.1 The refreshed programme will create a clearer link between strategic priorities and delivery. It will define key deliverables, establish repeatable assurance cycles and support regular reporting on the areas of greatest relevance to boards, including risk, control coverage, vulnerability management, incident preparedness and workforce awareness.
- 6.2 The programme will align with national plans and the ICB enterprise architecture approach, helping to ensure that cyber requirements are built into design, procurement and change rather than addressed retrospectively.
- 6.3 It will also strengthen people, culture and capability through awareness activity, role-based development, leadership behaviours, shared learning and board development.

7. Programme Structure and Workstreams

- 7.1 The cyber security programme will be embedded within wider system design requirements and governance arrangements across the ICB and provider collaborative. The approach will draw on provider expertise to support shared learning and system-wide improvement.
- 7.2 The proposed work programme will cover the areas summarised in Table Two.

Table Two

| Workstream | Purpose | Key deliverables | Evidence / assurance |
|---|---|---|---|
| Governance and escalation | Create clear programme governance across Trusts, ICB and provider collaborative arrangements. | Confirmed reporting route, escalation thresholds, decision logs, progress tracking and Company Secretary review of provider-led governance. | Approved governance structure, terms of reference, reporting schedule and escalation route. |
| Cyber strategy alignment | Translate the cyber strategy pillars into a prioritised programme of improvement. | Programme plan, milestones, deliverables and defined completion evidence. | Programme dashboard showing status, dependencies, risks and evidence of delivery. |
| Enterprise architecture and safe by design | Embed cyber into architecture, procurement, design and change governance. | Cyber requirements built into architecture standards, technical patterns, solution | Architecture review records, design standards and evidence of security sign-off. |

| Workstream | Purpose | Key deliverables | Evidence / assurance |
|--|--|---|--|
| | | designs and change controls. | |
| Assurance metrics and reporting | Create repeatable, comparable reporting across organisations. | Standard reporting pack covering risk, controls, incidents, vulnerabilities, patching, training, DSPT/CAF, MDE and DMA/Safe Practice. | Regular NED-level and system-level reporting with comparable metrics. |
| People, culture and capability | Reduce human-driven cyber risk and strengthen organisational maturity. | Awareness campaigns, role-based competence, leadership behaviours, board development and knowledge sharing. | Training uptake, board development attendance, phishing/awareness metrics and lessons learned. |
| Cyber Go Team | Use provider cyber subject matter experts to provide mutual aid and specialist support. | Funded in-year approach for a Cyber “Go Team” operating within agreed governance. | Named resource model, activation criteria and post-incident/exercise learning. |
| Incident response and testing | Improve system readiness for multi-organisation cyber incidents. | Three-day regional cyber incident simulation in July 2026, post-exercise review and plan updates. | Exercise report, lessons learned, action plan and updated incident response documents. |
| Supply chain and shared platform risk | Treat collaborative working as shared exposure and assess cross-organisational dependencies. | Identification of critical pathways, suppliers, shared platforms and assurance gaps. | Dependency map, risk register entries, supplier assurance outputs and mitigation plans. |

8. Governance and Board Oversight

- 8.1 Consistent non-executive oversight is a key requirement for the next phase of the programme. Current arrangements vary across the system in both reporting route and frequency.
- 8.2 The intended future state is a clear and consistent reporting route into the relevant non-executive-led committee, supported by comparable metrics and a shared basis for ICB and system oversight.

8.3 National guidance and development materials will support this approach and strengthen cyber understanding across trust boards and executive teams.

9. Principal Risks and Mitigations

9.1 The ICB continues to hold a Board Assurance Framework risk relating to system-wide digital and cyber resilience. The principal risk is that weaknesses in digital infrastructure, data-sharing arrangements or cyber controls could disrupt care, undermine confidence and slow delivery of digital transformation.

9.2 The refreshed programme will support mitigation of this risk through stronger governance, clearer assurance, improved visibility, better incident preparedness and a more systematic approach to shared dependencies across providers and suppliers.

10. Link to ICB Strategic Objectives and Cheshire and Merseyside Priorities

Table Three

| Strategic objective | Relevance of cyber security programme |
|--|--|
| Tackling health inequalities in access, outcomes and experience | Reliable provision of clinical and administrative systems across the ICS is essential to equitable access and service continuity. Levelling up cyber resilience helps reduce variation in system availability. |
| Improving population health and healthcare | Population health management and data into action capabilities rely on consistent, trusted and secure data flows from multiple systems across partner organisations. |
| Enhancing productivity and value for money | A coordinated cyber function enables economies of scale, reduces duplication and supports safe adoption of artificial intelligence and productivity tools by protecting underlying data and systems. |
| Supporting broader social and economic development | Digital infrastructure and clinical systems are key enablers of the ICB strategic objectives and priorities. Cyber resilience protects the digital foundations required for service transformation. |

11. Link to Annual Delivery Plan Objectives

Table Four

| Annual delivery plan theme | Cyber programme contribution |
|----------------------------|---|
| Quality and safety | Managing cyber risk is essential to safe and effective care. Loss of key clinical and operational systems can delay treatment and reduce the quality of decision-making where patient information is unavailable. |
| Integration | Shared systems and interoperable data support integrated care, but also increase shared exposure. Cyber security at system level must therefore be a priority for integrated clinical pathways and platforms. |
| Leadership | The ICB has clearly defined responsibilities for leading strategic cyber security standards, system assurance and improvement across constituent organisations. |

12. Next Steps, Accountability and Timescales

12.1 John Llewellyn, Chief Digital Information Officer, will oversee delivery of the ICB actions. Sarah Barr, Chief Digital Information Officer at The Clatterbridge Cancer Centre and Cheshire and Merseyside Cyber Lead, will lead delivery of the wider programme and support provider engagement through the Cheshire and Merseyside Provider Collaborative.

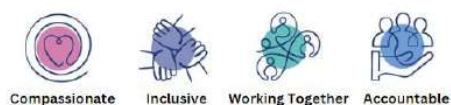
12.2 The immediate priorities are to:

- Implement the programme structure and reporting arrangements, with clear workstreams, milestones and evidence requirements.
- Confirm governance and escalation routes across trusts, the ICB and provider collaborative arrangements.
- Use assurance and benchmarking information to prioritise improvement activity across the system.
- Agree a baseline of cyber understanding for boards and senior leaders, supported by consistent development.
- Ensure assurance reflects cross-organisational dependencies, shared platforms and supplier risk.
- Prepare for the regional cyber incident simulation in July 2026 and ensure learning informs updated response arrangements.

13. Recommendations

13.1 **The Board is asked to:**

- **Note** the current cyber risk context for healthcare organisations nationally and across Cheshire and Merseyside.
- **Note** the refresh of the Cheshire and Merseyside Cyber Programme and its alignment with wider system design, assurance and governance arrangements.



- **Endorse** the principle that assurance should reflect cross-organisational pathways, suppliers and shared platforms, as well as individual organisational risks.
- **Support** the development of a consistent provider-level oversight route and reporting cadence for cyber assurance.
- **Note** the proposed use of provider subject matter expertise to support system resilience, future planning and support of the planned national/regional cyber incident simulation in July 2026.
- **Support** the development of a consistent baseline of cyber understanding across trust boards and executive leaders.

14. Appendices

Appendix One: Draft Programme Assurance Dashboard

15. Officer contact details for more information

John Llewellyn

Chief Digital Information Officer,
NHS Cheshire and Merseyside ICB

john.llewellyn@cheshireandmerseyside.nhs.uk

Appendix One – Draft Programme Assurance Dashboard

The following dashboard structure illustrates the type of information that could support regular reporting to the relevant non-executive-led committee and system oversight forum. It will be refined over time as national metrics and local data arrangements develop.

| Domain | Example measures | Reporting frequency | Escalation trigger | Lead | Status |
|--|--|-----------------------------|--|---------------------------------|-------------------------------------|
| Risk and governance | Top cyber risks; overdue actions; decisions required; assurance gaps | Monthly / bi-monthly | Significant risk movement, overdue actions or issues affecting system delivery | Programme SRO / Cyber Lead | To establish |
| Controls and standards | DSPT, CAF, ISO27001 where applicable, Cyber Essentials Plus, policy adoption | Quarterly | Material non-compliance or insufficient assurance evidence | Trust CIO / SIRO / Cyber Lead | To establish |
| Endpoint and vulnerability exposure | MDE score, onboarding coverage, critical vulnerabilities, patch performance | Monthly | Sustained performance below expected standards | Trust technical leads / Go Team | Pending national MDE data |
| Incident readiness | Exercises completed, lessons learned, response plan updates, BCP alignment | Quarterly and post-exercise | Findings with wider system implications or gaps in ownership | EPRR / Cyber Lead | National July 2026 exercise planned |
| People and culture | Board training, role-based cyber competence, awareness activity, phishing resilience | Quarterly | Low completion rates or limited board engagement | OD / Cyber Lead | To establish |



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| Domain | Example measures | Reporting frequency | Escalation trigger | Lead | Status |
|--|---|---------------------|---|---|--------------|
| Supply chain and shared platforms | Critical supplier assurance, shared pathway dependency mapping, third-party risks | Quarterly | Material supplier assurance concerns or significant dependency risk | Procurement / Architecture / Cyber Lead | To establish |



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Meeting of the Board of NHS Cheshire and Merseyside

28 May 2026

NHS Cheshire & Merseyside Antimicrobial Resistance (AMR) and Infection Prevention & Control (IPC) Update

Agenda Item No: ICB/05/26/12



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REPORT SUMMARY SNAPSHOT

| Required Information | Details | | | |
|---|---|------------------|---|-----|
| Responsible Executive Director | Dr Fiona Lemmens, Executive Clinical Director NHS Cheshire and Merseyside ICB | | | |
| Report approval | By | Dr Fiona Lemmens | | |
| | Date | 18 May 2026 | | |
| Presented by | Dr Fiona Lemmens, Executive Clinical Director NHS Cheshire and Merseyside ICB | | | |
| Ask of the Board | Approval | | Decision | |
| | Endorsement | ✓ | Ratification | |
| | Receive assurance | ✓ | Note | ✓ |
| Route to Board – where has this report been discussed | NHS Cheshire and Merseyside Quality and Performance Committee Meeting 12 March 2026 | | | |
| ICB Strategic Objective(s) the report relates to | Tackling Health Inequalities in access, outcomes and experience | ✓ | Improving Population Health and Healthcare | ✓ |
| | Enhancing Productivity and Value for Money | | Helping to support broader social and economic development | |
| Board Assurance Framework Risk(s) the report relates to* | P12 - Tackle inequalities in outcomes, experience and access | | | |
| Financial Implications* | Yes | | No | ✓ |
| | If Yes: | | | |
| | Have the financial implications been reviewed by the Director of Finance | | | n/a |
| | Has a budget been identified | | | n/a |
| Legal Implications* | n/a | | | |
| Conflicts of Interest associated with this report | n/a | | | |
| Impact assessments undertaken* | Equality | | | n/a |
| | Quality | | | n/a |
| | Data | | | n/a |
| | Sustainability | | | n/a |
| Public or Clinical engagement undertaken | n/a | | | |

NHS Cheshire & Merseyside Antimicrobial Resistance (AMR) and Infection Prevention & Control (IPC) Update

1. Executive Summary

- 1.1 Antimicrobial resistance (AMR) is a critical and growing threat to patient safety and public health, accelerated by inappropriate antimicrobial use and suboptimal infection prevention practices. In response to a national NHS England call to action (November 2025), NHS Cheshire and Merseyside (C&M) has strengthened board-level oversight, undertaken system self-assessment, and identified key priorities for improvement.
- 1.2 Current performance shows a mixed picture. While broad-spectrum antibiotic prescribing remains within national thresholds and shorter (5-day) antibiotic courses are improving—achieving leading performance nationally for amoxicillin—overall antibiotic prescribing in primary care remains above target, particularly among children aged 0–9 years. Some acute prescribing indicators, including intravenous antibiotic use, are comparatively high, and governance and assurance processes require further development.
- 1.3 In line with national requirements, three priority areas for improvement have been agreed:
 - Reducing inappropriate antibiotic use in children (0–9 years) through prescriber education, improved data access, and public awareness.
 - Increasing use of 5-day antibiotic courses to minimise unnecessary prolonged treatment and reduce resistance risk.
 - Penicillin allergy de-labelling to improve accuracy of patient records, enable optimal antibiotic choice, and enhance stewardship.
- 1.4 The Board is asked to note national expectations and current system performance, and endorse the three AMR priority areas to strengthen stewardship, governance, and patient outcomes across Cheshire and Merseyside.

2. Ask of the Board

- 2.1 **The Board is asked to:**
 - **Note** the requirements of the NHS England Act now: protect our present, secure our future letter (Appendix One) **and** the current AMR/IPC reporting mechanism across NHS Cheshire and Merseyside.
 - **Endorse** the three priority areas for AMR improvement within NHS Cheshire and Merseyside.

3. Introduction

- 3.1 AMR arises when the organisms that cause infection evolve ways to survive treatments. The term antimicrobial includes antibiotic, antiprotozoal, antiviral and antifungal medicines.

- 3.2 Resistance is a natural biological phenomenon, but it is increased and accelerated by various factors such as misuse of medicines, poor infection control practices, and global trade and travel.
- 3.3 AMR is recognised nationally as a major threat to patient safety and public health. In November 2025, NHS England issued a call to action in the form of a letter to all Trust and ICB Chairs and Chief Executive officers (Appendix One) requiring strengthened board-level oversight, completion of assurance frameworks and agreement of three AMR improvement priorities.
- 3.4 Currently, across NHS C&M, AMR and IPC assurance is provided through joint system reporting, with escalation through to NHS C&M Quality and Performance Committee.

4. Key areas of Note for the Board

- 4.1 In March 2026, NHS C&M Quality and Performance received a joint AMR/IPC update which included an overview of the system's responsibilities in line with the NHS England Act now: protect our present, secure our future letter. The update contained the current performance against national AMR targets by completion of the ICB Antimicrobial Stewardship Self-Assessment Toolkit which evaluated current performance to identify any current gaps in leadership, workforce capability, and resource allocation (Appendix Two).
- 4.2 For NHS C&M, total antibiotic prescribing in primary care remains above the legacy national target however broad-spectrum antibiotic prescribing remains within national thresholds. Other areas of focus include prescribing in children aged 0–9 years which remains above the NHS Oversight Framework target and the use of evidence-based 5-day antibiotic courses continues to improve.
- 4.3 Integrated IPC and AMR oversight continues, recognising the relationship between antimicrobial use and healthcare-associated infections, including Gram-negative bloodstream infections.
- 4.4 NHS C&M Quality and Performance Committee reiterated the importance of AMR as a strategic priority, acknowledging the need to strengthen alignment between IPC teams, national expectations and internal reporting processes, agreeing that updates should continue to be received by the committee with an annual update through to the Board of NHS C&M.
- 4.5 Included in the call for action letter, there is an ask that organisations agree and publish three priority areas for AMR improvement, and for each priority:
 - define specific, measurable objectives.
 - assign executive-level accountability.
 - establish timelines and reporting mechanisms.

4.6 **Priority 1: Reduce Inappropriate Antibiotic Use in Children**

Aim: To reduce exposure to antibiotics across primary care in children aged 0-9.

Key Objectives:

- reduce the percentage of antibiotic prescribing in children in line with the NHS Oversight Framework: Children prescribed antibiotics in primary care.
- increase public awareness of self-care for common childhood illnesses
- ensure Primary Care prescribers have access to practice level data to assess performance
- to use system expertise for management of common childhood infections
- to provide education sessions for prescribers to encourage appropriate prescribing.

4.7 **Priority 2: Increase the percentage of 5-day course lengths across NHS C&M**

Aim: To increase the percentage of 5 day prescribing of antibiotic courses, avoiding prolonged durations of antibiotic therapy means fewer side effects and reduces the risk of antibiotic resistance.

Key Objectives:

- to increase the NHS C&M percentage of 5-day courses as a total of all amoxicillin courses to $\geq 75\%$
- to increase the NHS C&M percentage of 5-day courses as a total of all doxycycline courses to $\geq 65\%$
- to encourage providers of urgent care e.g. Urgent Treatment Centres and Out of Hours to adhere to 5/7 course lengths when clinically appropriate.

4.8 **Priority 3: Increase NHS C&M system awareness of Penicillin allergy de-labelling and develop an NHS C&M guideline for assessment and removal of incorrect penicillin allergy statuses on patient records.**

Aim: To reduce unnecessary restrictions on antibiotic treatment and improve patient care.

Key Objectives:

- identification of patients with a documented penicillin allergy who may be suitable for allergy challenge test and subsequent de-labelling
- to reduce inappropriate penicillin allergy labels and improve detail and accuracy of allergy history documentation in patients' clinical records, to optimise infection treatment and antimicrobial stewardship.
- develop an NHS C&M Penicillin allergy de-labelling (PADL) guidance
- to provide education sessions for clinicians to increase awareness of penicillin de-labelling.

4.9 For all three priorities, the executive level accountability will be with the Executive Clinical Director NHS C&M, the completion time frames will be by April 2027 and the reporting mechanism will continue with the current arrangements in the form of quarterly reports to NHS C&M Quality and Performance Committee.

5. Next Steps

- 5.1 NHS C&M Quality and Performance Committee to continue receive AMR/IPC updates that will contain a focus on the progress made with the three priority areas.
- 5.2 A further NHS Cheshire & Merseyside AMR/IPC Update to come to board in May 2027 with relevant updates.
- 5.3 Further work on the ICB Antimicrobial Stewardship Self-Assessment Toolkit to rectify any gaps in leadership, workforce capability and resource allocation.

6. Officer contact details for more information

Dr Fiona Lemmens
Executive Clinical Director NHS Cheshire and Merseyside
Fiona.Lemmens@cheshireandmerseyside.nhs.uk

7. Appendices

Appendix One: NHS England Act now: protect our present, secure our future letter

Appendix Two: Antimicrobial stewardship – integrated care boards (ICB) situation report and Documentary evidence of antimicrobial stewardship

Appendix One



- To:
 - Trusts and integrated care boards:
 - chairs
 - chief executive officers
- cc.
 - Chief nurses
 - Medical directors
 - Chief pharmacists

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

November 2025

Dear colleagues,

Act now: protect our present, secure our future

The World Health Organisation has declared antimicrobial resistance (AMR) as one of the top global public health and development threats, and AMR is listed on the UK government's National Risk Register.

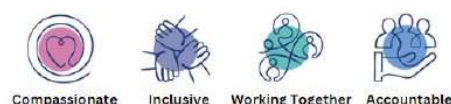
As a senior NHS leader, your commitment is critical to tackling AMR and protecting patient safety. We are writing to you with a **call to action** – to work with your prescribers and your clinical leads to make the changes required to meet the targets in the [national action plan](#) for AMR.

Why Action Is Urgent

Antimicrobial resistance is not a future challenge – it's happening now.

While overall antibiotic prescribing is decreasing, prescribing in secondary care is rising. Rates of Gram-negative bloodstream infections are increasing and already exceed the 2028/29 targets in most areas.

In the UK, AMR is associated with **twice as many deaths annually as breast cancer**. It makes infections harder or sometimes impossible to treat, prolonging illness and increasing the risk of harm or death. AMR also drives up healthcare costs and threatens the delivery of safe and effective care across the NHS.



Actions Required by Q1 2026

Cheshire and Merseyside

The [national action plan](#) for AMR sets ambitious targets. Meeting them will require coordinated, sustained action across all levels of the NHS.



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To ensure your organisation is on track to meet AMR targets, we ask that you take the following actions **by the end of Q1 2026**:

Board-Level Review & Executive oversight

- Schedule a joint presentation to your board from IPC and AMS teams covering:
 - Current performance against national AMR targets
 - Benchmarking using the latest English surveillance programme for antimicrobial utilisation and resistance ([ESPAUR report](#)) and AMR information found on [Model Health System](#), together with the thresholds for each trust to reduce exposure to antibiotics, announced in the Medium Term Planning Framework¹, and shortly to be issued.
 - Key concerns and immediate actions required.

Risk and Capability Assessment

- Complete the following assessments to i) Evaluate current performance and compliance ii) Identify gaps in leadership, workforce capability, and resource allocation and iii) Inform risk registers and strategic planning.
 - The national infection prevention and control [board assurance framework](#)
 - The ICB Antimicrobial Stewardship [Self-Assessment Toolkit](#)

Set Priorities and Deliver Improvement

- By April 2026, agree and publish three priority areas for AMR improvement within your organisation. For each priority:
 - Define specific, measurable objectives.
 - Assign executive-level accountability.
 - Establish timelines and reporting mechanisms.

Progress should be reviewed quarterly, with a formal update to the board at least annually.

Thank you for your continued leadership in confronting this growing threat to patient safety and public health.

Yours sincerely,

Dr Claire Fuller

National Medical Director
and AMR Senior
Responsible Officer
NHS England

Duncan Burton

Chief Nursing Officer
for England

Dr Shona Arora

Interim Chief Medical Advisor
UK Health Security Agency



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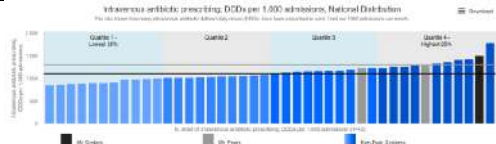

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Appendix Two:

Antimicrobial stewardship – integrated care boards (ICB) situation report

| ICB performance against key performance indicators of antimicrobial prescribing quality and AMS | | | | | |
|---|---|--|-----------------------------|----------------|----------------------------------|
| | Key performance indicators | Performance goal | Latest position | Date | Comments |
| 1a | Primary care total antibiotic prescribing Source: Model Health System ** Metric: Antibacterial items per STAR-PU | Benchmarking (lower is better*) | 0.92 | September 2025 | Target <0.861 See graph below |
| 1b | Primary care total antibiotic prescribing Source: Model Health System ** Metric: Antibacterial items per STAR-PU | Trend over time (decreasing is better) | Decreasing | September 2025 | |
| 2a | Primary care broad-spectrum antibiotic prescribing Source: Model Health System ** Metric: Co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of antibiotics | Benchmarking (lower is better*) | 7.29% (below 10% threshold) | September 2025 | |

| ICB performance against key performance indicators of antimicrobial prescribing quality and AMS | | | | | |
|---|--|--|---|----------------|---------------------------------|
| | Key performance indicators | Performance goal | Latest position | Date | Comments |
| 2b | Primary care broad-spectrum antibiotic prescribing Source: Model Health System ** Metric: Co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of antibiotics | Trend over time (decreasing is better) | Increasing | September 2025 | |
| 3a | Primary care antibiotic duration Source: Model Health System Metric: Proportion of amoxicillin 500mg capsules items prescribed and dispensed in primary care 5-day duration | Benchmarking (higher is better) | 83% Highest value in the country | October 2025 | <p>Highest of our peers</p> |
| 3b | Primary care antibiotic duration Source: Model Health System Metric: Proportion of amoxicillin 500mg capsules items prescribed and dispensed in primary care 5-day duration | Trend over time (increasing is better) | Increasing | October 2025 | <p>Highest of our peers</p> |
| 4a | Acute hospital trusts' Watch + Reserve prescribing Source: Model Health System Metric: Antibiotic prescribing from the "Watch" and "Reserve" categories of the WHO Essential Medicines List AWaRe Index | Benchmarking (lower is better*) | 2,144 DDD per 1,000 admissions 3 rd quartile | Q1 25/26 | <p>Middle of regional peers</p> |

| ICB performance against key performance indicators of antimicrobial prescribing quality and AMS | | | | | |
|---|--|--|---|----------------|---|
| | Key performance indicators | Performance goal | Latest position | Date | Comments |
| 4b | Acute hospital trusts' Watch + Reserve prescribing Source: Model Health System Metric: Antibiotic prescribing from the "Watch" and "Reserve" categories of the WHO Essential Medicines List AWaRe Index | Trend over time (decreasing is better) | decreasing | Q1 25/26 |  <p>Within regional peer performance</p> |
| 5a | Acute hospital trusts' IV antibiotic prescribing Source: Model Health System Metric: Proportion of total antibiotic prescribing administered intravenously | Benchmarking (lower is better*) | 1,491 DDD per 1,000 admissions 4 th quartile | June 2025 data |  <p>Highest of regional peers</p> |
| 5b | Acute hospital trusts' IV antibiotic prescribing Source: Model Health System Metric: Proportion of total antibiotic prescribing administered intravenously | Trend over time (decreasing is better) | Increase | June 2025 data |  <p>Highest of regional peers</p> |

Documentary evidence of antimicrobial stewardship

| | Source document and recommended elements | Met/not met | Evidence |
|----------|---|----------------|-----------------------------|
| 1 | ICB antimicrobial resistance strategic plan | | |
| 1.1 | Ratification by senior leadership of ICB | Not met | Board 28/5/26 |
| 1.2 | Inclusion of antimicrobial stewardship | Not met | |
| 1.3 | Inclusion of monitoring and evaluation mechanisms | Not met | |
| 1.4 | Inclusion of workforce strategy for antimicrobial stewardship (and infection prevention and control) with capacity plan, training and accreditation | Not met | |
| 1.5 | Inclusion of implementation plan with goals, priorities, delivery milestones and accountability | Not met | |
| 1.6 | Inclusion of programme of audit and feedback | Not met | |
| 1.7 | Allocation of financial and human resources | Not met | |
| 2 | Board terms of reference | | |
| 2.1 | Responsibility for oversight of antimicrobial resistance and stewardship assigned to named board member | Met | Executive Clinical Director |
| 2.2 | Requirement for at least annual board review of performance against antimicrobial resistance key performance indicators | Not met | Board 28/5/26 |
| 3 | Board Assurance Framework | | |
| 3.1 | Compliance assessed for infection prevention and control and antimicrobial stewardship domains [National infection prevention and control manual for England] | In progress | |
| 4 | Board risk register | | |
| 4.1 | Antimicrobial resistance included as risk or issue with evidence of mitigating actions taken or planned | Not met | |
| 5 | Board minutes where antimicrobial stewardship report and antimicrobial prescribing data are presented | Not met | |
| 5.1 | Presentation of (annual) report of antimicrobial stewardship activities and accomplishments | Not met | Board 28/5/26 |
| 5.2 | Accurate reporting of ICB performance, including underperformance | Not met | |



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Leading **integration** through **collaboration**

| Source document and recommended elements | | Met/not met | Evidence |
|---|---|-------------|---|
| 5.3 | Presentation of ICB benchmarking with peers and trend over time compared to national targets for key performance indicators | Not met | |
| 5.4 | Presentation of primary care key performance indicators by sub-ICB and presentation of secondary care indicators by trust(s) | Not met | |
| 5.5 | Interpretation of data provided to the board with recommended actions and action plan, where required | Not met | |
| 5.6 | Evidence of accountability and action taken to investigate and address underperformance | Not met | |
| 6 ICB antimicrobial stewardship committee terms of reference | | | |
| 6.1 | Appropriate multi-professional representation including: microbiology/infectious diseases, pharmacy, nursing, medical | Met | Legacy TOR for Joint AMR/IPC quarterly workshops |
| 6.2 | Adequate representation from key stakeholders in primary care and secondary care provider organisations | Met | |
| 6.3 | Named ICB lead with responsibility for antimicrobial stewardship | Met | |
| 6.4 | Adequate meeting frequency (minimum 6-monthly) | Met | |
| 6.5 | Adequate committee oversight, governance, and reporting arrangements up to board level. | Met | |
| 7 ICB antimicrobial stewardship committee risk register | | | |
| 7.1 | Risks and issues documented with evidence of mitigating actions | Nil | |
| 8 ICB antimicrobial stewardship committee minutes | | | |
| 8.1 | Attendance by core antimicrobial stewardship multi-professional team and representation from healthcare provider organisations | Met | Joint bi-monthly Antimicrobial Stewardship Group to allow joint conversation and analysis of place and system data. |
| 8.2 | Meaningful review of ICB performance, including underperformance | Met | |
| 8.3 | Review of ICB benchmarking with peers and trend over time compared to national targets for key performance indicators | Met | |
| 8.4 | Review of primary care key performance indicators by sub-ICB (and primary care network) and presentation of secondary care key performance indicators by trust(s) | Met | |
| 8.5 | Review of focussed audit or point prevalence survey reports | Not met | |
| 8.6 | Interpretation of data is documented with recommended actions and action plan where | Not met | |



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| Source document and recommended elements | | Met/not met | Evidence |
|--|--|-------------|--|
| | required to investigate and address any underperformance | | |
| 9 | ICB antimicrobial stewardship committee action plan | | |
| 9.1 | Evidence of actions completed and underway, with milestones and accountability | Not met | |
| 9.2 | Local needs and inequalities considered as part of planned actions | Met | Each place has a place AMR Lead to prioritise place need analysing place specific data and trends. |

Key informant evidence

| Key informants and lines of enquiry | | Evidence |
|-------------------------------------|---|---|
| 1 | ICB board member with nominated responsibility for antimicrobial resistance | |
| 1.1 | Awareness of ICB antimicrobial resistance and stewardship leads | Yes Dr Fiona Lemmens |
| 1.2 | Awareness of ICB performance against antimicrobial prescribing key performance indicators | Yes |
| 1.3 | Assurance of priority level of improving quality of antimicrobial prescribing and antimicrobial stewardship | Yes |
| 1.4 | Knowledge of ICB antimicrobial resistance risks and actions being taken to address them | Yes |
| 2 | ICB medical director | |
| 2.1 | Awareness of ICB antimicrobial resistance and stewardship leads | Yes |
| 2.2 | Awareness of ICB performance against antimicrobial prescribing key performance indicators | Yes |
| 2.3 | Assurance of priority level of improving quality of antimicrobial prescribing and antimicrobial stewardship | Yes |
| 2.4 | Knowledge of ICB antimicrobial resistance risks and actions being taken to address them, and mechanism in place to escalate concerns to the ICB board | Yes |
| 3 | ICB antimicrobial resistance senior responsible officer | |
| 3.1 | Assurance of sufficient capacity and capability to undertake role (protected time and training/qualifications) | Nil |
| 3.2 | Awareness of ICB performance against antimicrobial prescribing key performance indicators | Yes – via AMR report to NHS C&M Medicines |
| 3.3 | Assurance of priority level of improving quality of antimicrobial prescribing and antimicrobial stewardship | |



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| Key informants and lines of enquiry | | Evidence |
|-------------------------------------|--|--|
| 3.4 | Knowledge of ICB antimicrobial resistance risks and actions being taken to address them, and mechanism in place to escalate concerns to the medical director | optimisation and Pharmacy Group |
| 4 | ICB nominated lead for antimicrobial stewardship | |
| 4.1 | Sufficient capacity and capability to undertake role (protected time and training or qualifications) | Nil (unsure of what specific qualifications are required around AMR) |
| 4.2 | Awareness of ICB performance against antimicrobial prescribing key performance indicators | Yes – via quarterly report to MOP |
| 4.3 | Adequate senior leadership engagement and support | Yes |
| 4.4 | Effective microbiology/infectious diseases collaboration, engagement and support | Nil |
| 4.5 | Effective infection prevention and control collaboration, engagement and support | Yes – joint meetings |
| 4.6 | Adequate healthcare provider organisation engagement and action | Yes – joint meetings |
| 4.7 | Appraisal and personal development plan in place | Nil |
| 4.8 | Knowledge of ICB antimicrobial resistance risks and actions being taken to address them, and mechanism in place to escalate to the ICB antimicrobial resistance senior responsible officer | Yes – via quarterly report to MOP |

Meeting of the Board of NHS Cheshire and Merseyside

28 May 2026

Freedom to Speak Up (FTSU) Report

Agenda Item No: ICB/05/26/13



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REPORT SUMMARY SNAPSHOT

| Required Information | Details | | | |
|---|--|-----------------------------------|---|---|
| Responsible Executive Director | Ben Vinter, Executive Director of Corporate Services and Governance | | | |
| Report approval | By | Mike Gibney, Chief People Officer | | |
| | Date | 17 April 2026 | | |
| Presented by | Ben Vinter | | | |
| Ask of the Board | Approval | | Decision | |
| | Endorsement | ✓ | Ratification | |
| | Receive assurance | ✓ | Note | ✓ |
| Route to Board – where has this report been discussed | People Committee – 18 th December 2025, Audit Committee – 2 nd December 2025. | | | |
| ICB Strategic Objective(s) the report relates to | Tackling Health Inequalities in access, outcomes and experience | ✓ | Improving Population Health and Healthcare | ✓ |
| | Enhancing Productivity and Value for Money | ✓ | Helping to support broader social and economic development | ✓ |
| Board Assurance Framework Risk(s) the report relates to* | P4: Quality & Safety Failures in commissioned services and P17: Workforce Capacity, Capability, and Morale. See supporting notes. | | | |
| Financial Implications* | Yes | ✓ | No | |
| | If Yes: | | | |
| | Have the financial implications been reviewed by the Director of Finance | | | ✓ |
| | Has a budget been identified | | | ✗ |
| Legal Implications* | n/a | | | |
| Conflicts of Interest associated with this report | n/a | | | |
| Impact assessments undertaken* | Equality | | | ✓ |
| | Quality | | | ✗ |
| | Data | | | ✗ |
| | Sustainability | | | ✗ |
| Public or Clinical engagement undertaken | <p>The Stakeholders we engaged with were Equality Diversity Inclusion (EDI) lead, PRG chair/HR representative, union representative on 6th November 2025. The outcome of this engagement lead to an Appendix on the difference between whistleblowing and speaking up being added to the FTSU policy. Other stakeholders include chairs of the ICB's eight staff network groups during the Joint staff network meeting on the 3rd of December 2025. And the staff engagement forum via email on the 17th of December 2025. Please see FTSU hub page - Freedom to Speak Up</p> | | | |



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Freedom to Speak Up (FTSU) Report

1. Executive Summary

- 1.1 The purpose of this report is to update the Board on national and local developments around FTSU. In addition, it would provide an overview of progress across Cheshire and Merseyside and identify next steps.
- 1.2 Freedom to speak up is referenced in Care Quality Commission (CQC) ICS theme three, leadership QS12. When people speak up, everyone benefits. Building a more open culture, in which leadership encourages learning and improvement, leads to safer care and treatment and improved patient experience. FTSU provides an alternative channel for workers to voice their suggestions, concerns or any other matter.
- 1.3 NHS England outlined its expectations of ICBs and ICSs in relation to FTSU in primary care and the National Guardians' Office (NGO) clarified that the role of ICB FTSU Guardians are appointed to support workers within the ICB only. Unless explicitly agreed with NHS trusts or other organisations, ICB Guardians are not intended to take on cases from NHS trusts or other organisations.
- 1.4 The NGO has been disbanded and final closure on 30 June 2026 with NHSE undertaking the support and training of FTSU Guardians going forward.
- 1.5 The ICB FTSU Survey is completed annually by all staff to check the temperature of the FTSU culture of the ICB and every two years, the FTSU Self-assessment/reflection tool is completed with the ICB board members to support the FTSU Action plan and improve the FTSU process in the ICB. The ICB FTSU Survey 2026 highlighted all ICB staff are aware of the FTSU arrangements in place but less than half would use it due to fear of inaction and reprisal, these were the main themes and aligns with the national staff survey findings.(see appendix one and two).
- 1.6 FTSU data shows increased levels of speaking up across the organisation and next steps include sharing positive examples of how this has contributed to improvements in patient and staff experience. There remains much to be done in building trust and confidence in the FTSU process.
- 1.7 The trend and theme from Q1 to Q4 FTSU data peaked at worker safety/wellbeing category and this links in with the workforce priorities objective within the Annual Delivery Plan. This report highlights the need to further support the wellbeing of ICB staff, which is an important factor in addressing all other objectives within the Annual Delivery Plan.
- 1.8 The FTSU Guardians and Ambassadors have been working in partnership with senior leaders, internal and external stakeholders (such as Safeguarding teams,

People team/Staff-Engagement forum, Patient Safety, Quality teams, PALS, NGO and NHSE) to create a safe environment for staff to speak up, be listened to, feel valued and identify actions leading to learning and improvement.

2. Ask of the Board

2.1 The Board is asked to:

- **Note** the development of national risk assessment checklist of the detriment guidance and approve its adoption within Cheshire and Merseyside.
- To **re-affirm Board support** for senior leaders' awareness and completion of FTSU processes within the ICB, and FTSU E-learning module 3 – 'Follow up with action' and familiarise with the information on the FTSU staff hub [Freedom to Speak Up](#) and actively engage with promoting speaking up within the ICB.
- To **support** the integration and promotion of a strong FTSU culture into future leadership training and cultural programmes.
- To **support** the development and implementation of the action plan that results from the ICB FTSU survey completed during March 2026, supporting implementation of the ICB operating model and integration of teams.
- To **note** the progress made with the ICB FTSU arrangements within the ICB and ICS and note the continuing need to support and embed FTSU approaches with partners in primary care (Appendix Three and Four).

3. Introduction / Background

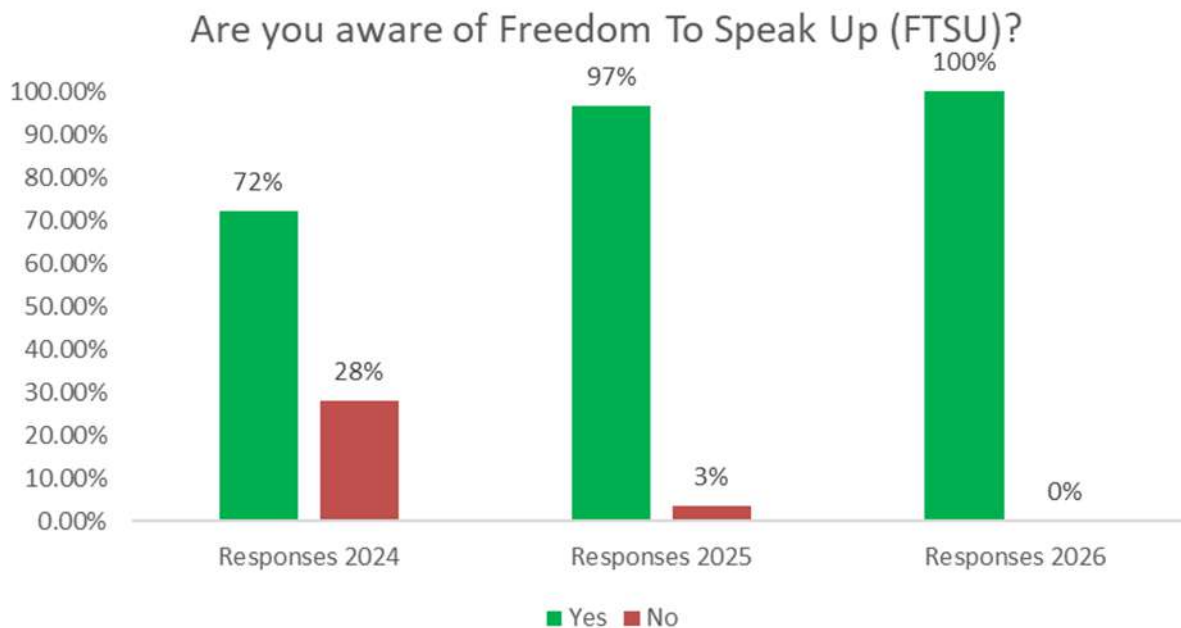
- 3.1 NHS England stipulates that everyone that works within the NHS should feel valued and respected at work and know that their views are welcomed. By meeting their needs, we also enable them to deliver the best possible care, and the Care Quality Commission (CQC) assesses a speaking up culture under Key Line of Enquiry (KLOE) 3 as part of the well-led domain of inspection.
- 3.2 In 2015 Sir Robert Francis published his review into how to create a more open and honest reporting culture in the NHS and the NHSE and CQC requires all NHS organisations to adhere and have a well-established speaking up culture.
- 3.3 Updates have been regularly provided to the Staff Engagement Forum, Joint staff network groups, People Operations group, People Committee, FTSU SUMMIT and Audit Committee explaining the organisation's responsibilities in relation to FTSU and setting out the intended approach to developing FTSU arrangements across the ICB, and progress made against those plans.

3.4 An annual report on the effectiveness of FTSU arrangements is provided to the Audit Committee.

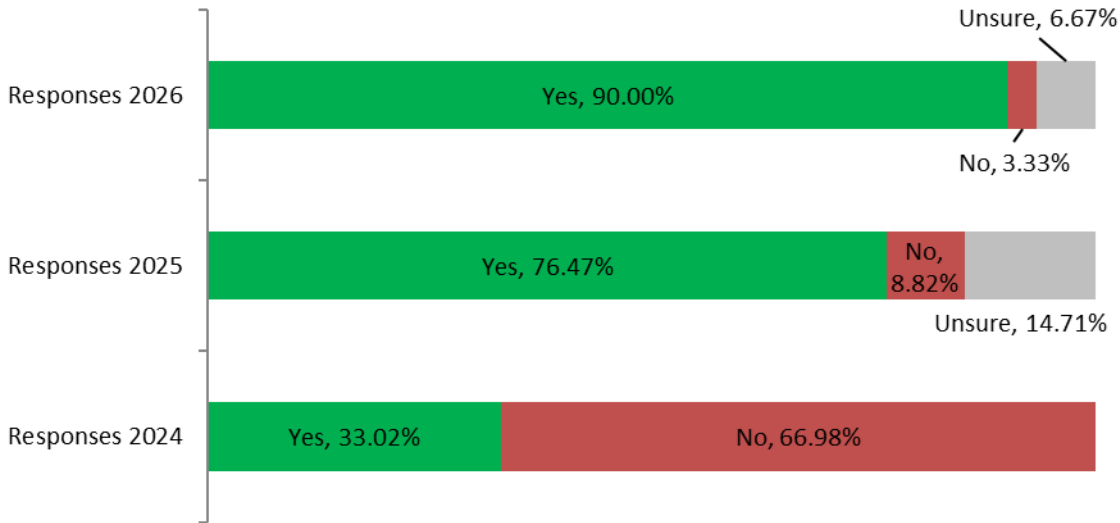
4. Key areas of Note, Discussion and Assurance for the Board

- 4.1 NHS England outlined its expectations of ICBs and ICSs in relation to FTSU in October 2024 and are working with the NGO to ensure that FTSU arrangements are in place for system partners in primary care by 2026. Work is underway with C&M ICB primary care, particularly the medical services, to provide assurance to NHS England that their staff know how to reach a FTSU guardian who is trained, registered with the NGO, and named in their local FTSU policy. This will support workers with speaking up where needed. The other three primary care providers – dentistry, pharmacy and optometry are yet to confirm their FTSU arrangements with the ICB, (please see appendix three and four).
- 4.2 The NGO is due to close in June, 2026 due to being disbanded with their responsibilities being taken over by the NHSE and provided further clarification on the role of ICB FTSU Guardians in primary care; that NHS organisations and private providers should not utilise ICB FTSU Guardians for their cases rather each NHS organisation should have its own FTSU Guardian, named in its policy, and responsible for supporting its staff.
- 4.3 The ICB has used and will continue to use the self-assessment and reflection tool (see appendix two) to help develop its FTSU arrangements as required by the NHSE. Whilst the 2025/2026 assessment overall showed an improvement in the FTSU arrangements in the ICB, it was only completed by 36% of the Board members and two areas fell below the score of 3 out of a total of 5. These include: *'we know who isn't speaking up and why?'* and *'there is an effective plan in place to cover the guardian's absence'*.
- 4.4 A few key areas for improvement were identified following the self-assessment and actions have been taken to address these, for example, the update of the FTSU Strategy with identification of the new senior responsible officer (SRO) for FTSU who supports to cover the guardian's absence, update of the FTSU operational plan and FTSU policy aligned to the NHSE FTSU policy standard template. (see [Freedom to Speak Up](#)).
- 4.5 The C&M ICB has an FTSU Ambassadors network that consists currently of 17 staff from across the organisation to help with raising awareness and promoting FTSU across the various teams but there is a need to continue to encourage participation from all staff at all levels to become an Ambassador for FTSU, as we are losing a few FTSU Ambassadors due to the organisational changes.

- 4.6 The FTSU Awareness month in October 2025 with the theme of ‘Follow Up in action’ saw the FTSU Ambassadors network working together with other staff networks who share October as their awareness month, such as the Mental Health First Aiders, Race Equality Network (REN) and carers network.
- 4.7 Our induction training includes a section regarding the FTSU agenda. The FTSU Guardian seeks to ensure that all the FTSU information is helpful, accessible, providing confidence, awareness, and clarity on our processes and usage of the FTSU within the ICB. The team remain committed to aligning FTSU with ongoing organisational change currently underway. It is recognised as both appropriate and important that FTSU is and remains available as one route to share staff experience and provides a critical back stop to capture staff experience.
- 4.8 The FTSU survey is completed annually and in March 2026, compared to previous year, it shows that more staff, 100% are aware of the FTSU process within the ICB and 90% are aware of the FTSU arrangements within the ICB, however there were no respondents from the 25–29-year age group. The FTSU Guardian Lead attended one of the Early Careers staff network group meetings as part of engagement with the ICB staff network groups to discuss how this can be improved.



Are you aware of the FTSU arrangements in place with the NHS Cheshire and Merseyside ICB?)



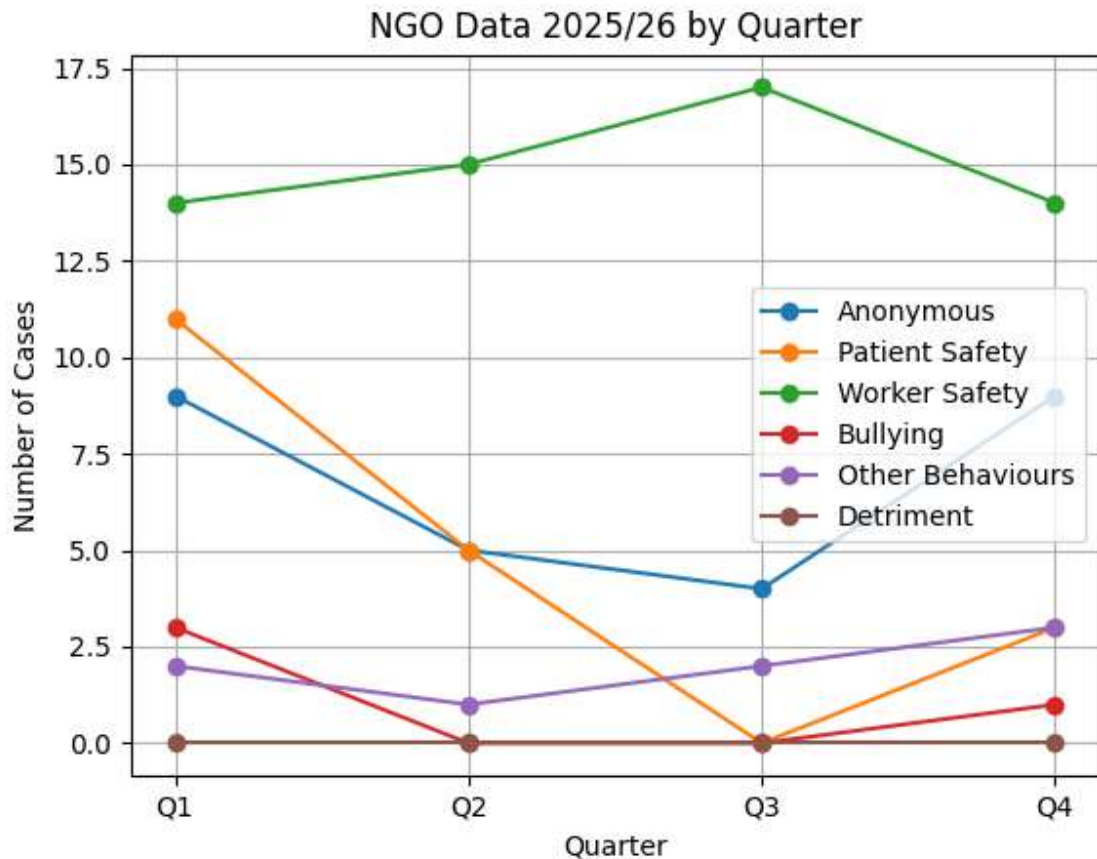
4.9 The FTSU e-learning mandatory training compliance for the three FTSU modules; 1- 'speak up' for all staff, module 2- 'listen up' for managers and made accessible to all staff and module 3 – Follow up' e-learning for senior leaders has increased. There is need for all staff to complete the FTSU training to help develop an effective FTSU culture within our organisation.

Compliance at 31/03/2026 shown below:

| FTSU E-Learning modules 1, 2 & 3 | Compliant | Non-compliant |
|--|---------------|---------------|
| NHS MAND Freedom to Speak Up - All Workers - Speak Up | 93.10% | 6.90% |
| NHS MAND Freedom to Speak Up - Managers - Listen Up | 84.36% | 15.64% |
| NHS MAND Freedom to Speak Up - Senior Managers - Follow Up | 63.33% | 36.67% |
| Grand Total | 87.80% | 12.20% |

4.10 FTSU Guardians report high level data on cases raised with them to the NGO quarterly. The ICB has reported for 2024/25 and 2025/26 as shown below –

| Total Numbers of cases 2024/25 | Q1 2024/25 | Q2 2024/25 | Q3 2024/25 | Q4 2024/25 |
|--------------------------------|------------|------------|------------|------------|
| 39 | 7 | 10 | 12 | 10 |
| Total Numbers of cases 2025/26 | Q1 2025/26 | Q2 2025/26 | Q3 2025/26 | Q4 2025/26 |
| 96 | 31 | 21 | 23 | 21 |



- 4.11 The main themes of FTSU concerns received are worker safety/wellbeing, followed by patient safety/quality, and increase in anonymous concerns which highlight a divide between corporate and place teams, lack of communication, and low staff morale due to ongoing organisational changes.
- 4.12 The Pulse survey 2025 indicated a challenging climate, with most colleagues reporting negative mood. The leading causes are stress, communication gaps, rapid change and workload and confirms the FTSU themes. The latest FTSU survey (April 2026) for this organisation identifies a few cultural barriers to raising concerns. There are two key areas identified:
 1. Fear of inaction
 2. Fear of Reprisal.
- 4.13 Provision of various avenues for staff to speak up such as the FTSU Anonymous form on the FTSU page (and there has been an increase usage of this avenue), the FTSU icon on all staff's desktop, and staff can use the icon to raise concerns openly, confidently and anonymously. Some of the feedback received from staff who have used the FTSU process include: *'Need to create a psychological safe environment for staff to speak up and leaders to see it as an opportunity to learn and improve and not for adversary/personal reactions. Suggestions around FTSU buddy for support; 'If I need to speak up it is easy to*

do so and I will be heard'; 'I found the process very easy and responsive to my concerns, I don't think managers fully understand the process'.

- 4.14 Response to the above described issues, experiences and perceptions are important and will in part be progressed by the already committed to organisational development response which it is planned will follow the implementation of the new ICB target operating model and management of change processes.

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

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

- 5.1 All staff are aware of their rights to speak up, whether via the FTSU Guardian or other routes freely without fear or any potential victimisation. There is a dedicated FTSU page [Freedom to Speak Up](#) on the staff hub with information and resource on FTSU and our FTSU policy includes the detriment guidance published by the NGO, January 2025. During the We Are One staff update sessions, the CEO and the FTSU Guardian and lead have often reminded all staff that the ICB welcomes staff speaking up without any recrimination. There is an FTSU icon on all staff desktops in addition to the FTSU page on the staff hub which has links to speaking up anonymously, confidentially and openly.
- 5.2 Demographic data of staff who have used the FTSU process is not representative of the ICB's diverse workforce, that is; not all ICB staff are engaging with the FTSU process and there is need to understand 'why' to ensure that all staff categories feel able to use the FTSU route or alternative routes to raise concerns should it be needed. This position was confirmed by the FTSU self-assessment/reflection tool completed by Board members in 2025, with a low score of 2.8 out of 5 to the question '*We know who isn't speaking up and why*'.
- 5.3 Our staff from ethnically diverse and neuro-diverse groups may feel more vulnerable to disadvantage from speaking up than others (highlighted from concerns raised to FTSU Guardian). Staff may have suffered from discrimination in speaking up previously. We expect our FTSU policy to have a positive impact on individuals from protected characteristics in terms of breaking down barriers to speaking up, reducing anxiety and hopefully reducing any perceived stigma attached to speaking up.

Objective Two: Improving Population Health and Healthcare

- 5.4 FTSU helps in creating an open culture where staff report risks and ideas, leading to earlier problem prevention, safer care, better patient experiences,

and improved staff morale, ultimately making services more effective and equitable by addressing systemic issues like bullying or unequal access. This proactive approach transforms mistakes into learning opportunities, preventing harm before it affects patients, and encouraging innovation for better public health outcomes and promoting better staff experiences and improving public trust (NGO, NHSE).

Objective Three: Enhancing Productivity and Value for Money

- 5.5 Our vision is that everyone, regardless of their role or employing organisation, feels that they have a voice and therefore feel safe to raise a concern with anyone, and know that they will be listened to, taken seriously and that the issue will be acted upon appropriately'. When staff are able to speak up about anything that gets in the way of doing a good job, it prevents worse things happening such as death and organisations facing high-cost legal charges and damage to their reputation and ability to be productive (NHSE, NGO).

Objective Four: Helping to support broader social and economic development

- 5.6 The CMICB FTSU process supports the development of FTSU culture with its provider services, engaging and sharing information on how FTSU can be established, as this creates positive benefits for staff and the organisation and the public they serve.

6. Risks

- 6.1 The themes from the FTSU concerns raised and highlighted in this report links with Board Assurance Framework (BAF) Risk ID P17 – Workforce Capacity, Capability, and Morale. FTSU data shows that staff are feeling demoralised, deskilled, apathy, understaffed and under resourced to deliver on tasks with fear of being targeted, a position further complicated by current and pending organisational change. Our teams also report that they don't think that senior management can change anything, thereby causing barriers to speaking up.
- 6.2 The ICB now has an FTSU icon on staff desktops in addition to the FTSU Anonymous form on the FTSU staff hub page for staff to safely raise concerns, thus addressing barrier to speaking up from fear of being targeted. Ongoing access to a confidential, remote, reporting route is at risk due to the organisational redesign.
- 6.3 The gap between raising concerns and seeing change is a key barrier and a safety risk that aligns with BAF Risk P4 -Quality & Safety failures in commissioned services. Simply put, workers will only speak up when they believe their actions will make a difference. Therefore, it is essential to develop a systematic approach to action planning. It is vital that staff continue to speak up as the NHS ten-year health plan is implemented – and Freedom to Speak

Up Guardians continue to provide an essential route for healthcare workers to do so during this time.” ‘Culture is a patient safety issue’.

- 6.4 It is recognised that minority groups or those with protected characteristics can often experience greater barriers in having their voice heard (NGO, NHSE). Compassionate and inclusive working environments also have a positive impact on staff engagement. Work is ongoing with the Associate Director of EDI, leading on the reasonable adjustment working group. The Associate Director of OD in relation to wider cultural improvement helped with creating the FTSU strategy and operational plan that aligns with the development of a healthy speak up culture according to the NHSE standard FTSU policy. Consideration of how people might raise concerns in relation to health inequalities, or inequality in the workforce, potential barriers to doing so and the potential disproportionate impact on minority groups and staff with other protected characteristics will be a key consideration of this work.

7. Finance, efficiency and people centred approach

- 7.1 The workforce metrics for the year 2024/2025 and the first quarter of 2025/2026 shows that the sickness absence rate and calendar days lost to sickness has been on the increase.
- 7.2 FTSU could help save money/cost to the ICB, ideas and suggestions raised by staff who are nearer to the service can spot and help avoid a waste of money and stop the ICB investing in systems that do not work or are not working.
- 7.3 The ICB is going through an organisational change, and it is important that staff have somewhere to go to during this period of big change.
- 7.4 The FTSU process within the ICB promotes prevention and early identification of cases where things are not working well and reduce the risk of patient harm.
- 7.5 FTSU helps the ICB to avoid grievance and the time it takes to resolve and money to bring in external investigators. If things are not captured in time, they can lead to monetary cost, reputational cost, and tribunals.
- 7.6 In a big organisation like the C&M ICB, despite having senior leaders who support staff speaking up, they are unable to know everything that is happening on ground, and it's only by staff speaking up that behaviours that are inappropriate, bullying and harassment can be checked and managed.
- 7.7 FTSU helps to improve the efficiency and sustainability of the workforce. Bullying can make productivity go down, as the health and wellbeing of the workforce is impacted and can result in high rates of sickness absence and calendar days lost to sickness, whether short term or long term.

- 7.8 The role of the FTSU Guardian and Lead includes being approachable, hence some staff who feel unable to use the standard line management route to speaking up, feel more able to use the alternative speaking up route and their voices are heard and they feel listened to and action for improvement taken, such as the digital suggestions made by staff, SARs process improvement following a FTSU concern raised and many more. Promoting FTSU and speak up routes for the function of the organisation through the 'Speak Up month', these activities are not without cost but part of the BAU.
- 7.9 This aligns with the NHS 10-year plan of Prevention and Digitalisation and saving costs.

8. Communication and Engagement

- 8.1 Communication and engagement have taken place throughout the year including 'We are One' sessions, FTSU Guardian and Lead attending local staff meetings, new staff induction organisation orientation programmes, FTSU Ambassadors network, Executive Team meeting discussions, Operations group, People Committee and Audit Committee.
- 8.2 There are also strong links between the FTSU Lead/Guardian and neighbouring ICBs and the regional and national leads with regular joint meetings and attendance at regional and national network meetings.

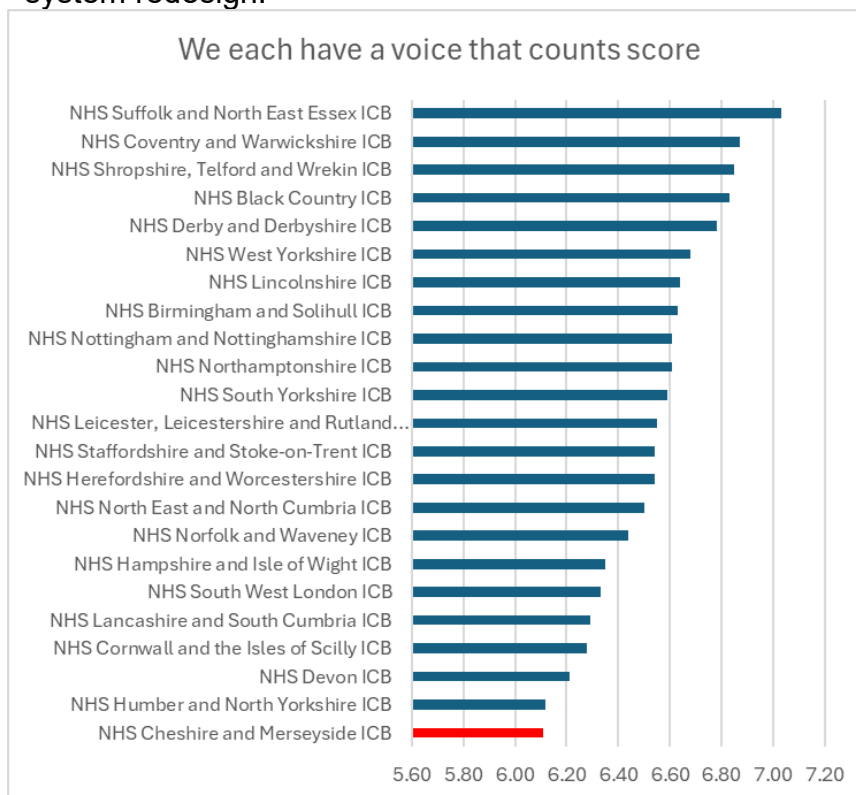
9. Equality, Diversity and Inclusion

- 9.1 Support staff concerns safely and in a supported way where existing organisational systems and processes cannot.
- 9.2 Afford bespoke efforts to the welfare of underrepresented groups in speaking up who face structural racism and wider structural discrimination.
- 9.3 Provide an impartial, objective and trusted independent process that serves as a bridge between the staff member speaking up and relevant stakeholders who are best positioned to address the concern.
- 9.4 Provide an opportunity to address concerns with civility and respect and cultivate a no blame culture that welcomes speaking up as a means of learning for continuous improvement for all stakeholders and recognise and reward speakers for their organisational loyalty, courage and bravery in the pursuit and service of continuous improvement.

10. Freedom to Speak Up within C&M ICS

- 10.1 The precise role of ICBs in relation to FTSU within a System context is still developing. NHSE and NGO outlined its expectations of Integrated Care Boards (ICBs) and Integrated Care Systems (ICSs) regarding Freedom to Speak Up for Primary Care workers and workers across their system.
- 10.2 Nevertheless, following the publication of the Patient Safety Landscape Review, the DHSC, NHSE and NGO have confirmed Freedom to Speak Up, and the role of Guardians, will be incorporated into the NHS Standard Contract for 2026/27 with NHSE assuming responsibility for leading this work from 2026/27 onwards. This reaffirms the vital role that Freedom to Speak Up Guardians continue to play across the NHS. Guardians are instrumental in ensuring that staff voices are heard that patients are protected from harm, and in supporting the development of safer, fairer, and more transparent healthcare systems.
- 10.3 The FTSU Guardian and Lead with the help of the Executive FTSU Lead presented a paper with recommendations for developing FTSU process within the four primary care providers in Cheshire and Merseyside at the System Primary Care Committee meeting in April, 2025 and the Non-Executive Director for FTSU has been instrumental in moving this agenda forward to the forefront of the primary care board, in order to ensure that all our primary care providers have an effective FTSU process where staff can raise concerns.
- 10.4 The FTSU Guardian and Lead has engaged with the four primary care providers through attendance at their team meetings, sharing how to develop an effective model for supporting and seeking assurance of FTSU process and what this might look like in primary care; supported the GP practices and PCNs across Cheshire and Merseyside in developing their FTSU process and most of the GP practices now have a FTSU Guardian representative but it is not so with the Dentistry, Pharmacy and Optometry and ways to achieve this are being considered. We know that reporting through FTSU in primary care settings is improving, but substantial gaps remain, with relatively low reported numbers overall. Routes to escalate concerns are more limited than in secondary care, with risks to individual confidentiality due to the size of some providers (NGO, NHSE).
- 10.5 The FTSU Guardian and Lead supports the ICB quality and contracting team with reviewing the quality schedules of our provider organisations in ensuring they have an effective FTSU process for their staff to raise concerns.
- 10.6 The FTSU Guardian and Lead and SRO FTSU with engagement of the FTSU Ambassadors working with the ICB Safeguarding team to help develop the anonymous reporting pathway for the sexual safety and misconduct charter policy, NHSE asked all NHS organisations to establish an appropriate reporting route. Locally, we have used the FTSU Anonymous form on the FTSU staff page and the FTSU icon on staff desktop.

- 10.7 This aligns with the NGO update that states from 6 April 2026, sexual harassment becomes an explicit category of protected disclosure under the Public Interest Disclosure Act (PIDA) – a legal change, however a healthy speaking up culture should prevent concerns from ever escalating to the point where PIDA protections become relevant.
- 10.8 The FTSU Guardian and Lead engaged with the CM primary care safeguarding team to promote FTSU to our primary care colleagues at their future platform webinar in 2025.
- 10.9 The FTSU Guardian and Lead also works in partnership with the PALS service in the secondary services.
- 10.10 CMICB FTSU leaders’ response form created by the FTSU Guardian and Lead featured in NHSE embedding a healthy speaking up culture event in 2025.
- 10.11 The CMICB FTSU Guardian and Lead has been successfully elected as the National ICB FTSU Guardians Network Chair in April 2026, voluntarily supporting other ICB FTSU Guardians across the country.
- 10.12 There is uncertainty around several functions that are currently delivered across the system, especially involving NHS Trusts. FTSU is not immune from the system redesign.



- 10.13 The NHS staff survey 2025 shows our ICB compared with other ICBs as scoring the lowest under the theme we have a voice that counts. While this provides important considerations for FTSU we need to recognise and acknowledge a number of leadership and cultural challenges and changes occurred in the year to Autumn 2025.
- 10.14 The NGO in March 2026, published a review on temporary workers' experience in speaking up (barriers & enablers) and the CQC has developed an assessment framework to ensure action is taken according to NGO recommendations due in March 2027. The FTSU Guardian and Lead with support from senior leaders sought to ensure that ICB commissioned providers create a psychological safe space for their temporary staff as well as permanent staff to speak up. Please see appendix five.

11. Recommendations:

11.1 The Board is asked to:

- **Support** that All Executives be encouraged to attend the training offered to FTSU Ambassadors as part of the requirements needed to develop and evidence an effective FTSU culture in the ICB.
- **Champion and sponsor** a push for managers and senior leaders to complete the FTSU 'Listen Up' and 'Follow Up' modules to ensure compliance to the mandatory FTSU training and process. Our FTSU and engagement approach should be proactive in identifying issues and acting upon them, ensuring that all staff feel valued and heard. Proactively re-enforcing psychological safety.
- **Support** the introduction of a realistic timescale for responding to FTSU concerns – moving from 7 working days to 14 working days due to the current organisational climate and 21 working days in cases of exceptionally circumstance.
- Creating appropriate opportunities for workers to speak up is essential but insufficient – through the implementation of the ICB's new operating model we need a stronger focus on listening and responding. This is central to the NGO's strategic framework, launched last year.
- **Agree** with partners how to manage concerns across organisational boundaries and a clear pathway to support primary care in developing a well-established FTSU process for their staff.
- **Support** the strengthening and standardising the Guardian role – aligning with NHSE feedback to ensure that Guardians have sufficient time and resources to carry out their duties effectively in a way, that demonstrates and promotes the impartiality of the role. (NGO & NHSE).

12. Next Steps and Responsible Person to take forward

- 12.1 An ongoing challenge with the FTSU process is identifying and measuring the nature of detriment, the principal issue is to quantify detriment in a way that is not subjective. Following the publication of the detriment guidance by the NGO in January 2025, the FTSU Guardian and Lead is developing a risk assessment/check list template in accordance with other FTSU Guardians in NHS organisations to help capture and measure the subjectivity of reporting experience of detriment by staff to better support staff and improve the FTSU culture of the organisation. The next step is to adopt the template as soon as it becomes available. See [Freedom to Speak Up](#).
- 12.2 The FTSU Guardian would be working closely with ICB HR/People to emphasise the priority of FTSU training for our leaders/line managers as they are currently developing a revised approach for the organisation.
- 12.3 Creation of an annual FTSU newsletter with support from the Communications team focussed on how speaking up is helping us to improve staff wellbeing, patient safety and working environment within the ICB from FTSU case studies.
- 12.4 Identification of other ways to feedback on FTSU anonymous concerns, other than FTSU page on the staff hub, including embedding FTSU in appropriate policies and processes such as induction and exit interviews.
- 12.5 The FTSU Guardian and Lead will continue to engage with ICB senior leaders and other stakeholders to identify and remove any barriers to speaking up and support wider cultural improvement work to ensure that speaking up remains a priority and leads to meaningful change and necessary action taken to improve staff wellbeing and cultivate an open and learning culture where ICB staff feel valued, informed and included. This will extend to continued efforts to establish a framework approach within primary care.
- 12.6 Continue to promote speaking up across the ICB and engage both staff and senior leaders in making speaking up 'business as usual'(BAU) with support from FTSU SUMMIT to improve the triangulation of data across the ICB to inform learning and development.
- 12.7 Themes from the ICB FTSU survey 2026 and outcomes from feedback to be shared with the Board and other committees where FTSU reports are shared and engage necessary action that needs to be taken for improvement.
- 12.8 To use the ICB FTSU survey findings to understand and engage 'who isn't speaking up and why' as part of the action needed following the outcome of the FTSU self-assessment and reflection tool 2025/26 completed by the ICB board.

13. Officer contact details for more information

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14. Appendices

Appendix One: [ICB FTSU Survey 2026](#)

Appendix Two: [CMICB Board FTSU Reflection and Self-Assessment tool 2025](#)

Appendix Three: [System Primary Care Committee paper- April 2025](#)

Appendix Four: [Exploring FTSU in Primary Care](#)

Appendix Five: (Temporary Workers' Speak Up Review: Update)

- [Give your views on draft sector-specific assessment frameworks - Care Quality Commission](#)
- [Temporary Workers, Permanent Voices: A Speak Up Review - National Guardian's Office](#)

Appendix Six: NGO Annual Report 24/25

- [NGO AR 2025 Digital-3.pdf](#)
- [20250702-Annual-data-report-2425-Publishable.pdf](#)

Meeting of the Board of NHS Cheshire and Merseyside

28 May 2026

National NHS Staff Survey ICB Response and Actions

Agenda Item No: ICB/05/26/14

REPORT SUMMARY SNAPSHOT

| Required Information | Details | | | |
|---|--|-----------------------------------|---|---|
| Responsible Executive Director | Liz Bishop, Chief Executive | | | |
| Report approval | By | Mike Gibney, Chief People Officer | | |
| | Date | 15.05.2026 | | |
| Presented by | Katie Horan, Programme Manager Staff Experience and Retention | | | |
| Ask of the Board | Approval | | Decision | |
| | Endorsement | ✓ | Ratification | |
| | Receive assurance | ✓ | Note | |
| Route to Board – where has this report been discussed | Presentations at People Operations Group and People Committee | | | |
| ICB Strategic Objective(s) the report relates to | Tackling Health Inequalities in access, outcomes and experience | ✓ | Improving Population Health and Healthcare | ✓ |
| | Enhancing Productivity and Value for Money | ✓ | Helping to support broader social and economic development | ✓ |
| Board Assurance Framework Risk(s) the report relates to* | Report relates to all risks to support the ICB to have a skilled, motivated workforce to improve outcomes in population health, tackle health inequalities, enhance productivity and help the broader NHS support social and economic development. | | | |
| Financial Implications* | Yes | | No | ✓ |
| | If Yes: | | | |
| | Have the financial implications been reviewed by the Director of Finance | | | |
| | Has a budget been identified | | | |
| Legal Implications* | N/A | | | |
| Conflicts of Interest associated with this report | N/A | | | |
| Impact assessments undertaken* | Equality | | | ✗ |
| | Quality | | | ✗ |
| | Data | | | ✗ |
| | Sustainability | | | ✗ |
| Public or Clinical engagement undertaken | Staff engagement through Staff Engagement Forum, People Operations Group and Staff Networks | | | |

National NHS Staff Survey ICB Response and Actions

1. Executive Summary

- 1.1 This report and the accompanying presentation (Appendix One) provide an overview of the ICB's NHS Staff Survey results for 2025. The results are presented against the seven areas of the NHS People Promise and the key themes of staff engagement and morale.
- 1.2 The survey response rate was 58% and 126 staff also provided free text comments. Staff engagement was 5.69, a decrease from 6.50 in 2024. Staff morale was 5.09, down from 5.73 in 2024. Scores declined across every People Promise area compared to 2024, with the lowest scoring theme being "We are always learning".
- 1.3 The results show a committed workforce with strong local team support and collaboration. However, the overall picture is of rising pressure on staff experience. Free text feedback points to fatigue and uncertainty, concerns about workload and change, and a need for clearer communication and greater confidence that speaking up leads to action. A thematic summary of the free text comments is provided at Appendix One.
- 1.4 Activity to date has included a presentation to the Executive Team, dedicated sessions with individual directorates, engagement through the Staff Engagement Forum and People Operations Group.
- 1.5 The organisational priorities recommended for 2026 focus on protecting wellbeing and reducing work pressure, rebuilding confidence that staff voice leads to change, and improving the learning and performance experience.

2. Ask of the Board/Committee and Recommendations

- 2.1 **The Board is asked to:**
 - **Note** the ICB staff survey results, including the themes from the free text feedback.
 - **Endorse** the proposed organisational priorities and the approach to delivery and assurance.
 - **Support** a continued "you said, we did" approach so staff can see what has been done, what has not been done, and why.

3. Introduction / Background

- 3.1 Although not mandated, this is the fourth year the ICB has undertaken the survey to understand staff experience and track changes over time. Following

the 2024 survey, an action plan was developed through staff engagement and communicated through “You Said, We Did” messaging (Appendix One)

- 3.2 The national Staff Survey 2025 was undertaken during the period September to November 2025 and followed an agreed national format aligned to the seven areas of the NHS People Promise and the themes of staff engagement and morale.

4. Key areas of Note, Discussion and Assurance for the Board / Committee

- 4.1 The survey response rate was 58% down from 73% in 2024. Staff engagement score (out of ten) was 5.69, a decrease from 6.50 in 2024. Staff morale was 5.09, down from 5.73 in 2024. Scores declined across every People Promise area compared to 2024 by an average of 0.6. With the lowest scoring theme being “We are always learning”.

- 4.2 The results show a committed workforce with strong local team support and collaboration. However, the overall picture is of rising pressure on staff experience.

4.3 What’s Working and Worth Protecting

- Equality and diversity remain a clear strength (8.22), even with a slight dip.
- Line management continues to stabilise teams (7.21), providing local support.
- Flexible working is still positive (7.20) - Pulse survey results support this – 63.4% stated we champion flexible working and 87.8% know where to access information on flexible working
- Compassionate leadership scores 7.30.

4.3 Where Pressure is Building

- Learning and performance was our weakest area at 4.37 (down 0.76), with appraisals at 3.83.
- Voice and psychological safety are declining at 6.11 (down 0.68) with raising concerns 5.95 down from 6.26
- Wellbeing risks are rising: burnout at 4.82, work pressure at 4.63.
- Engagement and advocacy have dropped sharply: advocacy down 1.01 to 5.05 – an early warning for retention and reputation.
- Morale and retention signals are fragile: “Thinking about leaving” down 0.99 to 4.58.

- 4.4 Equality and diversity remains a relative strength within the results. Free text feedback highlights concerns about perceived inequity and fairness in processes. Actions to improve consistency and fairness will be reflected within the action plan and monitored through ongoing engagement. Our staff networks will be engaged with the action plan and involved in the equality impact assessments undertaken for the specific areas of priority.

4.5 Recommended Organisational Priorities for 2026

- Understand work pressures and protect wellbeing. We need to take visible action on burnout drivers. We will prioritise continued promotion of occupational health and additional counselling offer, a staff health passport will be launched, renewed health checks for staff and our wellbeing offer refreshed. With the management of change process there will be new structures, job and roles and responsibilities which staff have highlighted will bring more clarity.
- Rebuild confidence that voice leads to change – strengthen listening and response. Employee voice reflects both how safe staff feel to speak up and whether they feel listened to and see action taken. As part of the staff engagement to present back the survey data and priority areas we have been asking staff their views on our speaking up culture to enable us to develop a maturity score for the organisation and to discuss barriers and best practice. We have worked with our FTSU Guardian to ensure the work aligns with FTSU priorities. We intend to complete this by July and can provide an appropriate update to the board at that time.
- Fix the learning and performance experience – make development meaningful and fair. Three clear actions to achieve this are the development and roll out of a skills and development questionnaire to all staff to understand our baseline of skills, knowledge and gaps, a new online (via ESR) appraisal process which will increase usability, confidence and development conversations and a refreshed streamlined learning and development offer, including promotion of North West Leadership Academy, NHS Elect, NH Digital, apprenticeship levy and importantly a change in our culture of blended approaches to learning and development.

4.6 Regarding ICS staff survey, NHS England are taking the lead on supporting our Trust providers through the North West Region workforce team.

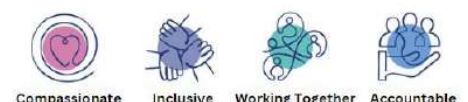
4.7 For General Practice for 2026/27 it will now be mandatory to take part in the GP staff survey. NHSE will amend both the core practice contract and the Network Contract DES to require that practices and PCNs participate in the General Practice Staff Survey. More details are still to be confirmed and we will work with the Primary Care teams to offer support and resource.

5. Risks

5.1 **Risk:** Workforce instability and retention risk increases, with loss of skills and experience.

Mitigation and controls:

- Maintain visible action planning and regular updates to staff on progress and decisions, including what has changed and what has not changed and why.



- Use People Committee and People Operations Group oversight to track delivery, escalate barriers, and maintain pace on commitments.
- Prioritise targeted support for teams experiencing highest pressure through team development discussions and responsive interventions informed by local feedback.

5.2 **Risk:** Burnout and capacity pressure lead to rising sickness absence and reduced resilience.

Mitigation and controls:

- Take visible action on known drivers of work pressure and burnout, including strengthening signposting and uptake of occupational health and wellbeing support.
- Use engagement/ workforce insights to identify pressure points and practical changes that reduce avoidable workload.
- Align change activity to clear role clarity and communication so staff understand structures, responsibilities, and support available.

5.3 **Risk:** Reduced confidence in learning and appraisal processes undermines development, fairness, and motivation.

Mitigation and controls:

- Implement planned improvements to learning and development, including the skills and development questionnaire and refreshed learning offer.
- Improve the appraisal experience through a clearer, more meaningful and consistent approach, supported by guidance for managers and staff.
- Monitor progress through pulse checks and feedback routes, adjusting the offer where it is not landing well.

5.4 **Risk:** Declining confidence in speaking up and communication results in reduced psychological safety and missed learning.

Mitigation and controls:

- Strengthen listening routes and response, ensuring staff can see outcomes from raising issues and suggestions.
- Reinforce timely, transparent communication during periods of change, including clearer explanations of decisions.
- Use staff engagement sessions and local team discussions to test whether the experience is improving and to identify practical fixes early

6. Finance

6.1 Delivery will primarily be through prioritisation of existing workforce and organisational development activities.

- 6.2 Some elements of the wellbeing and learning offer may require targeted investment or reprioritisation. Financial implications will be managed within available budgets and existing commitments.

7. Communication and Engagement

- 7.1 Engagement activity has included executive briefings, directorate sessions, Staff Engagement Forum and People Operations Group discussions, and wider engagement sessions for staff. Dedicated engagement activities have taken place to develop the priorities with our staff networks, Trade Unions and Training Advisory Group.
- 7.2 Ongoing communication will focus on regular updates that show progress, decisions, and outcomes in a clear and honest way, including where something cannot be progressed and the reasons why.

8. Next Steps and Responsible Person to take forward

- Publish the staff survey action plan.
- Provide assurance reporting through People Committee, with oversight through People Operations Group.
- Continue engagement with staff and teams, including team level discussions and follow up on themes raised.
- Undertake a mid-year review of progress against the action plan and adjust priorities where needed.

9. Appendices

Appendix One: Staff Survey results summary

National Staff Survey

Appendix One

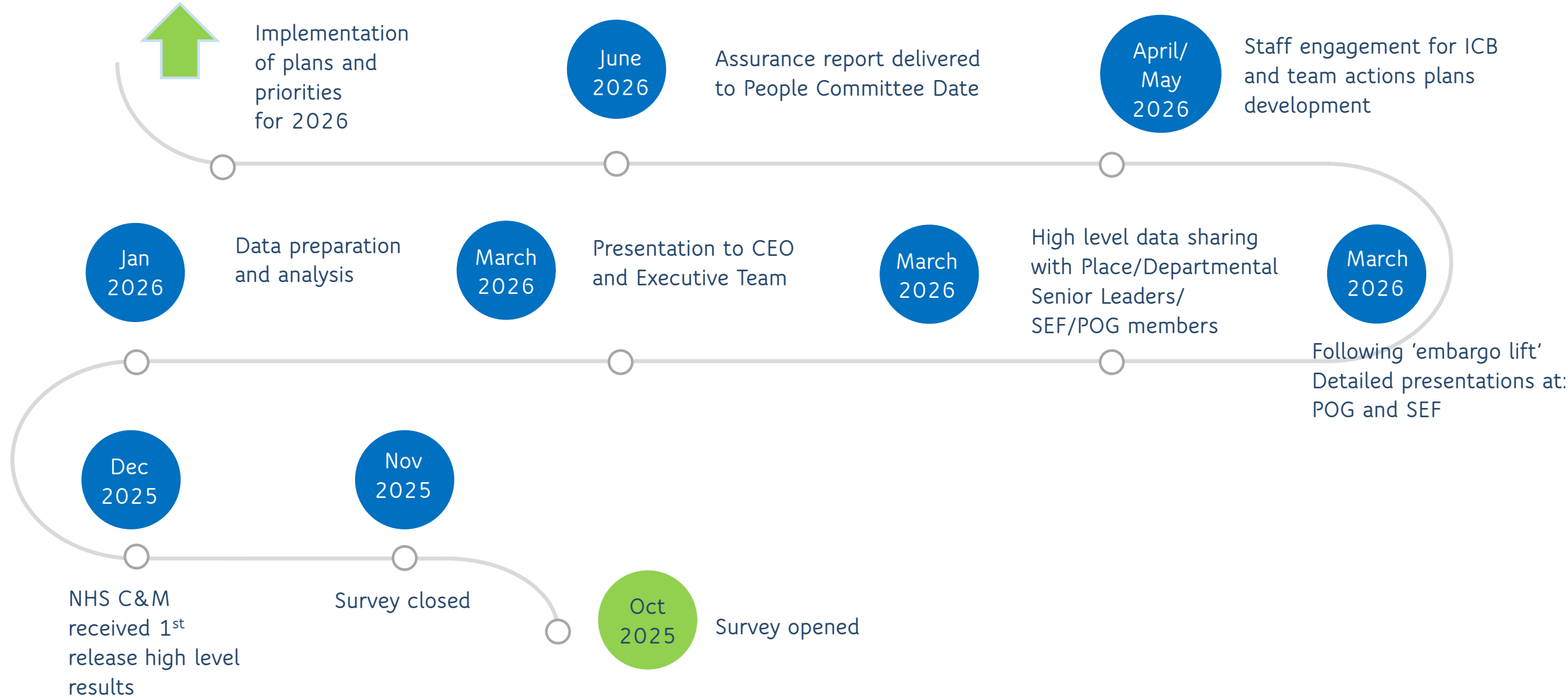
May 2026



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|--------------------------------------|---|
| Communication and engagement cascade | 3 |
| Response rates | 4 |
| Comparison of people promise scores | 5 |
| 2024 you said we did | 8 |
| Free text comments | 9 |

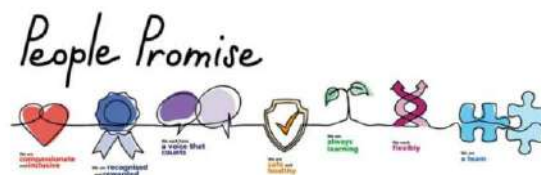
Staff Survey Results

Timeline and communication

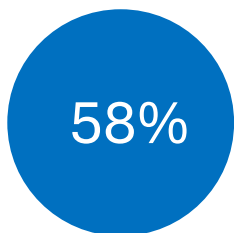


Staff Survey Results

Response Rates/Content



Response Rate



Compared to 73% in 2024

Total Staff In Post



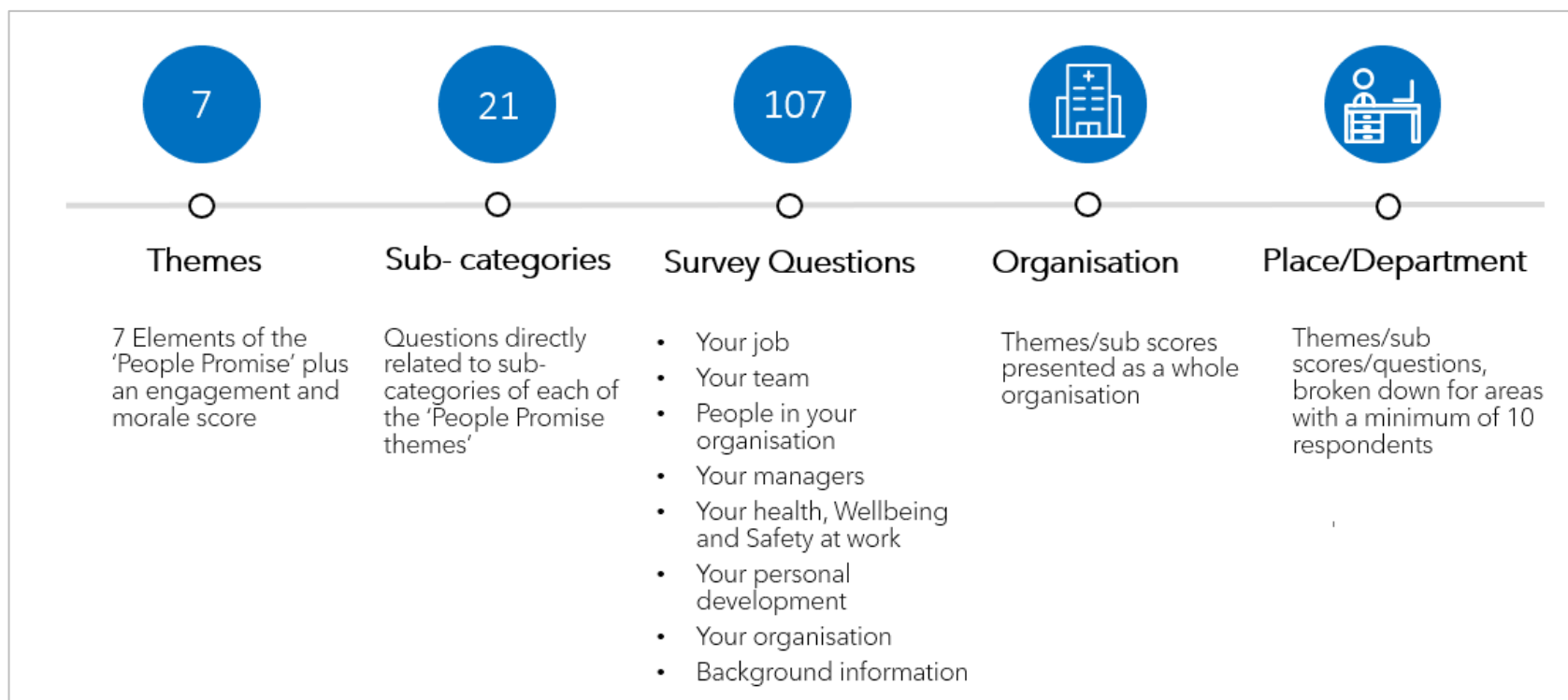
Compared to
1179 in 2024

Staff Participation



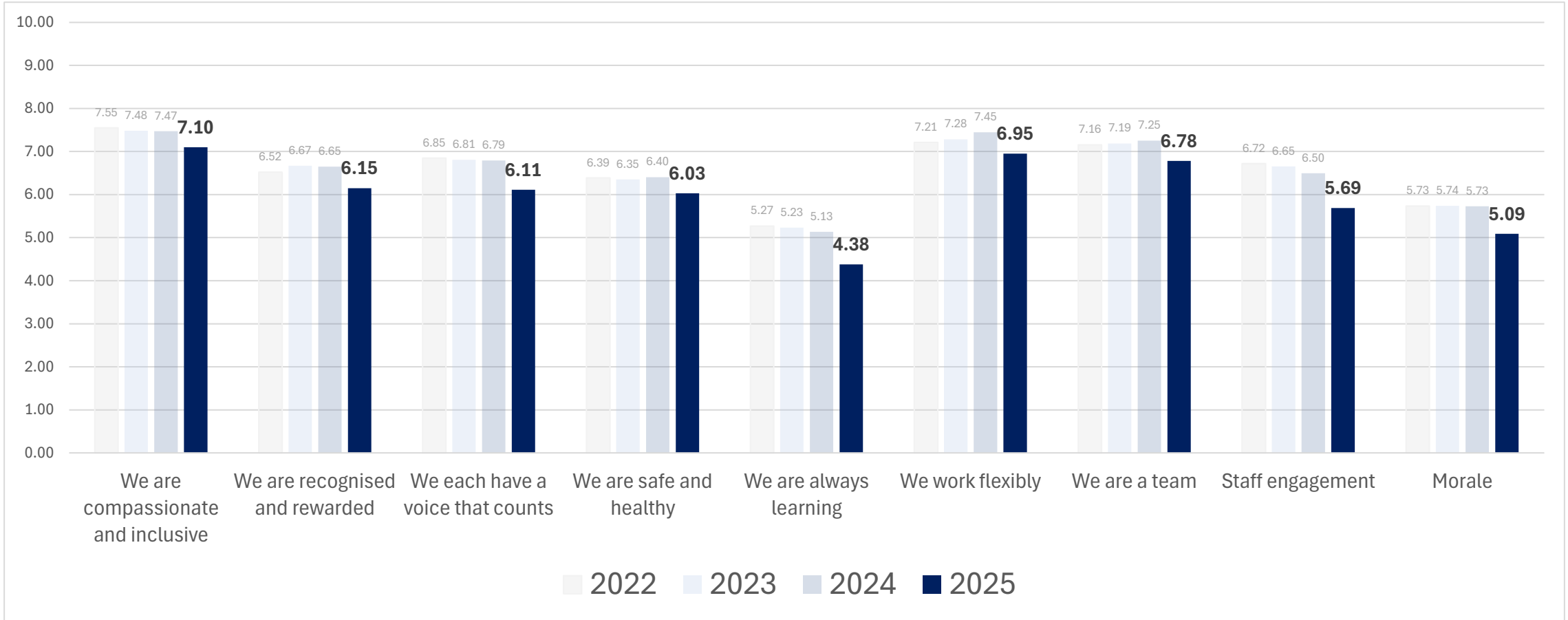
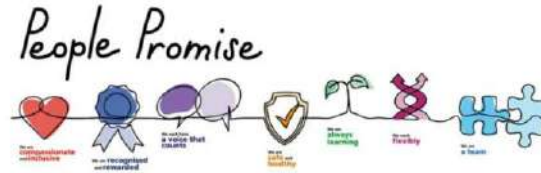
Compared to
852 in 2024

Survey Content



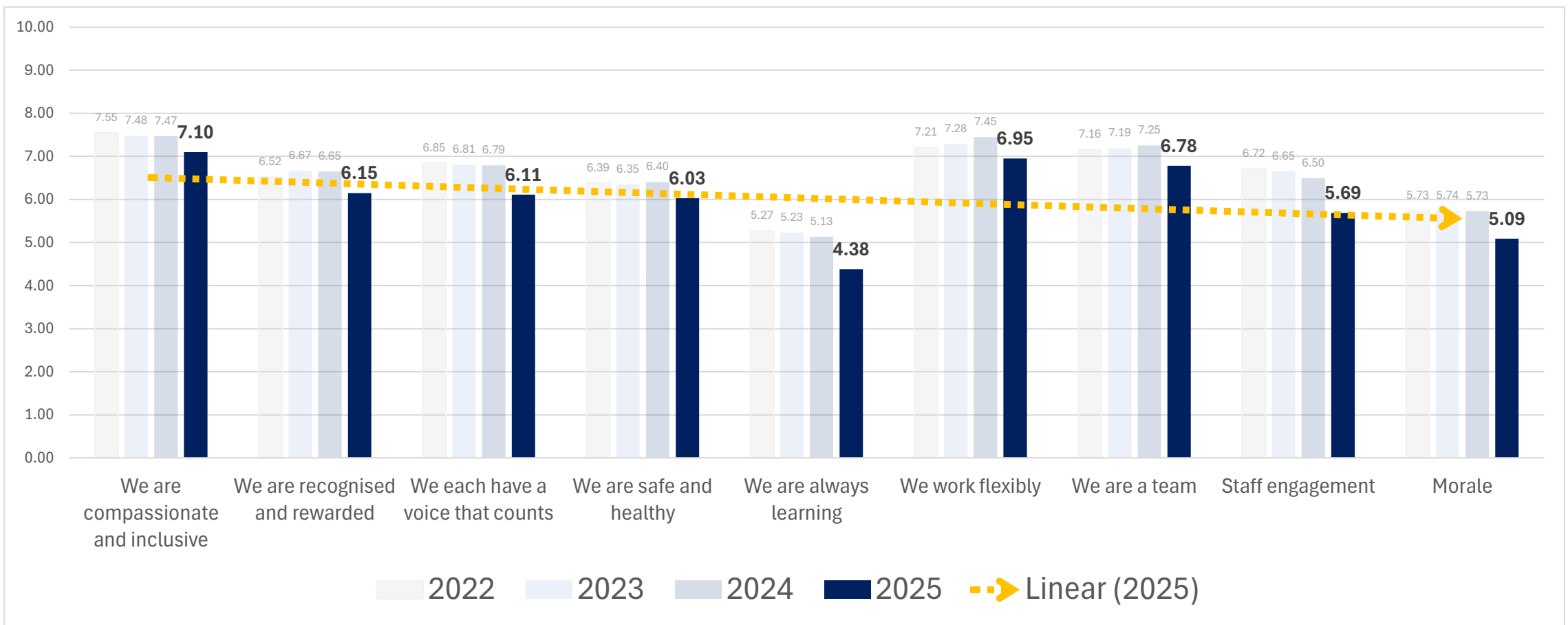
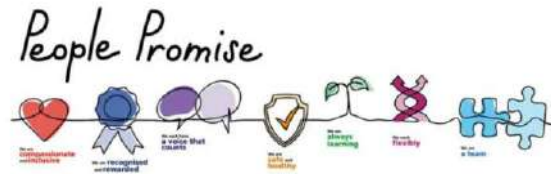
Staff Survey Results

Comparisons



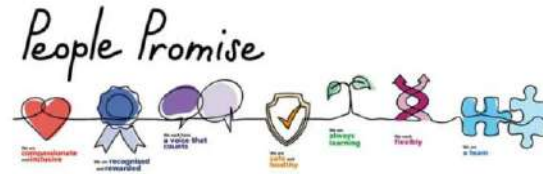
Staff Survey Results

Comparisons



Staff Survey Results

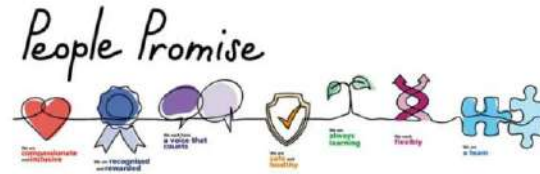
Comparisons



| People Promise Area | | Score (out of 10) | | |
|---------------------|------------------------------------|-------------------|------|------|
| | | 2025 | 2024 | 2023 |
| 1 | We are compassionate and inclusive | 7.10 | 7.47 | 7.48 |
| 2 | We work flexibly | 6.95 | 7.45 | 7.28 |
| 3 | We are a team | 6.78 | 7.25 | 7.19 |
| 4 | We have a voice that counts | 6.11 | 6.79 | 6.81 |
| 5 | We are recognised and rewarded | 6.15 | 6.65 | 6.67 |
| 6 | We are safe and healthy | 6.03 | 6.40 | 6.35 |
| 7 | We are always learning | 4.38 | 5.13 | 5.23 |

Staff Survey Results

2024 You said, we did



What we have delivered so far...

- **Championing staff wellbeing:** Expanded offer with [health checks](#), [financial support](#) and [self-care activities](#); engaging with leaders to encourage staff uptake
- **Wider colleague connection:** Set up [Brew Buddies](#) and [Managers Support Circle](#)
- **Staff have a voice that counts:** Use of [Staff Suggestion Scheme](#) for ideas related to organisational change
- **A simple 'thank you':** Relaunch of [High Five](#) for appreciating everyday work
- **Opportunities to feel connected and heard:** Further staff engagement sessions with CPO Mike Gibney and CEO Cathy Elliott
- **Importance of regular check-ins and feedback:** Promoted to managers for staff empowerment



Work in progress over the next 12 months...

- **Address barriers to staff Learning and Development:** Enhance communication and understanding of our offer
- **More face-to-face activities:** Further in-person regular staff engagement sessions and activities
- **Re-think and relaunch orientation sessions:** For all staff post organisational change
- **Staff directory:** Create an accurate directory so we know who to contact for support
- **Long-service awards:** Embed a consistent approach to long service across the organisation
- **Employee/Team of the Quarter:** Relaunch/raise awareness and encourage participation

Staff Survey Results

Free text comments

Critical Risks

Workforce instability

- Ongoing restructure and unclear future → staff “in limbo”

Burnout and capacity pressure

- Increased workload, rising sickness, teams “running on empty”

Patient care concerns

- Financial priorities perceived to outweigh quality and safety

Leadership & communication gaps

- Viewed as inconsistent, delayed, and lacking transparency

Key Strength

Strong local team support

- High levels of collaboration, compassion, and resilience at team level

In summary

Morale described as “lowest ever” / “breaking point”

Retention risk increasing – staff considering leaving

Loss of skills, engagement, and professional identity

Perceived inequity and unfairness in processes

**126 free
text
comments**

Meeting of the Board of NHS Cheshire and Merseyside

28 May 2026

Delegation of Specialised Services Update

Agenda Item No: ICB/05/26/15



Compassionate



Inclusive



Working Together



Accountable

Delegation of Specialised Services Update

1. Purpose of the Report

- 1.1 This paper provides an overview of the delegation of specialised services from NHS England to Cheshire & Merseyside ICB, setting out:
- the range, context, financial information and governance arrangements which supports the delegation of specialised services by NHS England to the ICB
 - the priority areas of focus within our 2026-31 Population Health Improvement Plan related to delegated specialised services and the anticipated strategic improvements we are aiming to achieve.

2. Executive Summary

- 2.1 Full commissioning responsibility of appropriate specialised services was delegated to North West ICBs in April 2024, after approval by the ICB Board in March 2023. A total of 70 services have now been delegated to ICBs nationally.
- 2.2 These changes aim to improve patient care and outcomes by enabling the joined-up planning and commissioning of services at a population level across whole pathways of care, i.e. across specialised and non-specialised services.
- 2.3 Based upon natural planning footprints and patient flows, delegated specialised services in the North West are segmented as those suitable for decision making at single ICB level and those that require multi-ICB collaboration across all three North West ICBs.
- 2.4 ICB Boards are responsible for delegated specialised services. Within this, single ICB services are overseen via the C&M Specialised Commissioning Oversight Group (SCOG) which reports into the ICB Executive Committee. Services with regional planning populations (multi-ICB) are overseen by the North West Specialised Services Committee (NWSSC). Financial decisions are undertaken by the relevant executive delegations.
- 2.6 A recently completed MIAA audit of specialised commissioning found that C&M ICB had appropriate governance structures in place to oversee the commissioning of delegated specialised services collaboratively with the other two North West ICBs.

3. Ask of the Board

- 3.1 The Board is asked to **note**:
- the range, context, financial information and governance arrangements which supports the delegation of specialised services by NHS England to the ICB
 - the priority areas of focus within our 2026-31 Population Health Improvement Plan related to delegated specialised services and the anticipated strategic improvements we are aiming to achieve.

4. Reasons for Recommendations

- 4.1 The ICB is responsible for delegated specialised services and needs to be assured that they are commissioned and overseen appropriately. The Specialised Commissioning Hub supports this role, working with and on behalf of the North West ICBs in accordance with the agreed Target Operating Model.

5. Summary: Delegation of Specialised Services

- 5.1 NHS England is the accountable commissioner for a portfolio of circa 150 specialised services. The list of services is set by the Secretary of State for Health and Social Care through regulations.
- 5.2 In February 2024, the NHS England Board approved plans to fully delegate the commissioning of 59 appropriate specialised services to ICBs in the East of England, Midlands and the North West regions of England from April 2024.
- 5.3 Further specialised services were deemed suitable for delegation from 1st April 2025 to all ICBs nationally, and a small number will follow in April 2027.
- 5.4 Any specialised services that haven't been delegated by April 2027 will become the responsibility of the Department of Health and Social Care due to the planned abolition of NHS England (subject to legislation). At this point, ICBs will be fully responsible for the services that have been delegated.
- 5.5 Delegated specialised services in the North West are segmented according to their natural planning footprints and based on patient flows. From this, they are categorised as being suitable for decision making at single-ICS level or those that will require multi-ICS collaboration across all three North West ICBs.
- 5.6 The C&M SCOG and NWSSC have been established to carry out strategic decision making, leadership and oversight functions related to the commissioning of delegated services.
- 5.7 A number of priority workstreams within specialised services have been agreed, informed by the North West Specialised Commissioning Health Inequalities & Prevention Strategy 2026-28 which align with the needs of the C&M population through our Integrated Needs Assessment and strategic priorities and which have been integrated within our Population Health Improvement Plan.
- 5.8 The Population Health Improvement Plan outlines the strategic, data-driven approach to improving the overall health, wellbeing, and health equity of a defined group of people by addressing root causes of illness and promoting wellness across communities, not just within individual clinical visits, but across wider pathways, involving collaboration between healthcare, local government, and community partners

6. [Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities](#)

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

Objective Two: Improving Population Health and Healthcare

Objective Three: Enhancing Productivity and Value for Money

Objective Four: Helping to support broader social and economic

6.1 The priorities outlined contribute to the delivery of the 5-Year Clinical and Strategic Commissioning Plan and Population Health Improvement Plan

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

7.1 The 5-Year Clinical and Strategic Commissioning Plan and Population Health Improvement Plan describe how the objectives will be achieved. They will be annually refreshed to maintain a focus on key priorities.

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

Theme One: Quality and Safety

Theme Two: Integration

Theme Three: Leadership

8.1 The key themes above are included in our 2026-31 plans and will be integral to delivery of our commissioning intentions.

9. [Risks](#)

9.1 Key delivery risks include:

- **Workforce:** Tension between plans for workforce reduction by providers set against ambitious delivery plans, and for commissioning workforce sustainability on reduced cost per head of population, set against programme management resource requirements to deliver plans.
- **Governance:** Significant structural change is ongoing as part of the new NHS operating model in the North West.

10. [Finance](#)

10.1 The delegation of specialised services presents opportunity to realise efficiencies and savings through a more integrated approach to commissioning.

- 10.2 A breakdown of the 2026/27 financial plan for delegated specialised services is provided in the attached presentation.

11. Communication and Engagement

- 11.1 As part of the Integrated Needs Assessment, feedback already gathered from our residents and service users was considered in identifying our priorities. Alongside this, plans were constructed to include intelligence gathered from NHS Providers and through Programme Leads who are working as part of the wider system to build plans.
- 11.2 Specialised Commissioning priorities were included in the plans engaged upon within the 5-Year Clinical and Strategic Commissioning and Population Health Improvement Plans. This included partner member representation.
- 11.5 As part of the overarching ICB approach to strategic commissioning, it is recognised that we need to embed codesign, codelivery and joint working into our revised target operating model to recognise the importance of all partners and have mechanisms at all levels from neighbourhood to whole “Cheshire and Merseyside” and to commence the planning process for 2027-28 as early as possible at the start of 2027-28.

12. Equality, Diversity and Inclusion

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

13. Climate Change / Sustainability

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

14. Next Steps and Responsible Person to take forward:

- 14.1 Progress against each of the priority areas is reported into the C&M SCOG and NWSSC. This is likely to be revised as part of the new NHS operating model in the North West.

15. Officer contact details for more information

Ian Johnston, Acting Acute Transformation Lead (C&M)
(ian.johnston12@nhs.net)

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

16. Appendices

Appendix One: Delegation of Specialised Services supporting slides

Specialised Commissioning Update

Cheshire & Merseyside ICB
Public Board Meeting
Thursday 28th May 2026

Commissioning Specialised Services for:

NHS England
NHS Cheshire and Merseyside ICB
NHS Greater Manchester ICB
NHS Lancashire and South Cumbria ICB

Purpose

The board is asked to **Note**:

- The range, context, financial information and governance arrangements which supports the delegation of specialised services by NHS England to the ICB
- The priority areas of focus within our 2026-31 Population Health Improvement Plan related to delegated specialised services and the anticipated strategic improvements we are aiming to achieve.

Commissioning Specialised Services for:

NHS England
NHS Cheshire and Merseyside ICB
NHS Greater Manchester ICB
NHS Lancashire and South Cumbria ICB

Delegation of Specialised Services

Background: Specialised services support people with a range of rare and complex conditions. They often involve treatments provided to patients with rare cancers, genetic disorders or complex medical or surgical conditions. In total, there are 150 specialised services, of which 70 have now been delegated. Three factors determine whether a service is a prescribed specialised service. These are:

- The number of individuals who require the service
- The cost of providing the service or facility
- The number of providers able to deliver the service or facility

The North West ICBs were in the first wave of delegation commencing in April 2024, as agreed by the board in March 2023.

Purpose: To improve patient care and outcomes by enabling the joined-up planning and commissioning of services at a population level across whole pathways of care, i.e. across specialised and non-specialised services.

Service Segmentation: Based upon natural planning footprints and patient flows/volumes, delegated specialised services are segmented as those suitable for decision making at single ICB level and those that require multi-ICB collaboration across all three North West ICBs.

Governance and Accountability: ICB Boards are responsible for delegated specialised services. Within this, single ICB services are overseen via the C&M Specialised Commissioning Oversight Group (SCOG) which reports into the ICB Executive Committee. Services with regional planning populations (multi-ICB) are overseen by the North West Specialised Services Committee which reports to the Board. Financial decisions are undertaken by the relevant executive delegations.

Assurance: A recently completed audit, by MIAA, to assess the effectiveness of the ICB's governance, risk management, financial control and operational delivery arrangements relating to specialised commissioning offered "substantial" assurance.

Commissioning Specialised Services for:

Why Are Services Delegated?

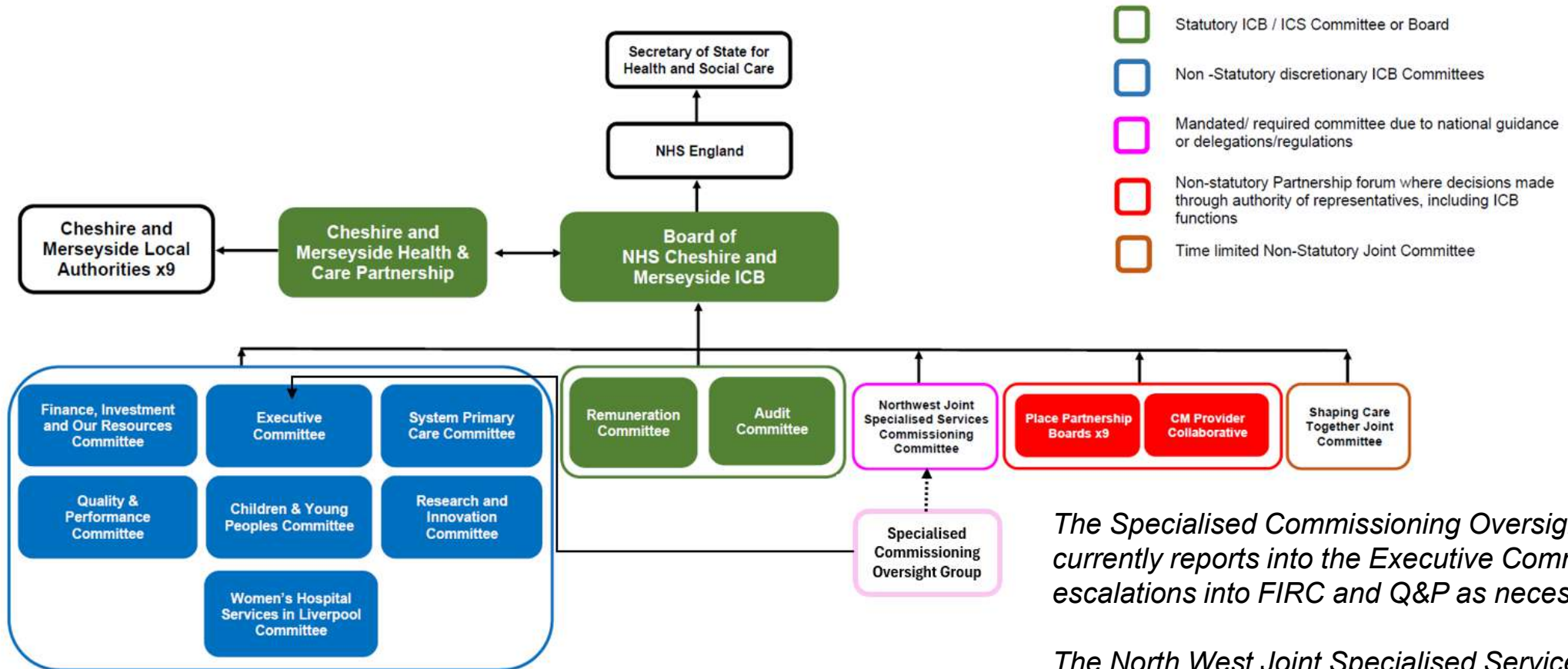
Delegation is part of a national programme aiming to enable the planning, commissioning and provision of better and more integrated services for patients across whole and linked pathways of care and placing greater focus on upstream intervention (“left shift”) could significantly reduce demand for certain specialised services. Examples include:

- **Renal** – Earlier investment in managing chronic kidney disease and acute kidney injury could reduce progression to expensive treatments like dialysis and transplantation.
- **Adult Critical Care** – The current split in funding for ICU patients makes long term service design harder, especially across transport, different care levels and rehabilitation.
- **Mental Health** – Delegation helps align incentives in the design of pathways that keep people out of hospital and supported within their local communities. It brings the funding and responsibility for the majority of mental health services with ICBs, giving the opportunity to deliver earlier intervention, and care closer to home.
- **Liver** – Prevention and early diagnosis opportunities lie largely within alcohol and obesity, whilst later stage treatment sits elsewhere, creating a disconnect across the pathway.

Commissioning Specialised Services for:

Governance

Specialised Commissioning North West



The Specialised Commissioning Oversight Group currently reports into the Executive Committee, with escalations into FIRC and Q&P as necessary.

The North West Joint Specialised Services Commissioning Committee reports to the Board

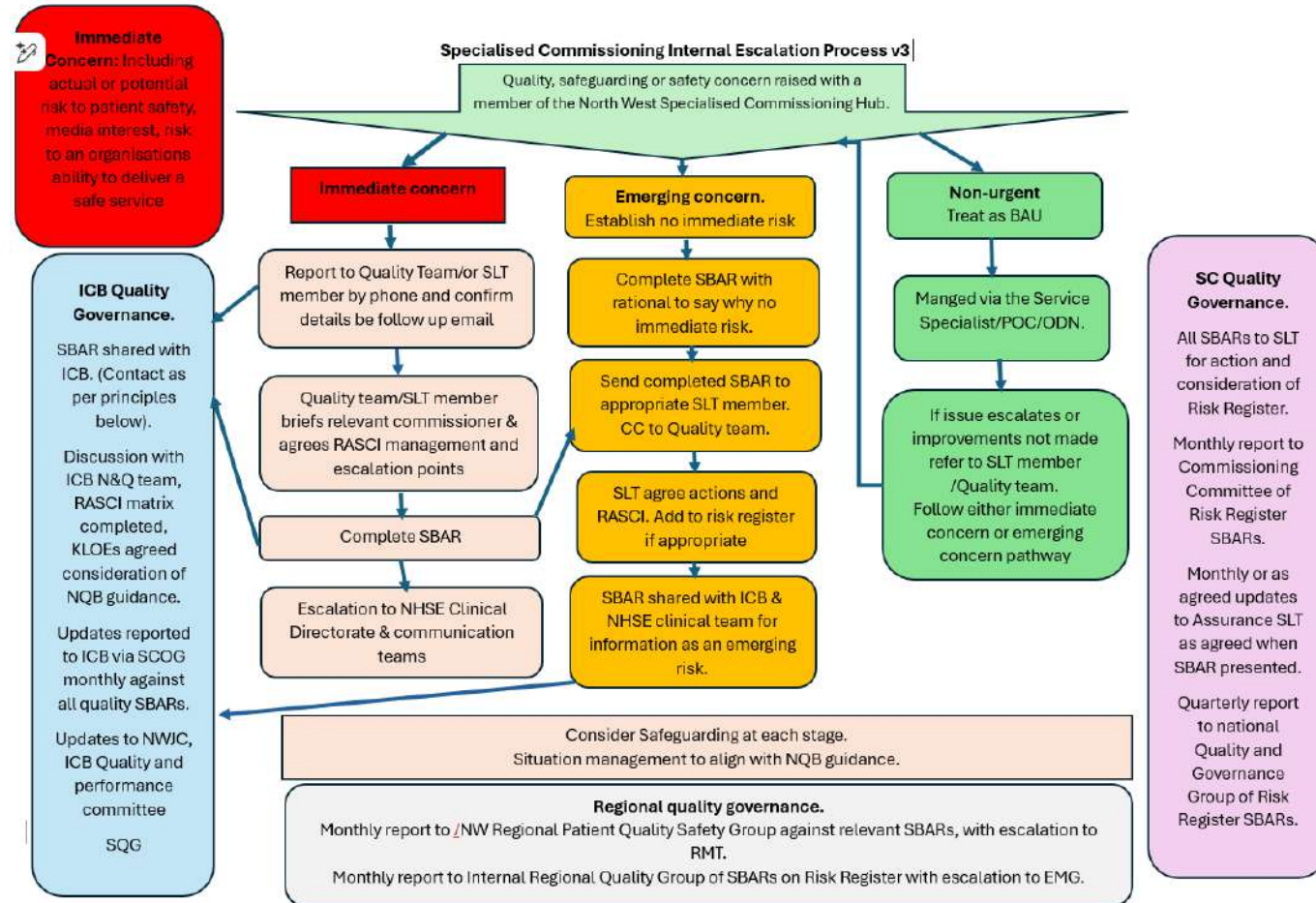
This governance is being reviewed as part of the “current” ICB governance review and the new NHS Operating Model in the North West.

Commissioning Specialised Services for:

- NHS England
- NHS Cheshire and Merseyside ICB
- NHS Greater Manchester ICB
- NHS Lancashire and South Cumbria ICB

The approach taken to quality oversight – A Case Study of how we work in an integrated way

- Quality oversight for specialised commissioning maintained by the North West “hub” Quality Team.
- Monthly quality report shared with Specialised Commissioning Oversight Group to inform ICB Quality Groups and Quality and Performance Committee, with escalation to Regional Quality Group in line with National Quality Board guidance.
- Use of the SBAR (Situation, Background, Assessment, and Recommendation) and RASCI (Responsible, Accountable, Supportive, Consulted, and Informed) matrix to share information between regional and ICB teams and to prevent duplication, drive improvement and gain the required assurance.
- As ICB quality and governance structures and reporting are revised, the established escalation process into the ICB structures will be revised.
- Discussions ongoing regarding the governance process via weekly Director of Nursing meetings with the 3 ICBs and via the Quality subgroup for the Target Operating Model.
- Ensuring alignment to the Executive Quality Group publication “Transitioning to the new NHS Operating Model: Changes to quality governance and risk escalation” published April 2026.



Finance

- C&M ICB have an allocation of £849m (breakdown on next slide) to commission delegated specialised services
 - C&M ICB are currently 4.27% over target with convergence being applied to the allocations
 - Specialised services are moving to a population needs based allocation for acute services
- Mental Health Investment Standard is applied to delegated mental health services
 - The mental health specialised allocation must be spent on specialised mental health to achieve the standard
 - Mental Health services are commissioned by Lead Provider Collaboratives (LPCs) who act as commissioners and are responsible for services for their population (part of a national approach)
- Plan submission based on brought forward specialised surplus position for CM ICB of £14.1m
- Specialised services forms part of the ICB contract with providers in 2026/27
 - Significant focus on productivity and improvements to RTT position in 2026/27 finance and contracting planning round
 - Specialised Commissioning Acute services received no additional allocations to support RTT in 2026/27
 - Multi ICB services to be managed on NW risk share basis as per 2025/26
 - Planned work around Contract (Block) Deconstruction exercise with Providers in 2026/27
- Finance, Investment and Contracting Committee received an update in April regarding the financial plan for specialised services, including risks and mitigations.

Financial Plan

Specialised Commissioning
North West

| Delegated Specialised Services Financial Plan 2026/27 | Acute £m | Mental Health £m | Total £m |
|--|----------------|------------------|----------------|
| Allocation | 757,085 | 92,463 | 849,548 |
| Expenditure Plan | | | |
| NHS Contracts* | 729,064 | 92,455 | 821,520 |
| Non-NHS Contracts | 3,567 | - | 3,567 |
| Other Non-Contract Activities | - | - | 0 |
| Reserves at Final Plan | 10,290 | 0,008 | 10,298 |
| Reserves (Brought Forward Surplus) | 14,164 | - | 14,164 |
| Total Expenditure | 757,085 | 92,463 | 849,548 |
| Surplus/Deficit | 0 | 0 | 0 |

* A breakdown of the NHS Contracts is included in slides 19&20 respectively

Commissioning Specialised Services for:

NHS England
NHS Cheshire and Merseyside ICB
NHS Greater Manchester ICB
NHS Lancashire and South Cumbria ICB

Population Health Improvement Plan

North West Specialised Commissioning Health Inequalities & Prevention Strategy 2026-28

- A Specialised Commissioning Health Inequalities & Prevention Strategy for the North West has been developed and aligns and informs the [Cheshire and Merseyside Integrated Needs Assessment that has directed the Cheshire & Merseyside ICB Population Health Improvement Plan \(PHIP\)](#) approved by the ICB Board in March 2026.
- Specialised services differ from other types of healthcare (small numbers of patients, smaller number of providers with necessary expertise, often accessed at the end of complex/multi-stage referral pathway) so their potential for helping to reduce inequalities are not always fully recognised.
- The strategy is focussed on aligning the key aspects of health inequalities such as access, experience and outcomes across the breadth of commissioned pathways and health services. All North West ICBs have been involved in the development of the strategy.
- It has been used to inform priorities for specialised services which fit with the needs of the C&M population and are integrated within the C&M ICB Population Health Improvement Plan.
- Specific work programmes include schemes related to cardiovascular disease – renal metabolic disease (CVD-RM), stroke and women’s and children’s, and have been identified as the areas with the greatest opportunity to improve outcomes.

Commissioning Specialised Services for:
outcomes.

Alignment with C&M ICB Strategic Priorities



*Specialised Commissioning
North West*

A small number of system-wide priorities will be identified in line with ICB plans over the next five years:

- Reducing unwarranted variation in access, outcomes, experience and service resilience across pathways
- Embedding a whole-pathway approach to commissioning, with stronger integration between specialised and non-specialised services
- Strengthening clinical networks and service models to improve equity, sustainability and workforce resilience
- Optimising the use of high-cost drugs, devices and technologies through consistent regional approaches
- Delivering measurable improvements in population health and reducing health inequalities
- Moving to value-based commissioning, linking quality, outcomes and financial sustainability
- Embedding the Office of Pan-ICB Commissioning (OPIC) as a mature, high-performing commissioning function.

Commissioning Specialised Services for:

NHS England
NHS Cheshire and Merseyside ICB
NHS Greater Manchester ICB
NHS Lancashire and South Cumbria ICB

Acute Priorities 2026/27 - Objectives

Specialised Commissioning
North West

| Single/Multi ICB Oversight | Workstream | Primary Ambition | 2026/27 Objective |
|-------------------------------|---|---|---|
| Single ICB Oversight via SCOG | Optimising Stroke Pathways: From 999 to Thrombectomy | Expansion of inter-arterial thrombectomy (IAT) to reduce mortality, morbidity and wider societal costs associated with stroke. | Pathway improvement to increase IAT rates for patients from all C&M sites and improve compliance with national standards. |
| | Neurorehabilitation: Integrated Case Management and Care Models | Develop and agree a model of care that utilises integrated case management as a core feature of service delivery to ensure that patient needs are met appropriately. | Implementation and evaluation of integrated case management team pilot to improve pathway efficiency and patient outcomes. |
| | Renal Transformation Programme | Enable earlier detection and intervention for chronic kidney disease (CKD) and acute kidney injury (AKI), improving quality, safety and equitable access to specialised renal services. | Standardised AKI detection, prevention and management and expansion of CKD identification through CVDRM aligned care pathways, halting disease progression. |
| | C&M Neonatal Surgery Partnership | Establish a single integrated neonatal intensive care service across Alder Hey and Liverpool Women's Hospital to provide a safer and efficient service. | Lead assurance process through enhanced surveillance to ensure compliance with national service specification. |

Acute Priorities 2026/27 - Objectives

Specialised Commissioning
North West

| Single/Multi ICB Oversight | Workstream | Primary Ambition | 2026/27 Objective |
|-------------------------------|--------------------------------------|--|--|
| Multi ICB Oversight via NWSSC | Neonatal Critical Care | Service reconfiguration in order to ensure compliance with national standards. | Development and analysis of short and long list options to inform preferred option and PCBC ahead of clinical senate and Gateway 2 review. |
| | Complex Termination of Pregnancy | Establishment of a North West service so patients do not need to travel to other regions. | Service implementation, mobilisation and monitoring following contract award in April 2026. |
| | Placenta Accreta Spectrum (PAS) | Reduce the harm associated with placenta accreta spectrum and improve clinical outcomes in women through development of a regional network and referral pathway in the North West. | Establishment of PAS service and clear clinical pathways. |
| | Adult Critical Care Transfer Service | Development of a single ACCTS for the North West to reduce variation and ensure a sustainable and standardised model. | Procurement of Host Trust for the ACCTS. |

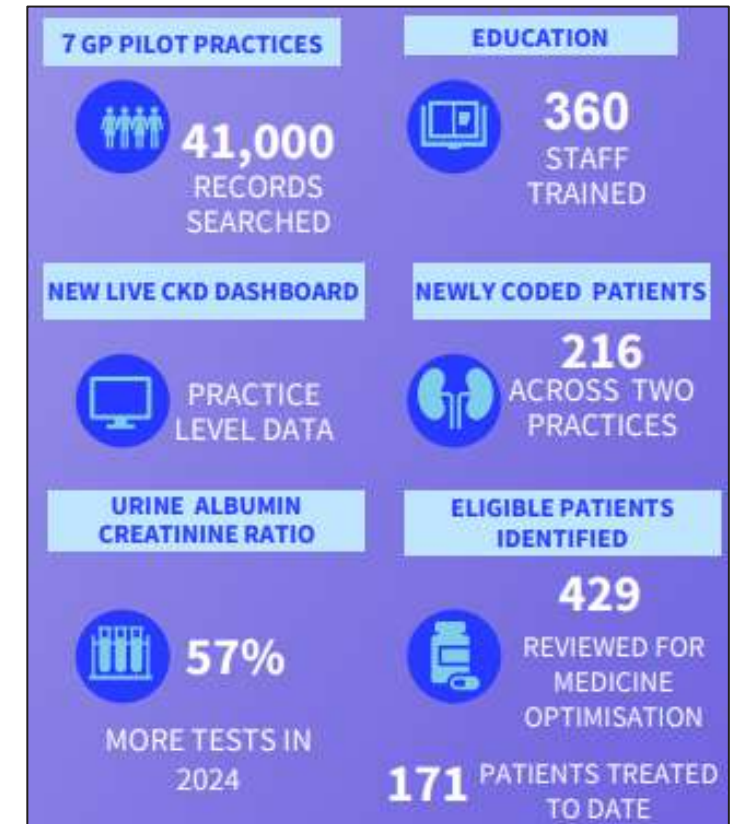
Case Study Population Health Improvement – CORE Kidney Pilot

Specialised Commissioning North West

In the North West, we are working to join up the end-to-end renal pathway, supported by the Renal Specialised Services Clinical Network. The aim of this work is to identify and implement interventions which better manage patients with acute and chronic kidney disease to reduce the likelihood of them from needing dialysis or transplantation.

The CORE Kidney pilot has focused on a shift of specialism from secondary/tertiary renal services into primary care, thereby supporting a broader prevention approach by identifying patients earlier in the disease trajectory, contributing to improved risk factor management and reducing progression to cardiovascular, renal, and metabolic diseases. Using the data from the pilot intervention, it was possible to estimate potential cost benefit of new prescriptions which slow kidney disease progression.

The programme is part of the 2026-31 ICB Population Health Improvement Plan in our programme of work around Cardiovascular Disease – Renal Metabolic Disease. The details of the programme are currently being finalised.



Commissioning Specialised Services for:

NHS England
 NHS Cheshire and Merseyside ICB
 NHS Greater Manchester ICB
 NHS Lancashire and South Cumbria ICB

Specialised Commissioning Update

Appendices

Commissioning Specialised Services for:

NHS England
NHS Cheshire and Merseyside ICB
NHS Greater Manchester ICB
NHS Lancashire and South Cumbria ICB

Delegated Services for Individual NW ICBs

Specialised Commissioning
North West

Internal Medicine

| |
|--|
| 29S - Severe Asthma |
| 29M - Interstitial Lung Disease |
| 29A - Pulmonary Vascular Services |
| 13C - Inherited Cardiac Conditions |
| 13B - Cardiology (EP and Ablation) |
| 13H - Cardiac MRI |
| 13E / 13Z - Cardiac Surgery |
| 13A - Cardiology (Complex Device Therapy) |
| 13F - PPCI (for STEMI) |
| 13T - TAVI |
| 11C - Access for Renal Dialysis |
| 11B - Renal Dialysis |
| 30Z - Vascular |
| 33B - Complex Inflammatory Bowel Disease |
| 33A - Faecal Incontinence |
| 33C - Transanal Endoscopic Microsurgery |
| 19Z (inc. 19L and 19P) - Complex Liver, Biliary and Pancreas |
| 29V - Complex Home Ventilation |

Cancer

| |
|--|
| 29B / 29Z - Complex Thoracic Surgery |
| 01C - Chemotherapy |
| 04F - Gynae Cancer |
| 01M - Head and Neck Cancer |
| 01N - Kidney Bladder & Prostate Cancer |
| 01U - Oesophageal and Gastric Cancer |
| 01Y - Cancer Outpatients |
| 24Y - Skin Cancer |
| 27E - Adrenal Cancer |

Mental Health

| |
|--|
| 22P - Perinatal Mental Health |
| 23Ka - Tier 4 CAMHS (Adolescent) |
| 23Kb - Tier 4 CAMHS (ED) |
| 23L - Tier 4 CAMHS (Low Secure) |
| 23O - Tier 4 CAMHS (PICU) |
| 23U - Tier 4 CAMHS (LD) |
| 23V - Tier 4 CAMHS (ASD) |
| 24C - Forensic CAMHS (community) |
| YYY - Specialised MH EPCs |
| 22Sb - Low & Medium Secure MH & LD (excl. LD; ASD; WEMS; ABI and Deaf) |
| 22Sc - Low & Medium Secure ASD |
| 22Sd - Low & Medium Secure LD |

Trauma

| |
|--|
| 08O - Specialised Neurology |
| 08P - Neurophysiology |
| 08R - Neuroradiology |
| 08S - Neurosurgery |
| 08T - Mechanical Thrombectomy |
| 37Z - Specialised Ophthalmology (Adult) |
| 34A - Specialised Orthopaedics (excl revisions) |
| 32B - BAHAs |
| 06Z - Complex Spinal Surgery |
| 34T - Major Trauma (Adults) |
| 07Z - Complex Rehabilitation |
| 05P - Specialised Prosthetic Limbs |
| ACC - Adult Critical Care |
| 08G - Neurosurgical Low Vol Procedures (Centres) |

Women's & Children's

| |
|---|
| 04A - Severe Endometriosis |
| 04D - Urinary Incontinence/Genital Prolapse |
| 23E - Paediatric Endocrinology & Diabetes |
| NIC - Neonatal Critical Care |

Blood & Infection

| |
|------------------------------------|
| 14A - HIV (Adult) |
| 17Za - Specialist Allergy (Adults) |

Commissioning Specialised Services for:

NHS England
NHS Cheshire and Merseyside ICB
NHS Greater Manchester ICB
NHS Lancashire and South Cumbria ICB

Delegated Services for NW Planning (Multi-ICB)



Internal Medicine

| |
|--|
| 10Z - Cystic Fibrosis |
| 11T - Renal Transplantation |
| 24Z - Specialised Dermatology |
| 26Z - Adult Highly Specialist Rheumatology |
| 27Z - Adult Specialist Endocrinology |

Cancer

| |
|---|
| 01V - Biliary Tract Cancer |
| 01W - Liver Cancer |
| 01X - Penile Cancer |
| 41S - Surgical Sperm Retrieval |
| 41U - Urethral Reconstructive Surgery |
| 01R - Radiotherapy (adult) |
| 51R - Radiotherapy (paed) |
| 01S - SRS/SRT |
| 01K - Malignant Mesothelioma |
| 01Y - Other Rare Cancers |
| 01Q - Brain and CNS Cancers |
| 01Z - Testicular Cancers |
| 23A - Paediatric Oncology |
| 01T - Teenage & Young Adult Cancer |
| 41P - Prosthetic Penis Implants |
| 01J - Anal Cancer |
| 19V - Pancreatic Cancer |
| 33D - Distal Sacrectomy for Advanced/ Recurrent Rectal Cancer |

Blood & Infection

| |
|--|
| 18A - Infectious Diseases |
| 18E - Bone and Joint Infections |
| 03X - Haemophilia (Adult) |
| 03Y - Haemophilia (Paediatric) |
| 38T - Thalassaemia - Direct Clinical Care |
| 38Xhcc - Haemoglobinopathies (Coordination) |
| 38Xsht - Haemoglobinopathies (Teams) |
| 38S - Sickle Cell Disease - Direct Clinical Care |
| 02Z - BMT |

Trauma

| |
|---|
| 31Z - Highly Specialised Pain Management |
| 37C - Artificial Eye Services |
| 34R - Specialised Orthopaedic Revisions |
| 32D - Middle Ear Implants |
| 32A - Cochlear Implants |
| 34T - Major Trauma (Paeds) |
| 08Y - Neuropsychiatry |
| 08F - Neurosurgical Low Vol Procedures (Regional) |
| 08E - Neurosurgical Low Vol Procedures (Natl) |
| 23N - Specialised Ophthalmology (Paed) |
| 05C - Specialised Communication Aids |
| 05E - Specialised Environmental Controls |

Women's & Children's

| |
|---|
| 13X - Adult CHD (Non Surgical) |
| 13Y - Adult CHD (Surgical) |
| 15Z - Cleft Lip and Palate |
| 04C - Foetal Medicine |
| 36Z - Metabolic Disorders |
| 23Y - Highly Specialist Paediatric Pain Mgmt |
| E23 - Highly Specialist Paediatric Palliative care |
| 23B - Paediatric Cardiac Services |
| 23P - Paediatric Dental Surgery |
| 23D - Paediatric ENT |
| 23F - Paediatric Gastro HPB and Nutrition |
| 23Xb - Paediatric Gynae Surgery |
| 23H - Paediatric Haematology Services |
| 04G - Abnormally Invasive Placenta |
| 23M - Paediatric Neurosciences |
| 07Y - Paediatric Neurorehabilitation |
| 08J - Selective Dorsal Rhizotomy |
| 23Q - Paediatric Orthopaedics |
| PIC - Paediatric Critical Care |
| 23R - Paediatric Plastic Surgery |
| 23S - Paediatric Renal Services |
| 23T - Paediatric Respiratory Services |
| 23W - Paediatric Rheumatology Services |
| 18C - Infectious Diseases (Children) |
| 23Xa - Specialist Paediatric General Surgery |
| 23Z - Paediatric Urology |
| 35Z - Morbid Obesity (Children) |
| 04P - Complex Termination of Pregnancy |
| 17Zp - Specialist Allergy (Paed) |
| 16Y - Immunology for children with immunodeficiency |

Specialised Commissioning North West

| |
|--|
| Paediatric Oncology |
| Children's Cancer Services - Principle treatment centres, including the Operational Delivery Network |
| Children's Cancer Services - Paediatric Oncology shared care units |
| Teenage and young adult cancer services - principle treatment centre |
| Teenage and young adult cancer services - network specification |
| Teenage and young adult cancer services - designated hospital |

Mental Health

22E - Eating Disorders (Adult)

Commissioning Specialised Services for:

- NHS England
- NHS Cheshire and Merseyside ICB
- NHS Greater Manchester ICB
- NHS Lancashire and South Cumbria ICB

NHSE England Retained Specialised Services



Blood & Infection

| |
|--|
| 18T - Tropical Medicine |
| 18D - HTLV I & II |
| 14C - HIV (Children) |
| 38Snhp - Haemoglobinopathies (Nat Panel) |
| 02A - Cryopyrin Associated Periodic Syndrome |
| 02B - Diagnostic Svc for Amyloidosis |
| 18J - Adult HCID (Airborne) Service |
| 18L - Adult HCID (Contact) Service |
| 18U - Infectious Disease Isolation Units |
| 03A - Paroxysmal Nocturnal Haemoglobinuria |
| 16C - Severe Combined Immunodeficiency & Rel Disorders |
| 18M - Paed HCID (Contact) Service |
| 03T - Thrombotic Thrombocytopenic Purpura |
| P23 - Stem Cell Transplant for JIA |
| 18K - Paed HCID (Airborne) Service |

**Denotes services planned to transfer to ICBs from April 2027*

Internal Medicine

| |
|--|
| 12Z - Intestinal Failure* |
| 23G - Adult Ataxia Telangiectasia |
| 29G - Primary Ciliary Dyskinesia Mgmt (Adult) |
| 11A - Atypical Haemolytic Uraemic Syndrome |
| 12A - Autologous Intestinal Reconstructn (Adult) |
| 16B - Behcets Syndrome (Adult & Adol) |
| 29Q - Chronic Pulmonary Aspergillosis (Adult) |
| M23 - Complex Ehlers Danlos Syndrome |
| 11D - Encapsulating Peritoneal Sclerosis (Adult) |
| 24A - Epidermolysis Bullosa |
| 13N - Heart & Lung Transplantation |
| 13V - Ventricular Assist Devices |
| 43S - Stevens-Johnson Syndrome & Toxic Epidermal Necrosis |
| 27A - Insulin Resistant Diabetes |
| 19A - Total Pancreatectomy with Islet Autotransplant |
| 27B - Islet Cell Transplant (Adult) |
| 19T - Liver Transplant |
| 29C - Lymphangiomyomatosis (Adult) |
| 27C - Pancreas Transplant (Adult) |
| 01F - Pseudomyxoma Peritonei (Adult) |
| 13M - Pulmonary Thromboendarterectomy |
| 12D - Small Bowel Transplant |
| 24D - DNA Nucleoside Excision Repair Disorders |
| 39A - Gastroelectrical Stimulation for Intractable Gastroparesis |
| 33E - Cytoreductive Surgery and HIPEC for Colorectal Cancer |
| 13G - Adult Pulmonary Hypertension* |
| 29H - Alpha 1 Antitrypsin Services |
| 36E - Cystinosis |

Trauma

Specialised Commissioning North West

| |
|--|
| 06A - Spinal Cord Injuries* |
| 08U - TcMRgFUS |
| 37E - Limbal Cell (Holoclar) Treatment for Eye Injuries |
| 37D - Retinal Gene Therapy |
| 08B - Rare Neuromuscular Disorders Diagnosis |
| 29F - ECMO (Respiratory - Adult) |
| 40A - Hand and Upper Limb Transplant |
| 08D - Neuromyelitis Optica |
| 01H - Ocular Oncology (Adult) |
| 37A - Ophthalmic Pathology |
| 37B.- Osteo-Odonto Keratoprosthesis for Corneal Blindness |
| 32E - Auditory Brainstem Implants for Children |
| 28Z - Hyperbaric Oxygen Therapy |
| 09A - Specialised Burns (Adult)* |
| 09C - Specialised Burns (Paed)* |
| 43A - Inherited White Matter Disorders (Adult) |
| 05V - Veterans Prosthetic Services |
| Orthopaedic Surgery: Joint Preservation Surgery (adults)* |

Commissioning Specialised Services for:

NHS England
NHS Cheshire and Merseyside ICB
NHS Greater Manchester ICB
NHS Lancashire and South Cumbria ICB

Women's & Children's

| |
|--|
| 04K - Complications of Vaginal Mesh |
| 04L - Congenital Abnormalities of Female Genital Tract |
| F23 - Perinatal Postmortem & Pathology |
| 20H - Pre-Implantation Genetic Diagnosis |
| 20A - Alkaptonuria (Adult) |
| H23 - Alstrom Syndrome |
| 23J - Ataxia Telangiectasia (Children) |
| 16A - Autoimmune Paediatric Gut Syndrome |
| 20B.- Bardet Biedl Syndrome |
| 36A - Barth Syndrome |
| 36B - Beckwith-Widemann Syndrome with Macroglossia |
| D23 - Bladder Exstrophy (Children) |
| K23 - Complex Childhood Osteogenesis Imperfecta |
| 08A - Complex Neurofibromatosis Type 1 |
| B23 - Complex Tracheal Disease |
| N23 - Congenital Hyperinsulinism |

**Denotes services planned to transfer to ICBs from April 2027*

| |
|---|
| 15A - Craniofacial |
| 29D - Primary Ciliary Dyskenesia (Diagnosis) |
| R23 - ECMO (Respiratory - Neonates; Infants and Children) |
| 36F - CLN2 Disease |
| 36C - Lysosomal Storage Disorders |
| 26A - McArdles Disease |
| 20D - Mitochondrial Donation service |
| 08C - Neurofibromatosis Type 2 |
| 12B - Paediatric Intestinal Pseudo-Obstruction |
| 13J - Paediatric Pulmonary Hypertension |
| 36D - Rare Mitochondrial Disorders |
| 27D - Severe Acute Porphyria |
| 08M - Spinal Muscular Atrophy |
| 43C - Inherited White Matter Disorders (Child) |
| T23 - Multiple Sclerosis Management for Children |
| U23 - Open Foetal Surgery to Treat Foetuses with Spina Bifida |
| C23 - Specialist Paediatric Liver Disease |
| 44A - Gonadal Tissue Cryopreservation for CYP at High Risk of Gonadal Failure due to Treatment or Disease |
| 20C - Stickler Syndrome (Diagnosis) |
| A23 - Vein of Galen Malformation |
| Q23 - Wolfram Syndrome |
| 04U - Uterine Transplantation |
| 04J - Urinary Fistulae (Gynae) |
| 29P - Primary Ciliary Dyskenesia Management (Children) |
| 73M - Children's Epilepsy Surgery |

Mental Health

| |
|---|
| 24E - CAMHS (Under 13)* |
| 22Se - Low & Medium Secure (WEMS) |
| 22Sf - Low & Medium Secure (ABI) |
| 22Sg - Low & Medium Secure (Deaf) |
| 22F - Severe OCD & BDD |
| 22D - Specialised Mental Health (Deaf)* |
| 22T - Severe Personality Disorders |
| 24F - Medium Secure CAMHS* |
| 22Ua - High Secure MH |
| 22Ub - High Secure LD |
| 22G - Veterans PTSD |
| 22B - CAMHS (Deaf)* |
| 22V - Psych. Inpatient for Severe and Complex Unexplained Physical Symptoms |
| 22O - Offender Personality Disorders |
| Infected Blood Psychological Service (IBPS)* |

Cancer

| |
|--|
| 01O - Bone Sarcoma |
| 01L - Soft Tissue Sarcoma |
| 01P - PET-CT |
| 02C - CART and ATMPs |
| 01A - Breast Radiotherapy Injury Service |
| 01I - Choriocarcinoma Service |
| 01D - Ev-vivo Partial Nephrectomy |
| 01B - Proton Beam Therapy |
| 01G - Retinoblastoma |

Commissioning Specialised Services for:

NHS England
NHS Cheshire and Merseyside ICB
NHS Greater Manchester ICB
NHS Lancashire and South Cumbria ICB

Breakdown of Acute NHS Contract Spend 2026/27



Specialised Commissioning
North West

| NW Providers | C&M ICB £m |
|---|----------------|
| University Hospitals Of Morecambe Bay NHS Foundation Trust | 0.002 |
| Blackpool Teaching Hospitals NHS Foundation Trust | 0.259 |
| Lancashire Teaching Hospitals NHS Foundation Trust | 0.877 |
| East Lancashire Hospitals NHS Trust | 0.003 |
| L&SC ICB | 1.141 |
| Manchester University NHS Foundation Trust | 35.991 |
| The Christie NHS Foundation Trust | 31.558 |
| Northern Care Alliance NHS Foundation Trust | 10.232 |
| Bolton NHS Foundation Trust | 0.194 |
| Tameside And Glossop Integrated Care NHS Foundation Trust | 0.099 |
| Wrightington, Wigan And Leigh NHS Foundation Trust | 0.549 |
| Stockport NHS Foundation Trust | 1.667 |
| GM ICB | 80.291 |
| Wirral University Teaching Hospital NHS Foundation Trust | 24.565 |
| Mersey and West Lancashire Teaching Hospitals NHS Trust | 14.340 |
| Liverpool Heart And Chest Hospital NHS Foundation Trust | 97.601 |
| Alder Hey Children's NHS Foundation Trust | 133.450 |
| Mid Cheshire Hospitals NHS Foundation Trust | 7.263 |
| Liverpool University Hospitals NHS Foundation Trust | 97.003 |
| The Clatterbridge Cancer Centre NHS Foundation Trust | 106.261 |
| Liverpool Women's NHS Foundation Trust | 24.618 |
| The Walton Centre NHS Foundation Trust | 90.714 |
| East Cheshire NHS Trust | 1.878 |
| Countess Of Chester Hospital NHS Foundation Trust | 6.739 |
| Warrington And Halton Teaching Hospitals NHS Foundation Trust | 5.990 |
| C&M ICB | 610.422 |
| Total NW NHS Providers | 691.854 |
| Non-NW NHS Providers | 37.210 |
| Total NHS Providers | 729.064 |

Commissioning Specialised Services for:

- NHS England
- NHS Cheshire and Merseyside ICB
- NHS Greater Manchester ICB
- NHS Lancashire and South Cumbria ICB

Breakdown of Mental Health LPCs Spend 2026/27

| Mental Health LPC | Provider | £m |
|---|--------------------------------------|---------------|
| Secure and Specialised Mental Health (low & medium) | Mersey Care NHS FT | 73,423 |
| Tier 4 CAMHS | Cheshire & Wirral Partnership NHS FT | 12,361 |
| Specialist Perinatal Mental Health Services | Cheshire & Wirral Partnership NHS FT | 2,696 |
| Adult Eating Disorders | Cheshire & Wirral Partnership NHS FT | 3,496 |
| F-CAMHS | Pennine Care Partnership NHS FT | 0,479 |
| Reserves (including growth & b/f position) | | 0,008 |
| Total Expenditure | | 92,464 |

- ICBs contract with the Lead Providers
- Lead Providers then contract with NHS and Non-NHS providers to deliver the service for C&M population
- Any mental health growth is given to the Lead Providers
- Lead Providers have to manage within their contract and manage any financial risk

Commissioning Specialised Services for:

NHS England
 NHS Cheshire and Merseyside ICB
 NHS Greater Manchester ICB
 NHS Lancashire and South Cumbria ICB

Meeting of the Board of NHS Cheshire and Merseyside

28 May 2026

Report of the Chief Executive

Agenda Item No: ICB/05/26/16



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Working Together



Accountable

REPORT SUMMARY SNAPSHOT

| Required Information | Details | | | |
|---|--|-------------|---|-----|
| Responsible Executive Director | Liz Bishop | | | |
| Report approval | By | Liz Bishop | | |
| | Date | 18 May 2026 | | |
| Presented by | Liz Bishop | | | |
| Ask of the Board | Approval | | Decision | |
| | Endorsement | | Ratification | |
| | Receive assurance | ✓ | Note | ✓ |
| Route to Board – where has this report been discussed | n/a | | | |
| ICB Strategic Objective(s) the report relates to | Tackling Health Inequalities in access, outcomes and experience | ✓ | Improving Population Health and Healthcare | ✓ |
| | Enhancing Productivity and Value for Money | ✓ | Helping to support broader social and economic development | ✓ |
| Board Assurance Framework Risk(s) the report relates to* | P12 – Failure to reduce health inequalities and improve population health P14 – Failure to recover access and performance standards | | | |
| Financial Implications* | Yes | | No | ✓ |
| | If Yes: | | | |
| | Have the financial implications been reviewed by the Director of Finance | | | n/a |
| | Has a budget been identified | | | n/a |
| Legal Implications* | n/a | | | |
| Conflicts of Interest associated with this report | n/a | | | |
| Impact assessments undertaken* | Equality | | | n/a |
| | Quality | | | n/a |
| | Data | | | n/a |
| | Sustainability | | | n/a |
| Public or Clinical engagement undertaken | n/a | | | |



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Report of the Chief Executive (May 2026)

1. Introduction

- 1.1 This report covers highlights of the work which takes place by the Integrated Care Board at a senior level and also key developments in health and care for Board information which is not reported elsewhere in detail on this meeting agenda.
- 1.2 Our role and responsibilities as a statutory organisation and system leader are considerable. Through this paper we have an opportunity to recognise the breadth of work that the organisation is accountable for or is a key partner in the delivery of.

2. Ask of the Board and Recommendations

- 2.1 **The Board is asked to:**
 - **consider** the updates to Board and seek any further clarification or details;
 - **disseminate** and cascade key messages and information as appropriate.

3. Key Updates

Operating Model

- 3.1 The ICB has progressed the second phase of its workforce change programme, with the conclusion of the Consultation with Staff from VSM to Band 8C level. This has also included the conclusion of the second round of the ICB Voluntary Redundancy (VR) scheme. Colleagues who applied to the scheme have now been informed of the outcome, and supported exits are being taken forward in line with nationally agreed arrangements. By 31 May 2026 a further 20 ICB colleagues will have left the ICB after applying for and having been accepted for the VR Scheme. To those colleagues who are leaving, you leave with the thanks and gratitude of the ICB for your dedication to the NHS.
- 3.2 Following conclusion of the second phase of its workforce challenge we published our revised staffing structure inclusive of posts at Very Senior Manager (VSM) to Band 8C levels, and are currently progressing the process of aligning, slotting in or interviewing to fill any vacant posts. It is anticipated that the third phase of our management change, covering all Bands below Band 8C, will progress during June 2026 and as before there will be active engagement with staff in scope and Trade unions as we progress this.
- 3.3 At the end of April we also published our updated Operating Model (Appendix One) which has been developed and shaped following extensive engagement with staff and partners during February and March 2026. The Operating Model describes the vision for our organisation, our objectives and how we are organising ourselves from 01 April 2026. It summarises how we intend to deliver



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our role as strategic commissioner in Cheshire and Merseyside, by commissioning based on population need. It is also accompanied by a supporting document (Appendix two) that outlines the key planning footprints that we will work on to enable delivery of our new operating model.

- 3.4 Our commitment is to ensure that our values and behaviours underpin our work to establish our new-look organisation on a firm footing. We believe that the new operating model has set us up to be able to meet the ambitions and requirements of the 10 Year Health Plan, which set the national strategy to improve service delivery through integration, digital transformation and population health management.
- 3.5 We know that our staff are committed to responding to these challenges and developing a neighbourhood health model for Cheshire and Merseyside that delivers increasingly proactive, preventative care for the populations we serve. Additionally, the new operating model puts us in a strong position to deliver our new requirements as a strategic commissioner, whilst reducing the running costs of the organisation in line with the national mandate.

Developing our governance

- 3.6 The ICB is undertaking a staged and considered process in strengthening its governance, The way I work with my team and how we together engage, direct and empower our leadership is a key part of this organisation wide development.
- 3.7 Part of our work in this area involves the development of a strengthened Executive Committee. We envisage that our refocused Executive Committee will act as the central engine of ICB delivery and decision-making, with delegated authority for day-to-day management, commissioning decisions, and performance oversight.
- 3.8 When established we will report on proposals to the Board (in July 2026) seeking your support. I propose that this committee would (like any committee)
- provide assurance to the Board on statutory duties, commissioning, and system performance
 - oversees operational, financial, quality and strategic risks
 - acts as the key forum linking strategy to delivery, supported by executive sub-groups covering people, estates and risk and compliance.
- 3.9 I expect that these arrangements will enhance our assurance, risk and accountability. Over the next period we will seek to strengthen our approach to assurance and control across our operations by:
- considering clearer delegation limits and decision-making roles for commissioning, transformation and investment decisions
 - improved risk management integration (CRR and BAF alignment with the work programmes and focus of our committees)
 - enhanced NED involvement, including targeted task and finish oversight and in our commissioning development cycles.

Hantavirus - MV Hondius Repatriation (Arrowe Park)

- 3.10 Colleagues will be aware of the situation that occurred on the MV Hondius in relation to hantavirus. Twenty-two passengers from the MV Hondius were safely repatriated to the UK and received at Arrowe Park Hospital for a short period of precautionary isolation and clinical assessment, in line with UK Health Security Agency (UKHSA) guidance. All individuals were asymptomatic on arrival and have tested negative for hantavirus. Robust infection prevention and control arrangements were implemented within a self-contained facility, ensuring no impact on routine hospital services, which have continued to operate as normal.
- 3.11 Following initial assessment, a phased discharge process is now underway. Six individuals have been cleared to leave Arrowe Park after negative test results and absence of symptoms, and are continuing the remainder of a 45-day precautionary isolation period at home or in appropriate accommodation with ongoing monitoring and daily support from health protection teams. The remaining cohort continue to be asymptomatic and are expected to step down in a managed way, with onward travel and follow-up arrangements in place. The risk to the public remains assessed as very low by UKHSA.
- 3.12 This has been a well-coordinated, multi-agency response across the NHS, UKHSA, local authorities and emergency services, demonstrating strong system capability to manage complex public health incidents. On behalf of the system, we place on record our thanks to colleagues at Wirral University Teaching Hospital, and in particular the teams at Arrowe Park, for their diligence, professionalism and clinical expertise. Their swift and effective response provides clear assurance that robust, well-rehearsed arrangements are in place to protect patients, staff and the wider public while maintaining continuity of services.

Census of people with mental health, learning disability and autism services

- 3.13 The Board is asked to note the findings of the Mental Health, Learning Disability and Autism (MHLDA) inpatient census undertaken across Cheshire and Merseyside as at 31 March 2026. This work responds to national requirements to strengthen ICB oversight of inpatient placements, particularly those that are out of area or do not align with the national commissioning framework, and confirms that the ICB has visibility of all adult patients placed outside local NHS provision.
- 3.14 The census identifies a cohort of patients currently receiving care out of area or in non-framework placements and informs a clear programme of work to improve centralised oversight, strengthen discharge planning, expand community alternatives and support delivery of the system's ambition to end adult out-of-area placements by March 2028. More detailed information on the census findings, oversight arrangements and next steps is set out in **Appendix Three** to this report.

International Day of the Midwife

- 3.15 The ICB celebrated International Day of the Midwife on the 05 May 2026 and International Day of the Nurse on 12 May 2026. To mark both days the ICB hosted a celebratory coffee morning at Regatta Place, where we invited our nurses and midwives to spend time reflecting and celebrating their valuable contribution to patient care and support, through the vital role they play in ensuring the ICB fulfils many of its statutory responsibilities. The clinical voice of this workforce is essential to commissioning care that is safe, effective and positively experienced by our population.
- 3.16 The theme for International Nurses Day 2026 is **Our Nurses. Our Future. Empowered Nurses Save Lives**. As the largest clinical workforce in NHS Cheshire and Merseyside, the professional voice of nursing in designing and delivering services that provide the best outcomes for our population is vital. Staff who feel supported to raise issues of safety and are able to challenge poor practice where it occurs, deliver better outcomes for our population.
- 3.17 Through our commitment to organisational development and support, I want nurses and midwives in NHS Cheshire and Merseyside to feel that their welfare and contribution is valued, and that they feel empowered through working in an environment that enables them to operate to their full potential.

Waiting times continue to substantially reduce across Cheshire and Merseyside

- 3.18 The Cheshire and Merseyside Provider Collaborative (CMPC) Elective Reform and Transformation Programme continues to deliver substantial progress in reducing waiting times, with NHS Cheshire and Mersey ICB now the 14th highest performing ICB.
- 3.19 The latest 18 weeks' Referral to Treatment performance is 65% (unvalidated), building on significant improvements made in the latter part of 2025/26. At the start of May 2026, 4,278 patients were waiting more than 52 weeks - a drop of over 300 since April 2026 and a 68% decrease compared to April 2025 (-9,787 patients).
- 3.20 The number of patients waiting more than 65 weeks remains low, at less than 30. Again, this is the result of last year's considerable efforts to reduce from 1003 patients waiting more than 65 weeks in April 2025.
- 3.21 In the last month, the programme started to develop a Cheshire and Mersey Integrated Referral Model. This uses the principle: 'the right care in the right place at the right time' to improve the productivity of outpatient services, delivering care in alternative settings where clinically appropriate. This three-year programme will also help support delivery of NHS Medium Term Plan performance deliverables – achievement of 92% for 18 weeks and reducing Cheshire and Merseyside's waiting list by 150k by March 2029.

Cheshire and Merseyside Pathology East Hub goes live

- 3.22 Cheshire and Merseyside Pathology East Hub went live on 01 April 2026, as pathology staff from North Cheshire and Mersey NHS Foundation Trust successfully transferred to Mersey and West Lancashire Teaching Hospitals NHS Trust. A key milestone towards delivering a more resilient, sustainable pathology service across the system, this followed a comprehensive engagement and support process and was completed without disruption to patient care.
- 3.23 One of many projects underway in pathology designed to deliver the ICB's ambition to establish a sustainable pathology network providing safe and resilient diagnostics at scale, the East Hub is one of three adult pathology service hubs, each with the critical mass to sustain specialist expertise, standardise ways of working, deliver best value for money and support reliable service continuity.
- 3.24 A positive example of CMPC trust's collaborative working, the approach addresses risks linked to workforce fragility, isolated teams and unwarranted variation, enabling shared digital platforms and common processes across hubs.
- 3.25 Its successful staff transition supports the system shift from fragmented provision to one that is coordinated and networked, providing quality, patient flow and long-term financial sustainability, enabling future development of the wider pathology model.

CMPC's Urgent Community Response providers significantly reduce unnecessary hospital admissions

- 3.26 Integral to the CMPC's Community Programme is the national directive to move healthcare from hospital to community. In line with this aim, the CMPC programme team has been supporting the CMPC's Urgent Community Response (UCR) providers over the last twelve months.
- 3.27 UCR teams provide fast, emergency care to adults in their homes within two hours. Central to the CMPC's work has been a focus on increasing UCR referral rates, providing community-based alternatives for patients who can be treated without the need for hospital attendance and or, admission.
- 3.28 The latest data, published May 2026, shows a substantial level of success from this initiative, with the total number of accepted UCR referrals 5,197, representing a 92% increase from the same month last year. The percentage of referrals from the ambulance service also rose within the same timeframe, from 7% to 13%, representing avoided ambulance conveyances and potentially admissions.
- 3.29 Work continues in this manner, underlining the collective ability of CMPC providers to ensure that more people within Cheshire and Merseyside receive the right care, in the right place.

Dermatology Alliance - Faster Diagnosis Performance above national standard, plus progress towards Autonomous AI Pathways

- 3.30 In February 2026 the Cheshire and Merseyside Dermatology Alliance saw a significant step forward in Faster Diagnosis performance across Cheshire and Merseyside, with the latest data showing that the system has achieved 86%, well above the national standard of 80% and the highest level recorded since March 2024.
- 3.31 This positive trajectory reflects the impact of sustained operational improvements and targeted investment across the pathway. The introduction of the Skin Analytics AI pathway, achieved through CMPC trusts' collective funding bid, has played an important supporting role, helping to accelerate clinical decision-making, reduce unnecessary face-to-face appointments, and stabilise urgent care capacity.
- 3.32 Building on this momentum, Wirral University Hospital Trust went live with the autonomous AI pathway in April, bringing the total to five out of six Trusts across Cheshire and Merseyside now adopting this innovative model. This marks a major milestone in scaling AI-enabled care across the system.
- 3.33 Together, these improvements demonstrate how innovation and coordinated delivery are driving measurable gains, positioning the system on a strong footing as performance continues to improve.

Liverpool Place shortlisted for NHS Excellence Awards

- 3.34 Congratulations go to colleagues working in Liverpool Place, where a project that is preventing people's conditions from worsening and keeping them out of hospital has been [named a regional champion](#) in the first-ever NHS Excellence Awards. Liverpool Place was recognised for its innovative use of data to identify patients most at risk and offer early, coordinated support in their communities.
- 3.35 Support includes telehealth monitoring - a service that uses apps and smartphones to help manage conditions - alongside community respiratory specialists and integrated care teams, helping patients with conditions such as COPD, chronic kidney disease and frailty.
- 3.36 Figures show a 28% reduction in A&E attendances, a 36% drop in emergency admissions and a 34% fall in GP appointments among telehealth patients, while 87% of patients took up proactive COPD reviews.

Health Innovation North West Coast's – New Strategy

- 3.37 At the end of March, we saw the launch of Health Innovation North West Coast's (HINWC) new strategy, Powering the Future of Health and Care Innovation. Louise Robson, and Dr Phil Jennings, Chair and Chief Executive of HINWC describe this as an ambitious strategy that signals a decisive shift in the way HINWC works, building on existing experience and strengths within our region to deliver innovations that impact on people's health and wellbeing.

- 3.38 Through a focus on collaboration and partnership the strategy details how HINWC aims to:
- lead the adoption and spread of proven innovations
 - strengthen the pipeline of new ideas
 - build system-readiness for change
 - influence national policy with real-world insights
 - catalyse regional growth through advanced technologies and bioscience.
- 3.39 A summary of the strategy can be found at the following link [Health Innovation North West Coast - Powering the Future of Health and Care Innovation: our strategy 2026-2030](#) and we look forward to our continued partnership with HINWC, using research and innovation to improve the health of our population.

Adult ADHD Webpage - Patient Communications

- 3.40 The ICBs Adult ADHD Programme Team has strengthened patient communication by enhancing the Cheshire & Merseyside Adult ADHD webpage,¹ which is now used as a central point to manage patient queries and complaints.
- 3.41 Following the page's launch at the end of January 2026, feedback from the Experts by Experience group highlighted the need for further improved accessibility. In response, content has been simplified to a reading age of 9, overall complexity reduced and drop-down headings introduced to make the page easier to navigate.
- 3.42 A tailored "What happens if..." section has been developed to address common themes arising from queries and complaints and is reviewed regularly to ensure it remains up to date.
- 3.43 The self-help and education section has been added, with QR codes on each page to support patient feedback and continuous improvement. Our Experts by Experience group have also provided feedback to widen the range of resources provided.
- 3.44 As the new Adult ADHD model is rolled out across Cheshire and Merseyside, the team will continue to develop the webpage to reflect service changes and support a consistent, positive informed patient experience.

Knowing Me Profiling Tool and Digital form

- 3.45 The *Knowing ME* neurodiversity profiling tool is a co-produced tool designed to understand the strengths and needs of neurodiverse children and young people. The tool is a collaborative process between children and young people, their families and the professionals who work with them to identify how best to support children and young people to thrive. It is currently being rolled out in

¹ <https://www.cheshireandmerseyside.nhs.uk/your-health/adhd-services-for-adults/>

schools and education settings across Cheshire and Merseyside, with each area developing plans that fit their local areas. Children and young people do not have to wait for assessment or diagnosis to complete the tool, which means they can access tailored, needs-led support at a much earlier stage. The *Knowing ME* profiling tool user guide and videos can be found [here](#).

- 3.46 We are also very pleased to announce that the *Knowing ME* profiling tool is now available electronically. There is a training form to look at in advance and the main form to complete in the profiling tool meeting. You can find both forms [here](#). This means that key professionals, parents, carers and children and young people can now complete a form together to help capture the information about their strengths and needs. We would welcome all feedback to help us improve the digital form, so please share your thoughts by providing your feedback in the form [here](#) or by emailing louise.sinclair@alderhey.nhs.uk.
- 3.47 We are committed to making sure that the views of young people, families and stakeholders shape our work to improve services for neurodiverse children and young people. We want to hear about your experiences and what you think of the Cheshire and Merseyside *Knowing ME* profiling tool. Please click [here](#) to get involved!

NHS Trust Senior Leaders Health Literacy Programme

- 3.48 Working in partnership with NHS England, the Office for Health Improvement and Disparities and North Cheshire and Mersey NHS Foundation Trust, the ICBs Population Health Team successfully secured funding to deliver a Health Literacy training programme for Senior Leaders working in NHS Trusts across Cheshire and Merseyside.
- 3.49 Each Trust was allocated two spaces on the programme, the nominated individuals were then provided with a one-hour online introduction to health literacy followed by a half-day in person session, both sessions were delivered by Dr Mike Oliver a Health Psychologist.
- 3.50 The programme initially sought to increase senior leaders' awareness of what health literacy is and how it can impact on a range of NHS priorities including patient safety, inappropriate use of services, medication compliance, increasing self-management, reducing DNAs, tackling waiting lists, cost savings, improving patient outcomes and reducing health inequalities.
- 3.51 The programme then focused on how the senior leaders in the room can enable their organisation to become health literate organisation through key changes to organisational leadership, staff inductions, training staff in teach-back and reviewing written materials.
- 3.52 Key examples of good practice were shared at the sessions for other parts of England including how one NHS Trust has reduced the size of their MRI leaflet from seven pages to two by creating an easy read version of the leaflet for all patients achieving significant cost savings in printing and postage. We will now

be working with Trusts across Cheshire and Merseyside to implement some of these changes as part of the NHS Prevention Pledge programme.

Work on Children's Asthma

- 3.53 Beyond (NHS Cheshire and Merseyside's Children and Young People's Transformation Programme) continue to support colleagues across Cheshire and Merseyside to access training on Children and Young People's (CYP's) asthma, supporting delivery of [NHSE's Bundle of Care](#).
- 3.54 Respiratory training is being delivered across Primary Care and community settings, recognising that the majority of CYP with asthma are managed in Primary Care. Beyond also delivers the BeatAsthma Tier 3 face-to-face CYP asthma training, targeted training for 0–19 and community nursing teams and will soon be launching Children & Young People Asthma Bitesize lunch and learn sessions. All training is open to any health care professional working with CYP with asthma and responds directly to national learning that shows that a lack of a personalised asthma action plan (PAAP) can be a contributing factor in the [National Child Mortality Database report \(2024\)](#). To date, 35 health care professionals have completed Tier 3 training, with 1,039 practice and PCN staff trained across the wider programme.

All Together Smiling – Cheshire and Merseyside Supervised Toothbrushing Programme

- 3.56 Participation in the All Together Smiling supervised toothbrushing programme for children aged 2-7 in CORE20 communities has continued to increase. 306 childminder, early years, and primary school settings were participating by the end of March 2026 with over 15,200 children now taking part in daily toothbrushing. This means that the programme has now achieved a significant milestone, with more than 50% of eligible childminder, early years, and primary settings across Cheshire and Merseyside now taking part. This level of participation marks an important tipping point, with evidence showing that programmes of this scale can begin to deliver measurable reductions in tooth decay among children and young people.
- 3.57 Oral health pack distribution is also ongoing, with over 382,000 packs (toothbrush, fluoride toothpaste, and key message leaflet) provided to children at highest risk of decay. Recent distribution has focused on CORE20 'PLUS' communities including children supported by Social Care, asylum seeker and refugee families, home educated children and traveller communities and through CORE20 General Dental Practices, Community Dental Services, and specialist settings for children with special educational needs and disabilities (SEND) and more - helping to reinforce positive habits at home and ensure every child has access to the essentials they need to care for their teeth.
- 3.58 The programme is also launching a 'Smile Month' campaign across partners and participating settings communications channels this month – sharing original content containing key information and guidance on oral health.



Compassionate



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Working Together



Accountable

Early success and recognition regarding Cheshire and Warrington WorkWell Children and Young People pilot

- 3.59 Further to the Board report received in September 2025 on the Cheshire and Merseyside Work and Health Strategy and Get Britain Working Plans, the WorkWell Children and Young People (CYP) pilot in Crewe represents a tangible early implementation of the strategy’s priorities, particularly the focus on young people, NEET prevention, population health inequalities and system integration.
- 3.60 As previously endorsed by the Board, this work aims to improve health and economic outcomes through earlier, coordinated intervention across education, health, local government, DWP and the VCFSE sector, supporting the wider ambitions of All Together Fairer and the system’s role as an anchor institution. A conservative estimate of life-time public cost of each NEET exceeds £50,000. Every year group across Cheshire and Warrington has approximately 1,000 young people at risk of dropping out and we currently (Feb 2026) have 8,960 16- to 24-year-olds claiming Universal Credit.
- 3.61 The ICB-funded pilot in Crewe has demonstrated the practical impact of this approach. Eight months after intervention, 93% of young people identified as being at high risk of disengagement remained in education, employment or training, directly contributing to the priority areas set out in both the Get Cheshire & Warrington Working Plan and the Get Liverpool City Region Working Plan, particularly support for young people and prevention of long-term economic inactivity. Importantly, this has been achieved by better coordinating existing services rather than creating new provision, reinforcing the Board’s earlier discussion on value for money, cost avoidance and whole-system benefit.
- 3.62 The programme has now received external national recognition, winning the Liverpool Hope Prize for Outstanding Achievement in Social Mobility at the Educate North Awards (May 2026), providing independent validation of the model first outlined to the Board in 2025. This award underlines the strength of the system-wide collaboration described in the September 2025 report and supports further consideration of scalable interventions that align with the agreed Work and Health governance arrangements, population health reporting through All Together Fairer, and the ICB’s strategic objectives on inequalities, productivity and broader social and economic development.

Whole Systems Approach to Healthy Weight

- 3.63 Leeds Beckett University has been commissioned to deliver the Whole Systems Approach to Healthy Weight development programme. Public health teams from all nine Local Authorities have accessed training and are mapping their local healthy weight system. The mapping will enable them to identify causes of unhealthy weight and prioritise sub-systems for action. Social network analysis will give Local Authorities an understanding of the current network of partners who are working on healthy weight to support collaborative approaches.

- Six training sessions delivered to colleagues nominated by Public Health leads across all nine Local Authorities. Fifty-one colleagues attended at least one session, with 18 participants completing all six sessions.
- Nine system mapping workshops have been delivered with five workshops delivered in 2025/26 and four in 2026/27.
- Nine system maps are in development which will create a visual representation of the healthy weight system in each Local Authority.

3.64 A social network analysis survey will map connections across the healthy weight system. The findings will be used to create a visual map of relationships between individuals and organisations, helping to better understand the current network and the connectivity driving this work.

Make the switch – communications campaign

3.65 NHS Cheshire and Merseyside’s Communications and Engagement Team, and Medicines Management Team, have developed a creative communications campaign - ‘Make the switch’:

www.cheshireandmerseyside.nhs.uk/MakeTheSwitch

3.66 This is an awareness and behaviour-change campaign focused on supporting patients to switch to using more readily available and cost-effective medication options – in support of the ICB’s financial recovery programme and wider NHS priorities around cost-effective prescribing.

3.67 The campaign launched in May 2026 across ICB and system partner channels, supported by a digital and roadside advertising campaign. The campaign content aims to raise awareness of the need to action more cost-effective prescribing, as well as using existing insight to tackle common barriers to switching medications, and includes materials targeting both patients and frontline and prescribing staff.

Celebrating a major Anchor Institute milestone

3.68 The Cheshire and Merseyside Anchor Institute has [marked an important milestone](#), celebrating 50 organisations signing up to the Anchor Framework. This achievement reflects the growing commitment across our region to harness the power of anchor institutions in reducing inequalities, improving population health, and strengthening our local communities.

3.69 The event held on 24 March 2026 brought together partners from across the NHS, local government, public health, employment services, the voluntary sector, and beyond. Attendees had the opportunity to connect, share learning, and explore how we can collectively create greater social, economic, and environmental value.

All Together Smokefree

- 3.70 Cheshire and Merseyside's All Together Smokefree programme, led by Champs Public Health Collaborative, is launching a new phase of the Smoking Ends Here campaign: Stop for Good. This is an insight-led, population level, multichannel campaign designed to reach smokers across Cheshire and Merseyside. It launches 26 May 2026, incorporating cinema advertising, television, radio, out-of-home, and targeted digital activity designed to direct our audience to the [Smoking Ends Here website](#). It highlights the emotional harm caused by smoking, focusing on the impact it has not just on the individual but on their family, friends and loved ones. The campaign aims to raise awareness of the benefits of quitting, encourage quit attempts, and connect individuals with accessible support services in our local area. The campaign places a strong emphasis on long-term success, recognising that quitting smoking is rarely a single event but a journey that may involve multiple attempts. Today's film for the Board shows the launch film of the campaign.
- 3.71 This follows the recent launch of another phase of the Smoking Ends Here campaign, targeting routine and manual workers. People in occupations such as construction, retail and logistics are more likely to smoke than the general population. This new campaign is designed to resonate with this group, featuring content they can relate to and offering tailored support to help them quit.
- 3.72 The All Together Smokefree programme has publicly supported the [passing of the Tobacco and Vapes Bill](#), which has now received Royal Assent, paving the way for the first smokefree generation. Our young people from across Cheshire and Merseyside have joined public health leaders in supporting the Bill, including members of the Merseyside Youth Association, who have previously attended Parliament to share their views directly with policymakers.

Executive Committee Activity

- 3.73 Across March and April 2026, the Executive Committee has concentrated its efforts on actions that contributed toward stabilising the organisation including closing 2025/26 in financial balance at ICB level, strengthening governance and grip and system leadership moving into 2026/27.
- 3.74 Key coverage across the period included:
- Delivery of 2025/26 financial duties
 - Establishment of a Single Improvement Plan (SIP) as the primary response to enforcement undertakings, with clear executive ownership and reporting
 - Management of delivery and risks through 2026/27, particularly in relation to system deficits, medicines costs and delivery of CRES and transformation
 - Progression of strategic transformation programmes, including urgent and emergency care, estates, digital enablement and neighbourhood health
 - Executive oversight of quality, safeguarding and workforce matters, including effective multi-agency responses where required.



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3.75 Finance and Performance

2025/26 Year-End:

- The ICB delivered a £30k surplus, meeting the revised NHS England break-even control total, subject to audit.
- The wider ICS reported a £288m deficit excluding Deficit Support Funding (DSF), against a planned £178m deficit (c. £110m adverse), reflecting ongoing provider pressures.
- CRES delivery totaled £130m against a £139m target, recognised by the Executive Committee as a significant achievement given system context.
- Several providers regained access to DSF following submission of compliant plans, improving overall system resilience.
- Draft Annual Accounts and Annual Report have been submitted and reviewed at Executive and Audit Committee level, with final approval scheduled for June 2026.

3.76 2026/27 Financial Outlook

- The system enters 2026/27 with **residual financial risk**, including:
 - Increased CRES requirement
 - Anticipated continued medicines cost growth
 - Limited headroom for unmanaged in-year pressures.

3.77 Enforcement Undertakings and Governance

Single Improvement Plan (SIP)

- A Single Improvement Plan has been endorsed by the Board and is now embedded as the primary mechanism for delivering and assuring against enforcement undertakings.
- Executive Committee approved a SIP framework that provides leadership, oversight and reporting on SIP activities
 - Recognises the established executive leadership for each domain
 - Monthly RAG-rated reporting covering scope, milestones, risks and dependencies
 - PMO-led synthesis with Executive oversight prior to external reporting
- Initial assurance ratings identify several domains as Amber, largely due to organisational change, which may clarify / shift ownership and transition risks rather than lack of progress.
- Work is underway to:
 - Introduce benefits tracking, not just process assurance
 - Clarify evidential requirements needed to exit undertakings.

3.78 Quality, Safety and Safeguarding

Significant Safeguarding Event – Cheshire East

- On 29–30 April 2026, Executive Committee oversaw NHS contribution to a major multi-agency, police led, safeguarding operation in Crewe, involving:
 - Identification of a number of vulnerable children
 - Arrests related to allegations of modern slavery, sexual assault and trafficking
 - Extensive deployment of NHS safeguarding, primary care, mental health, and 0–19 services
- NHS staff worked extended hours under significant operational and public-order risk.

- The Committee **formally recorded and wishes to convey its thanks** to all NHS colleagues involved and noted continued recovery-phase activity.

3.79 Transformation and Strategic Programmes

Urgent and Emergency Care (UEC)

- The Committee considered the UEC Strategic Plan whose development had been overseen and endorsed by the system UEC Board. It provides:
- A clear focus on frailty, urgent community response, community beds, mental health crisis pathways and children and young people's urgent care.
- Delivery focused on alignment with emerging neighbourhood health and place-based models.

3.80 Left-Shift Transformation Investment

- The system's £100m recurrent left-shift fund (over three years) has been reconfirmed as a strategic change opportunity
- Board expectations reiterated at Executive Committee:
 - A small number of major, system-level business cases
 - Tangible shifts toward out of hospital care
 - Measurable impact on quality, performance and system deficit
- ND pathways work has already met the transformation criteria and as such is ring-fenced;
- Urgent care and Tier-2 out-of-hospital workstreams are progressing.

3.81 Digital Enablement and Productivity

- Executive Committee considered the potential opportunities provided by digital platforms as an enabler for neighbourhood-level integrated care.
- The Committee supported further development subject to:
 - Neutral, robust procurement and governance
 - Broad partner engagement (NHS, local authorities, VCFSE)
 - Controlled pilots before any commitment
- Further governance and decision making points are expected

3.82 Estates and Infrastructure

- PACE plans for all 31 CHP buildings have been considered, with all classified as core estate.
- Occupancy and data validation exercises are underway, with refreshed plans due by end Q1 2026/27. This aligns with the need for a NHSE, short term, multiagency neighbourhood return being facilitated by the ICB and which is due during Q1.
- Estates governance is being reviewed alongside the wider operating model refresh.

3.83 Workforce, Transition and Organisational Change

- Voluntary redundancy rounds for this stage of management of change are complete, with transition support arrangements in place across Places.
- Pan-place leadership arrangements are operating to ensure continuity during organisational change.
- Draft Operating Model has been refined and released following staff and partner feedback.

- Workforce pressures remain challenging alongside management of change in specific services notably All-Age Continuing Care.

4. APPENDICES

Appendix One: NHS Cheshire and Merseyside Operating Model

Appendix Two: NHS Cheshire and Merseyside Operating Model – key planning footprints

Appendix Three: Inpatient Census Summary

5. Officer contact details for more information

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Chief Executive

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Operating Model

April 2026



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Foreword

NHS Cheshire and Merseyside has a critical role to play as a strategic commissioner in the local health and care system. Overseeing NHS services for a population of 2.7m people, we must ensure that our c£8bn annual budget delivers maximum value for local communities – helping to improve health both now and in the future, reduce inequalities and improve access to consistent, high-quality care.

The Model ICB Blueprint published by NHS England in May 2025 clarified the core purpose of all Integrated Care Boards but also initiated a challenging process of organisational change which requires us to streamline NHS Cheshire and Merseyside to its core functions and reduce the running costs of the organisation to £19 per head of population.

As a result, the Board must agree a new operating model for the organisation which both meets this challenge and ensures NHS Cheshire and Merseyside is best-placed to lead delivery of the key priorities of the national 10-Year Health Plan in 2026-27 and beyond.



Chair
Sir David Henshaw

Foreword (continued)

We believe this will be best achieved through a neighbourhood health model that delivers increasingly proactive, preventative care and builds on the strengths of our communities. To enable this model, we must transform how we work, align with the new national NHS operating model and strengthen collaboration with our partners.

Change is essential.

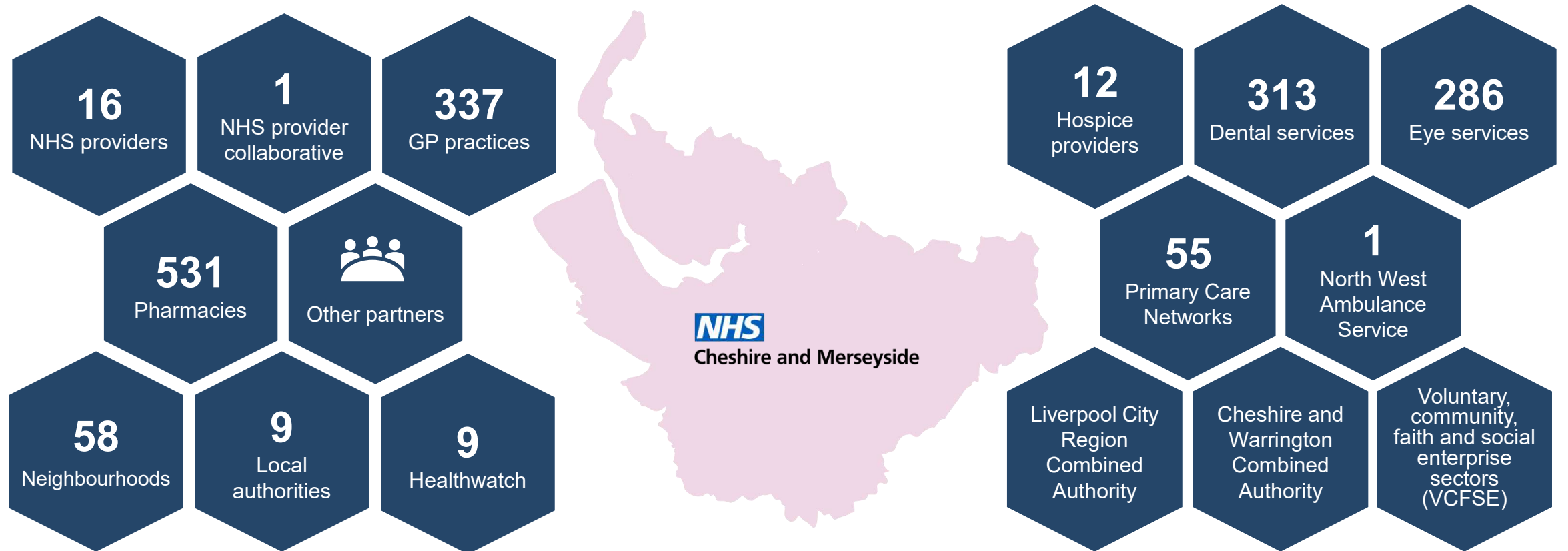
This document summarises our operating model and explains how we intend to deliver our role as a strategic commissioner. It has been updated to reflect feedback from staff, partners and stakeholders about how we will discharge our functions and accountabilities.

We look forward to working with you as we implement this model for Cheshire and Merseyside.



**Chief Executive
Liz Bishop**

Supporting 2.7m people across Cheshire and Merseyside



How our vision and values shape how we work

Chapter 1

Our vision and mission

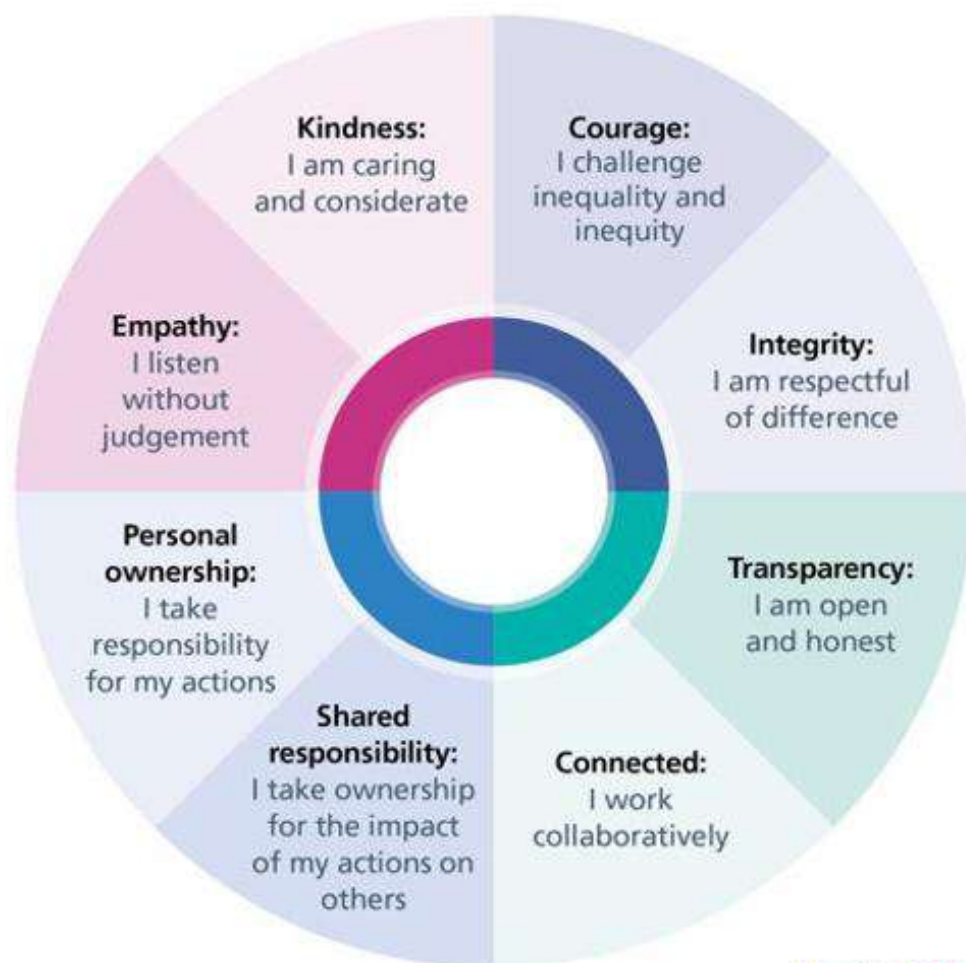
We want everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live healthier for longer.

To enable this, we will help to prevent ill-health and tackle health inequalities to improve the lives of the poorest fastest. We believe this can be best achieved by working in partnership.

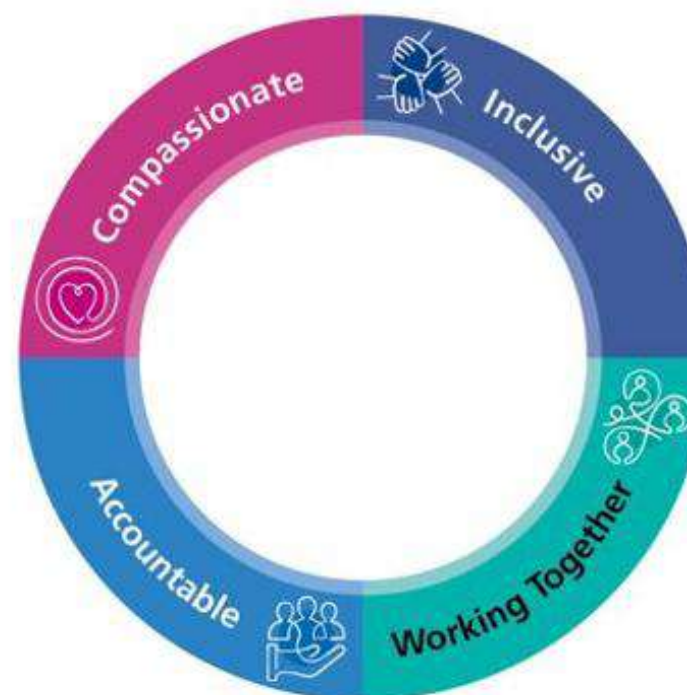
Delivery of our vision and mission is supported through our Strategic Objectives (see image - right).



Our behaviours:



Our values:



Our principles:



Leading **integration** through **collaboration**

Strategic commissioning as a whole organisation responsibility

Chapter 2

What is ‘strategic commissioning’?

As defined in the national Strategic Commissioning Framework, “strategic commissioning is a continuous evidence-based process to plan, purchase, monitor and evaluate services over the longer term and with this improve population health, reduce health inequalities and improve the equity of access to high-quality healthcare.”

Strategic commissioning is key to enabling the NHS to secure improvements in access, care, quality and greater value for money by delivering the 10 Year Health Plan’s three strategic shifts for the NHS – from sickness to prevention, hospital to community and analogue to digital.

To find out more, the national Strategic Commissioning Framework is available to view here: <https://www.england.nhs.uk/long-read/strategic-commissioning-framework/#2-what-is-strategic-commissioning>



NHS Cheshire and Merseyside's role

NHS Cheshire and Merseyside will act as a system convenor, architect and steward - embracing strategic leadership to shape the future of healthcare services for our residents in line with the [10 Year Health Plan](#).

In developing this operating model, we recognise that we are at the beginning of the journey to being an effective strategic commissioner and will need to rapidly strengthen our capability - both as an organisation and through working with partners.

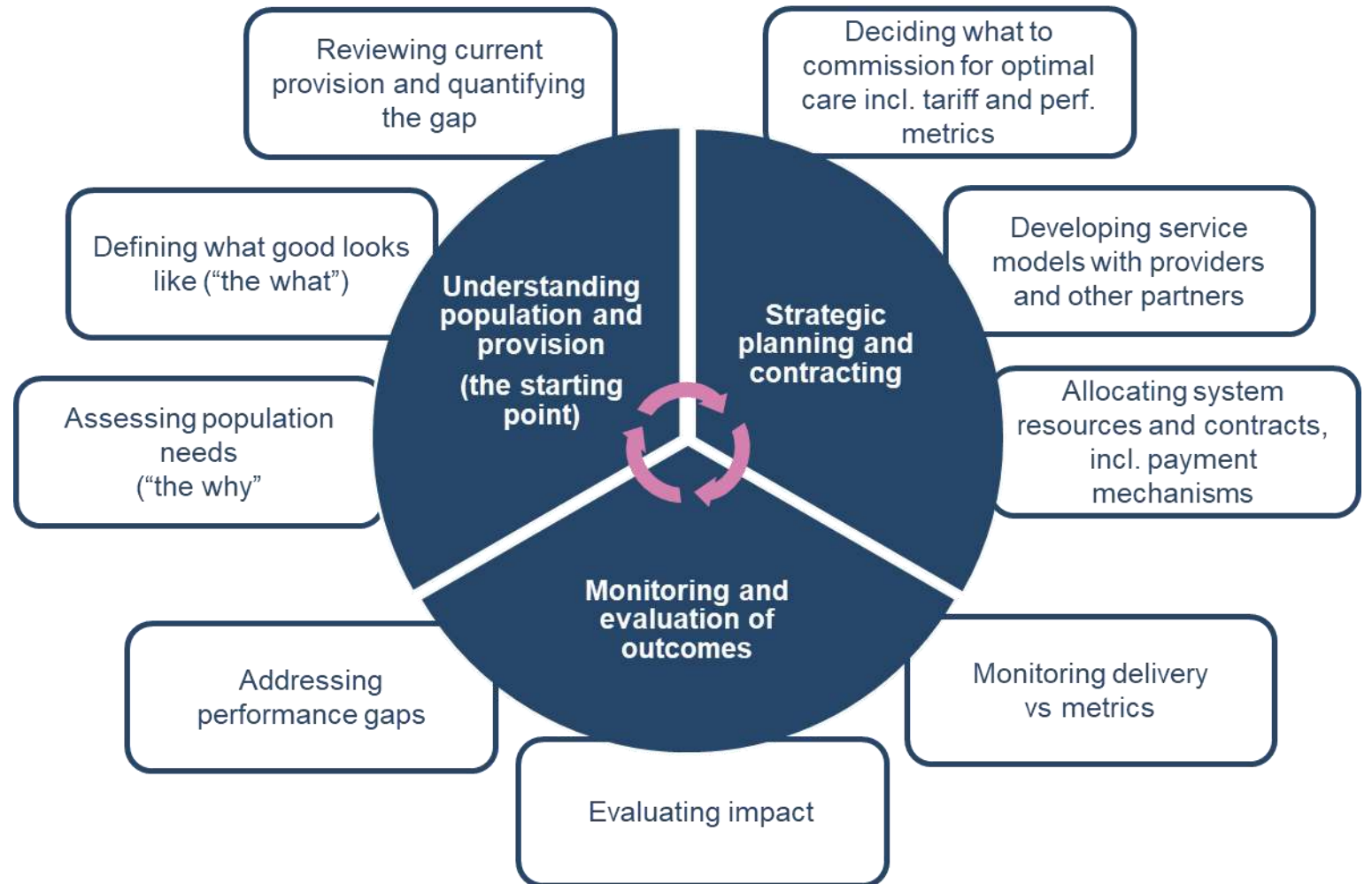


Our approach to strategic commissioning

Our team will commission based on **population need** at the most appropriate level for the population, service or partnership.

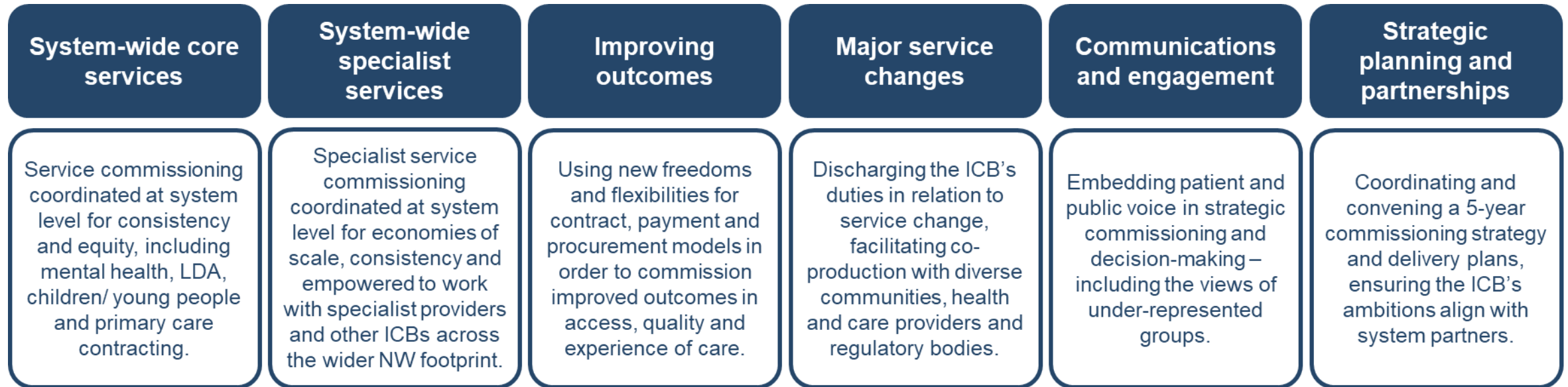
This may be:

- Across the North West region
- Across the whole Cheshire and Merseyside system
- Across local NHS footprints
- Across Combined Authority footprints (Liverpool City Region / Cheshire and Warrington)
- Across local authority footprints



Working at system level

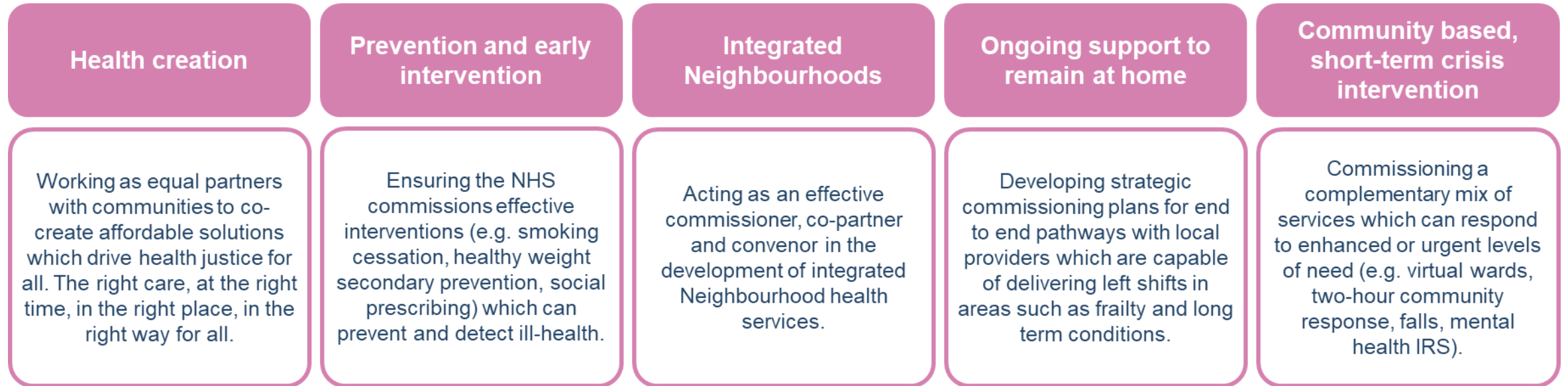
Our focus at Cheshire and Merseyside level will be on services which require consistency of approach to reduce unwarranted variation – for example with regard to core and specialist services, major service change and strategic partnerships:



Greater use of a population health management approach to planning.
Testing new models of integrated contracting with providers and partners (IHO/MNP).
Engagement, co-production and evaluation with our VCFSE colleagues and communities themselves.

Keeping it local

At local-level, our team will work in agile ways as part of local strategic commissioning partnerships, focusing on; health promotion, prevention and early intervention, integrated neighbourhoods and care at home and in the community:



Respond to the needs of our different neighbourhoods and communities.
Joint commissioning with local authorities through strategic commissioning partnerships.
Engagement, co-production and evaluation with our VCFSE colleagues and communities themselves.

Clinical leadership

Our clinical leadership model will be refreshed to bring clinical colleagues even closer to the commissioning process - while staying true to Clinical and Care Professional Leadership framework principles and our Clinical and Care Constitution.

Our revised model will feature clinical and care professional leads working at system, local NHS footprint and neighbourhood levels. We will also work closely with clinical networks and Provider Collaborative professional groups, including Directors of Nursing and Medical Directors.

At system level, clinical leads will be aligned to each of our strategic clinical priorities and will be integral members of commissioning teams - supporting the development of neighbourhoods and primary care.

We will have an advisory model for pharmacy, optometry and dentistry and, within our neighbourhoods, Clinical and Care Professional Leaders will work in an integrated way alongside Primary Care Network clinical leads.



Strategic partnerships with local authorities



How we will organise ourselves to deliver our work

Chapter 3

Our design principles – one organisation, one team, one way of working

Governance and alignment

- Clinically-led and user-informed
- Strategic alignment to Model ICB Blueprint, Model Region and neighbouring ICBs
- Transfer of duties over time, with effective risk management
- Transparency and accountability

Delivery and structure

- Lean workforce at all levels
- Organisational structure which reflects new portfolio-based approach
- Retain a connection in all Cheshire and Merseyside localities
- Embed digital and data-driven decision-making

Transformation and priorities

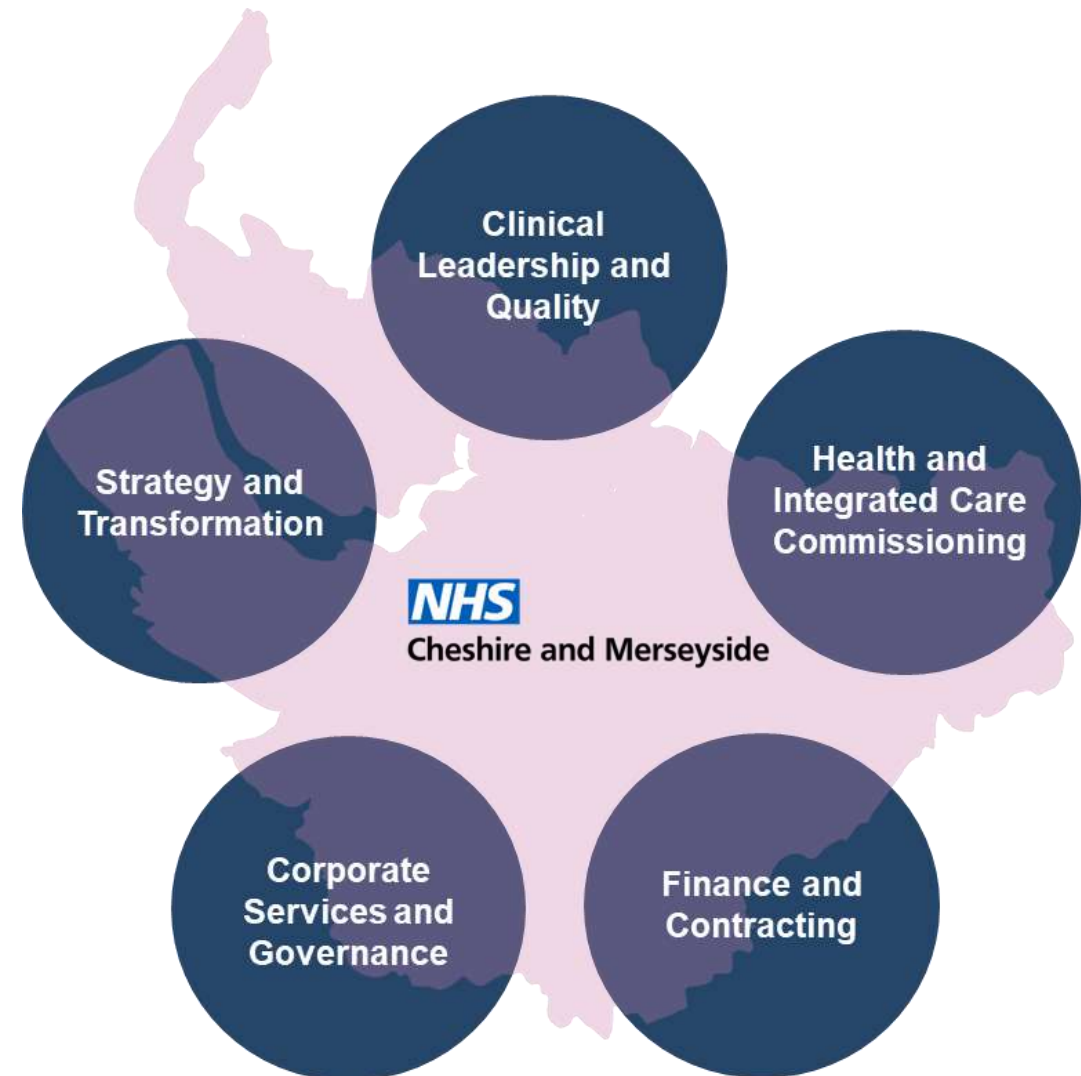
- Strengthen strategic commissioning capability
- Prioritise Primary Care and Integrated Neighbourhood healthcare
- Deliver the four national ICS strategic intentions
- Retain highly skilled staff committed to the pursuit of continuous improvement
- Financial sustainability and value for money
- Workforce development and OD principles

Our revised portfolios

Our new operating model will be delivered through a portfolio-based approach, working in close collaboration with system partners.

The Integrated Care Board will comprise of **one team** delivering five portfolios - each driving delivery through multi-disciplinary collaboration across NHS Cheshire and Merseyside and its partners to enable effective partnership working, streamlined decision-making and alignment with system-wide objectives.

Our People function will report into the Chief Executive and include workforce, learning and development, organisational development and staff engagement.



Clinical Leadership and Quality

Functions / areas of accountability

- Quality assurance, patient safety and experience
- Safeguarding (adults and children)
- Special Educational Needs and Disabilities (SEND)
- All Age Continuing Care and Individualised commissioning
- Learning Disability and Autism
- Medicines management and optimisation
- Digital leadership, transformation and delivery
- Strategic analytics, business intelligence and data science
- Caldicott Guardian
- Research and Innovation
- Clinical Governance and clinical policy oversight and development
- Strategic clinical leadership for medical, dental, pharmacy and ophthalmology professionals

Key delivery plans

- Clinical and Strategic Commissioning Plan
- Population Health Improvement Plan
- Quality Governance Framework

Clinical Leadership and Quality portfolio

Monitor clinical outcomes and drive multi-disciplinary approach to continuous improvement with commissioning and provider teams



Discharge duties re safeguarding, children in care, corporate parenting and court of protection



Oversee safe, effective and value for money use of medicines

Develop and implement digital strategies that enable innovation, improve service delivery and support transformation



Provide advice on evidence, best practice and outcomes for strategic commissioning teams working across both system and locality footprints



Discharge duties re All Age Continuing Care and Individual Commissioning. Ensure best quality and value from commissioned services

Health and Integrated Care Commissioning

Functions / areas of accountability

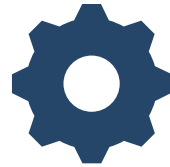
- Strategic commissioning for integrated services and cross-border flows
- Specialised commissioning
- Mental health, learning disabilities and neurodiversity commissioning and improvement
- Primary care commissioning
- Population health management and forecasting
- Health inequalities
- System mobilisation and delivery of the ICB's commissioning strategy
- Integrated working and neighbourhood development (with local authorities and partners)
- Partnership development and system design
- New ways of commissioning – Integrated Health Organisations and new contractual models
- National strategic commissioning framework – assessing and development

Key delivery plans

- 5 year Clinical and Strategic Commissioning Plan
- Population Health Improvement Plan
- Primary Care Access Plan

Health and Integrated Care Commissioning portfolio

Oversee, shape and support the development of health and care providers to ensure services are available, high-quality, sustainable and responsive to the needs of the population



Build trust, support transformation and ensure services reflect the needs and priorities of communities across Cheshire and Merseyside

Deliver commissioning priorities in local footprints for services which need to be tailored to the specific needs of localities / neighbourhoods



Where appropriate, deliver commissioning priorities on a consistent basis for the whole population - working with multiple providers and partners

Strategy and Transformation

Functions / areas of accountability

- Turnaround strategy and strategic planning
- Turnaround delivery
- Turnaround performance, improvement and assurance
- Major service change and reconfiguration
- Strategic programmes and transformation delivery
- Programme Management Office
- Provider development and Provider Collaboratives
- System convening
- Delivery of local response to capacity and demand pressures
- Operational planning
- Urgent care improvement
- Cost Improvement Plans
- Emergency Preparedness, Resilience and Response (EPRR) and Accountable Emergency Officer (AEO)

Key delivery plans

- Turnaround Strategy
- Cost Improvement Plans

Strategy and Transformation portfolio

Monitor and manage system and turnaround performance as a key function, ensuring strategic objectives are met and accountability for delivery



Convene partners to address complex challenges and develop and deliver plans for shared priorities



Ensure effective delivery of key projects, programmes and transformation initiatives across NHS Cheshire and Merseyside and the wider system

Finance and Contracting

Functions / areas of accountability

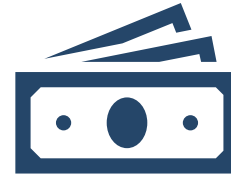
- Finance
- Contracting
- Procurement
- Financial strategy and improvement
- Planning and performance
- Resource planning and allocation
- Contract management and oversight
- Strategic financial development
- Financial governance
- Operational finance delivery
- Financial sustainability
- Strategic capital planning

Key delivery plans

- Financial Plan

Finance and Contracting portfolio

Discharge our financial duties for the use of public resources through strategy and planning, resource allocation, value for money and budget setting



Support the Integrated Care Board's ambitions to use new forms of contracting, procurement and market management approaches to deliver its objectives

Lead the development of a long-term system-wide approach to infrastructure which delivers the strategic commissioning priorities of the Integrated Care Board

Corporate Services and Governance

Functions / areas of accountability

- Corporate governance
- Risk management
- Information Governance
- Freedom to Speak Up
- Health and Safety
- Legal
- Business support
- Communications and Engagement
- Estates
- Data protection
- Senior Information Risk Owner (SIRO)

Key delivery plans

- Board Assurance Framework
- Involvement Plan
- Estates, Infrastructure and Capital Strategy

Corporate Services and Governance portfolio

Strategic oversight, development and implementation of robust governance and decision-making.

Lead on governance and leadership improvement plan. Facilitate effective Board and Committee structures, ensuring clarity of roles, robust reporting and clear information flows



Strategic support to the Chair and CEO's Offices. Oversight of progress and delivery against executive portfolios and core objectives. Equitable, centrally-managed business and administration support model across all executive portfolios

How we will work with our partners

Chapter 4

How we will work with our partners

We will work closely with partners to deliver the 10-Year Health Plan including:

Cheshire and Merseyside Provider Collaborative and local NHS Trusts

Re-designing care to make hospital care more effective and affordable. Improving outcomes through better access, flow and use of digital tools. Working together to re-design services across the system.

Primary care

Developing new, collaborative ways of working together to shape local services, share data and invest in prevention - putting clinical leadership and community insight at the heart of change.

Local government

Working together to develop neighbourhood health plans and on statutory responsibilities such as SEND and safeguarding.

VCFSE

Improving population health and ensure local people receive the right support at the right time. Address health inequalities, promote community engagement and reach diverse and under-served groups.

Our communities

Empowering people and communities to better understand issues, harness their will for change and work together to develop solutions for the future.

Our commitment to develop and support our people

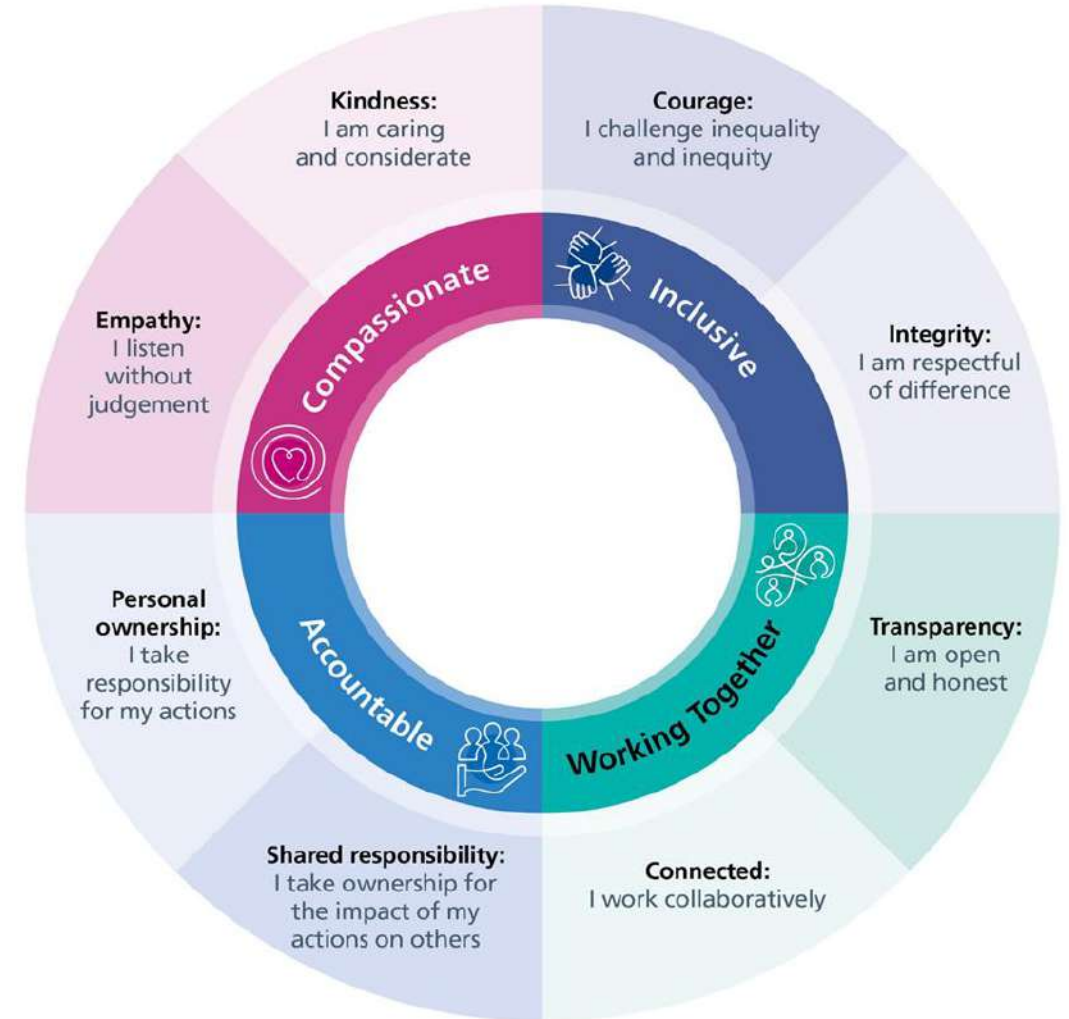
Chapter 5

Supporting people through change

Our values and behaviours will underpin all of our work to establish our new operating model on a firm footing.

We recognise that we must support and invest in our people to guide the organisation through a challenging period of organisational change and create the confidence to fulfil our roles as strategic commissioners.

This will include strengthening leadership, team effectiveness and commissioning capabilities, while ensuring all staff feel included and supported at work.



A phased approach to organisational development

The foundations

- Clear leadership
- Developing and implementing a new operating model
- Clarity about the different roles, responsibilities and functions of the ICB, NHSE and health and care providers
- Organisational and staff development needs identified
- Delivery of Single Improvement Plan in response to NHSE enforcement undertakings

Building capability

- Clear lines of accountability, assurance and governance
- Transparent decision-making systems and processes
- Build the skills and professional identity of strategic commissioners
- Work with key strategic commissioning partners to develop opportunities
- Establish consistent routines for performance, learning and continuous improvement
- Embrace the diversity of our workforce as a key strength

Transformation

- High-performance culture with continuous learning and improvement
- Strengthen strategic commissioning partnerships and adopt new contracting models
- Grow capability across the system through shared leadership and collaboration
- Effective application of evaluation and learning insights
- Collaboration and co-production with communities
- Embed digital and data-driven decision-making

Our commitments



Visible leadership,
transparent
communication and
engagement



Confirm structures,
roles and
accountabilities through
consultation with staff



Support induction into
new directorates and
teams



Provide clarity on roles,
priorities and ways of
working



Develop teamwork and
collaboration



Support staff health and
wellbeing

Find out more

Chapter 6

Links to useful documents

- [NHS Cheshire and Merseyside Five-year Clinical and Strategic Commissioning Plan](#)
- [NHS Cheshire and Merseyside Five-year Population Health Improvement Plan](#)
- [Cheshire and Merseyside Integrated Health Needs Assessment 2026 \(Interim\)](#)
- [10-Year Health Plan for England](#)
- [National Strategic Commissioning Framework](#)
- [National Neighbourhood Health Framework](#)

Delivering our Operating Model

Key planning footprints

May 2026



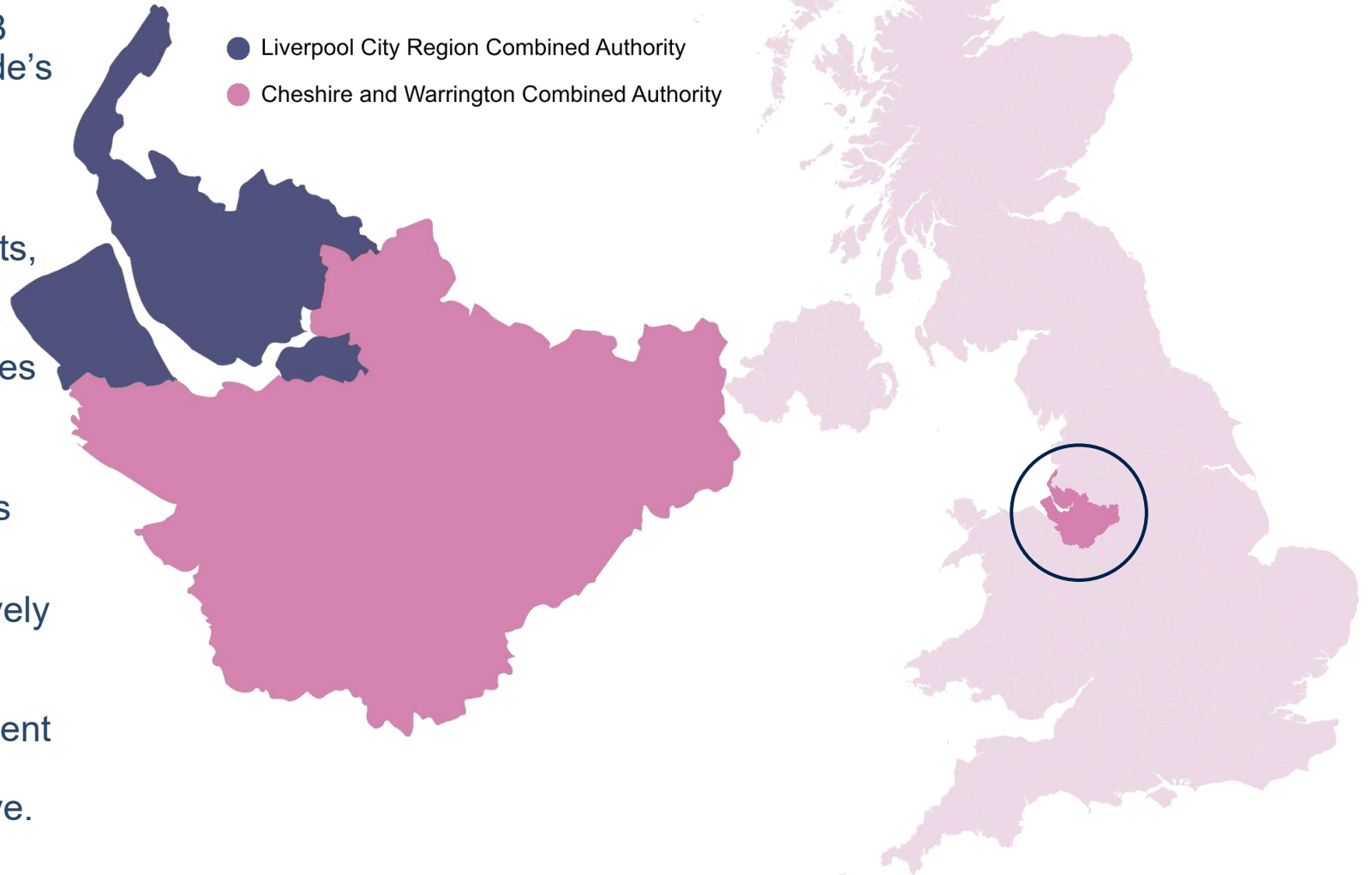
Working with combined authorities and local authorities

In response to NHS England's Model ICB Blueprint and the mandated reduction in ICB running costs, NHS Cheshire and Merseyside's Operating Model moves away from the previous structure of Place Directors and teams focussed solely on 'Place'.

Our teams will work across different footprints, whilst maintaining named senior staff who - within their responsibilities - will provide key points of contact for both combined authorities and each of our nine local authorities.

We have given thoughtful consideration to collective priorities and where we must focus our resources.

Our structures will enable us to work effectively with our partners to discharge our statutory responsibilities, develop integrated commissioning, population health management and provide increasingly proactive and preventative care to the populations we serve.



Liverpool City Region*

Mid Mersey – ONS population 811,842

NHS Trusts:

- Mersey and West Lancashire
- Wirral University
- Wirral Community
- Mersey Care
- Cheshire and Wirral Partnership

Neighbourhoods per local authority footprint:

- Knowsley – 4 Neighbourhoods
- St Helens – 4 Neighbourhoods
- Halton – 2 Neighbourhoods
- Wirral – 6 Neighbourhoods

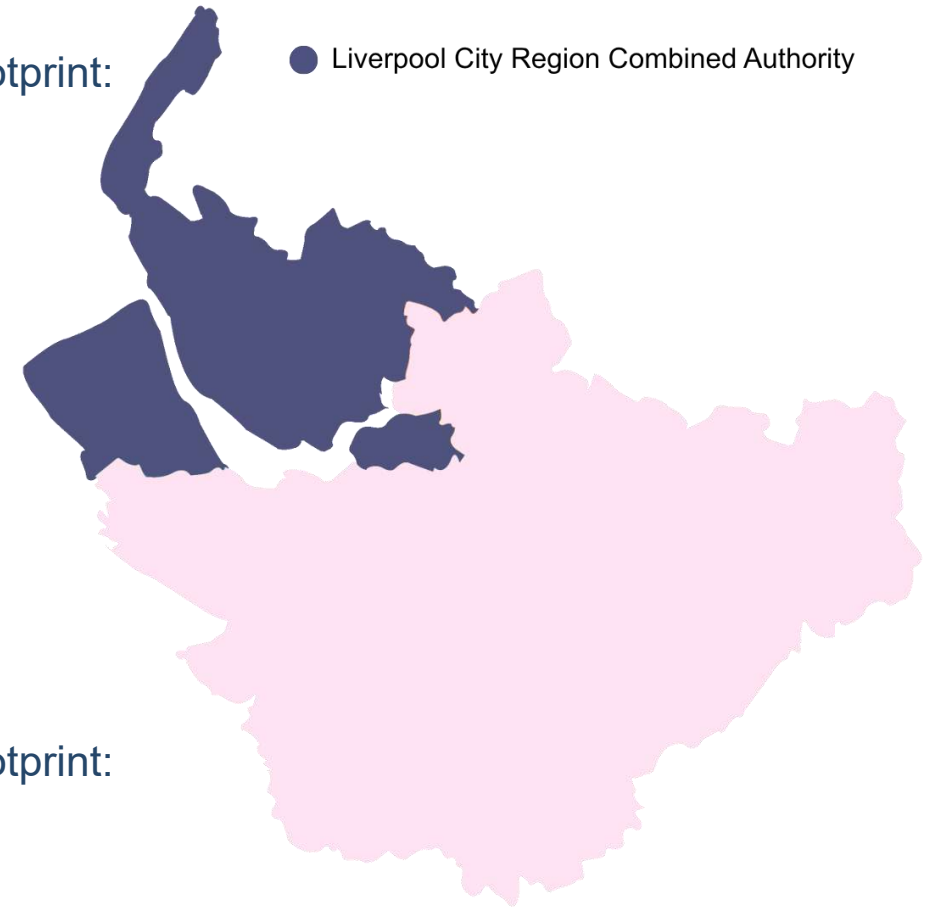
North Mersey – ONS population 795,242

NHS Trusts:

- UHLG (LUHFT, LWH, Liverpool Heart and Chest)
- Clatterbridge
- Walton Centre
- Alder Hey
- Mersey Care

Neighbourhoods per local authority footprint:

- Liverpool – 13 Neighbourhoods
- Sefton – 8 Neighbourhoods



Cheshire and Warrington*

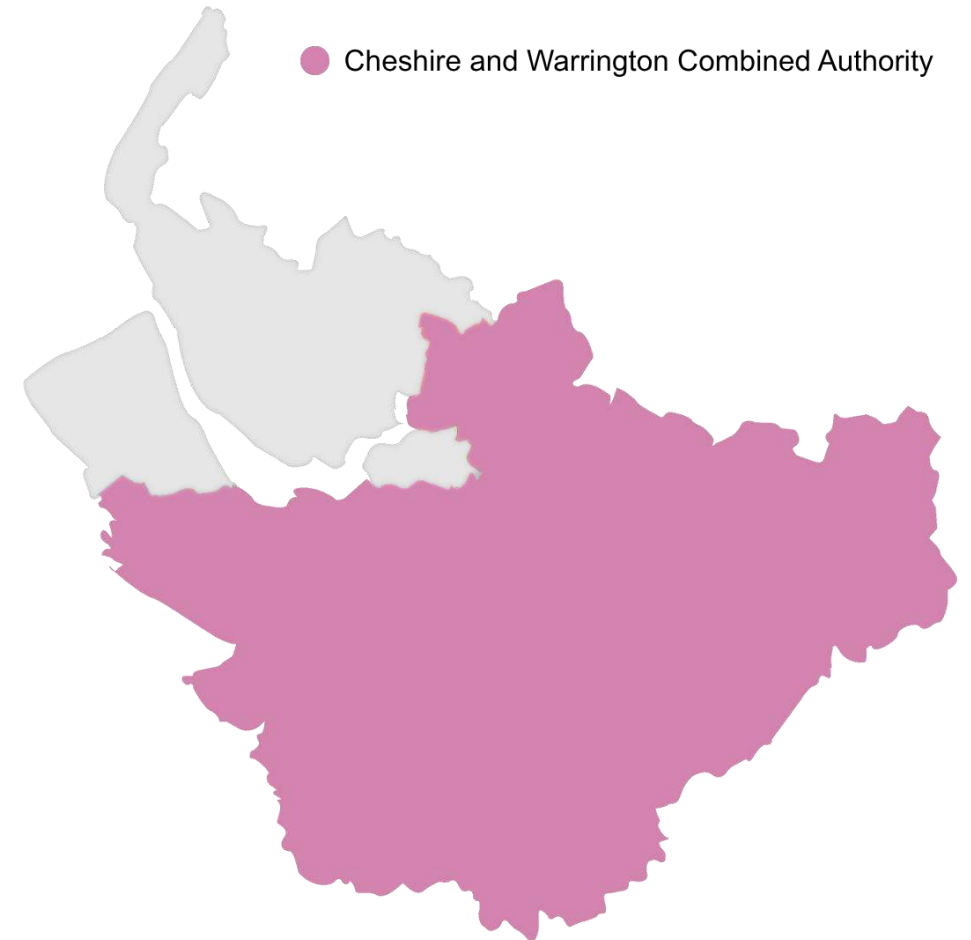
Cheshire and Warrington – ONS population 1,008,341

NHS Trusts:

- East Cheshire
- Mid Cheshire
- Countess of Chester
- North Cheshire and Merseyside
- Cheshire and Wirral Partnership
- Mersey Care

Neighbourhoods per local authority footprint:

- Cheshire East – 8 Neighbourhoods
- Cheshire West – 9 Neighbourhoods
- Warrington – 4 Neighbourhoods



*The ICB Operating Model is intended to provide clarity on how we will work and engage with partners and stakeholders. We recognise that patient flows and the communities that our NHS providers serve may cover different and/or additional geographical footprints..

How we will continue to work with our partners

We will continue to review governance arrangements to identify transformation opportunities and improve integrated working with partners, including:

Cheshire and Merseyside Provider Collaborative and local NHS Trusts

Re-designing care to make hospital care more effective and affordable. Improving outcomes through better access, flow and use of digital tools. Working together to re-design services across the system.

Primary care

Developing new, collaborative ways of working together to shape local services, share data and invest in prevention - putting clinical leadership and community insight at the heart of change.

Local government

Working together to develop neighbourhood health plans and on statutory responsibilities such as SEND and safeguarding.

VCFSE

Improving population health and ensure local people receive the right support at the right time. Address health inequalities, promote community engagement and reach diverse and under-served groups.

Our communities

Empowering people and communities to better understand issues, harness their will for change and work together to develop solutions for the future.

Appendix One Census of people with mental health, learning disability and autism services, 31st March 2026

1. Background

- 1.1 NHS England's Quality Committee met in January 2026 in response to serious quality and safety concerns uncovered at St Andrew's Healthcare – Northampton. The Committee approved several recommendations that seek to ensure that Integrated Care Boards (ICBs) have more robust oversight of all patients placed in mental health, learning disability and autism (MHLDA) inpatient services, especially out of area, and are delivering on their 3-Year Plans to localise and realign MHLDA inpatient care.
- 1.2 In March 2026, NHS England (NHS E) North West region emphasised the requirement to deliver on the ambition to only commission services in line with the National Inpatient Commissioning framework from 2027/28, as outlined in the Medium-Term Planning Framework (MTPF). This means in practice the ending all Out of Area placements and locked rehabilitation by March 2028.
- 1.3 To support this strategic intent there has been an urgent national request to clearly identify and understand how many people are in hospital settings that do not align with the ICB's 3-year plan, including:
- people in adult acute (including Psychiatric Intensive Care Units (PICU)) and rehabilitation Out of Area placements, regardless of whether they are considered inappropriate or appropriate
 - people in locked rehabilitation

The above includes people with a learning disability and autistic people.

- 1.4 NHS E have also asked that, by the end of Quarter 1 of 2026/27, all ICBs public boards have been updated on their intention to achieve the MTPF commitment, including:
- assurance that the ICB knows where all their adult patients who have been placed Out of Area are currently receiving care.
 - confirmation that the ICB will end all adult OAPs by March 2028 (adult Acute, PICU and Rehabilitation).
 - the ICB MHLDA Inpatient QTP Implementation Plan Year 3 (2026/27)

2. Inpatient Census summary

- 2.1 On 31st March 2026 all MHLDA inpatients from Cheshire and Merseyside (C&M) were collated into a centralised list, through a series of meetings with NHS Cheshire and Merseyside, the Cheshire and Merseyside Mental Health Programme and provider representatives from Mersey Care NHS Foundation Trust and Cheshire and Wirral Partnership (CWP) NHS Foundation Trust.
- 2.2 The outcomes from this census are that:

- There were 167 adults receiving inpatient care outside of Mersey Care and CWP. This number excludes children and young people and those on specialised commissioning pathways (i.e. secure services). Of these 167 people, 17 had a learning disability or autism diagnosis.
- The 167 people were placed across 31 placements (1 NHS hospital placement and 30 hospital placements in the independent sector). Of these 31 placements, 21 were outside of the Cheshire and Merseyside footprint, meaning 41 people were placed at a distance from their home, families and support networks.
- Of the 167 people, 17 people (5 male, 11 female) were in a placement receiving adult acute mental health care. Of these people 16 were from the CWP footprint and 1 person was from Mersey Care footprint. Despite some of the hospital placements being outside of the C&M footprint, it was reported that 16 (from CWP) were appropriately placed out of area as continuity principles could be applied.
- Out of the 167 people, 2 people were receiving specialist adult acute mental health care for people with a learning disability and autistic people. Both people were placed inappropriately out of area.
- There were 51 people who were inpatient receiving Level 1 Mental Health Rehabilitation. Of these people, 46 were placed in area within Alternative Future Group's C&M contracted provision, 1 person was in another hospital outside of C&M and 1 person was in a Level 1 rehabilitation unit within C&M footprint.
- For Level 2 Mental Health Rehabilitation, 63 people were inpatient receiving this level of care across 11 locations, 6 of which are out of area. This means that 16 people were placed outside of the C&M footprint.
- For services that are not described in the Commissioning Framework, 34 people were in such environments and 14 of these people were in placements that are outside of the C&M footprint. The breakdown of the needs of these people is as follows:
 - 5 people were reported to be inpatient due to their Acquired Brain Injury,
 - 14 people (all female) were receiving specialist intervention for their complex emotional and relational needs in a Personality Disorder provision,
 - 1 person was placed for needs relating to Dementia,
 - 1 person for needs relating to an Affective Disorder,
 - 1 person due to needs associated with being autistic
 - 1 person for intervention for needs associated with an eating disorder
 - 11 people were reported to be in 'locked rehabilitation' within the independent sector.

In summary, on 31st March 2026, 61 people from C&M were either out of area or placed in an inpatient unit that is outside of the Commissioning Framework.

3. Oversight arrangements

- 3.1 All the people placed in a MHLDA inpatient setting on 31st March 2026 were known to NHS Cheshire and Merseyside, one of our commissioned providers (CWP or Mersey Care) or, in most cases, both. The mechanisms to support oversight of individual cases and joint working varied at a locality level due to historical commissioning processes and ICB information technology (IT) systems. For example, both ADAM and Broadcare are used in different localities and therefore it is not easy to have centralised oversight of all people.
- 3.2 Individual cases are reviewed and case managed differently in the different providers and localities. Some of the intelligence and oversight has sat with individual place commissioners, some of these individuals have left NHS C&M due to voluntary redundancy and some may still move position within the re-structure.
- 3.3 There was a consensus that it is a priority to have a C&M centralised list of all people in inpatient care, to address data quality issues and to improve reporting through financial systems. A dedicated group from NHS C&M, local authorities and providers is needed to review individuals and support them to move out of hospital or to a local inpatient setting, where quality can be assured.

4. Supporting localised care

- 4.1 NHS Cheshire and Merseyside's Board has already approved a three-year Inpatient Quality Transformation Plan. For the last two years, the C&M system has been working on 3 key areas to maximise local inpatient capacity and a support a shift to the left to provide more preventative care and reduce reliance on MHLDA inpatient provision, these are:
 - *Improving the quality of the inpatient offer*- this has included the implementation of the culture of care programme within Mersey Care and CWP, reducing restrictive practice, and embedding the early warning signs and "I and We" statements in the ward accreditation process and quality schedules. This has also included implementation of inpatient guidance to improve the therapeutic offer, and through providing a better quality of care, and improved inpatient experience we are supporting people to recover and leave hospital more quickly.
 - *Improving the flow through inpatient care*- this has included embedding the 10 high impact initiatives across services and utilising Multi Agency Discharge Events (MADE) and SuperMADE meetings to enable system escalation and resolution of barriers to discharge when somebody is clinically ready. Multiple improvement programmes have been implemented to streamline processes and there has been investment in discharge co-ordination resource. Through the improvement of flow through inpatient

services, CWP have seen a significant reduction in inappropriate acute out of area placements and extra contracted appropriate acute out of area provision.

- *Improving community alternatives*- this has included commissioning HACT in C&M to support with strategically planning to address housing needs for people who access MHLDA services and practical housing actions to prevent people becoming clinically ready for discharge. The development and implementation of community rehabilitation teams within providers has seen a decrease in demand for inpatient rehabilitation and much more robust oversight and review of people in rehabilitation placements out of area. This MHLDA Inpatient Quality Transformation Programme has also closely aligned to the Urgent and Emergency Care (UEC) and crisis pathways, community mental health developments, such as 24/7 neighbourhood mental health centres, the Transforming Care workstreams for LDA and the community mental health transformation, including the whole system offer.

4.2 There is already a plan in train to address the people who are placed within adult acute mental health settings outside of CWP and Mersey Care. As noted, only 1 person of the 17 were in a placement where the continuity of care principles could not be applied. The 16 people from the CWP footprint have a dedicated team to support repatriation and discharge at the earliest opportunity. Similarly, the 2 people in adult acute mental health services for people with a learning disability or autistic people, are reviewed and supported via the Transforming Care Programme and are supported through the Care and Treatment Review process.

4.3 The majority of the people who were in a MHLDA inpatient bed outside of C&M on 31st March 2026 were in a mental health Level 1 or Level 2 rehabilitation placement (69%), or in inpatient settings that are outside of the commissioning framework (20%). These individuals are in scope for the C&M strategic mental health rehabilitation programme.

4.4 NHS C&M and system partners have an established programme of work to improve local care pathways for people with mental health rehabilitation needs. A plan has been developed and agreed to prioritise and address the following:

- *Centralised oversight of all inpatient rehabilitation placements* - this action is building upon the development of the C&M inpatient census list and exploring processes to ensure that information is updated at least monthly. This work is also scoping on how the finance flows can support the automation of reporting, including activity and costs, and exploration of the different oversight and review processes across providers and NHS C&M, to identify any unwarranted variance and plans to strengthen collaborative system oversight.
- *Determine the number of rehabilitation inpatient beds needed to be commissioned post April 2027* - using the demand and capacity modelling tool completed by Whole System Partnership, scenarios will be tested

alongside intelligence from the inpatient census. This will include a deep dive into the commissioned MHLDA beds that are outside the Commissioning Framework, and a review of the outcomes that have been realised through the development of community mental health rehabilitation teams. This action will support the identification of the required bed base and the setting of trajectories for reaching those targets.

- *Determine the local Providers of Level 1 and Level 2 inpatient rehabilitation Services to be commissioned* - this action will follow the bed modelling and will focus on ensuring there are consistent definitions of Level 1, Level 2 and 'locked rehabilitation' and a review of locally commissioned providers to determine which have the best outcomes (including quality, flow and addressing inequalities). This will also focus on the locations inpatient provision may be required that will serve that population's health needs and promote citizenship and explore robust commissioning arrangements that would support quality assurance and continuity of care.
- *Strengthen rehabilitation access pathways and commissioning processes* - the strategic group has already shared rehabilitation inpatient access assessment and agreement processes, with a plan to have a C&M wide approach, including a system wide escalation process to address any requests for commissioning outside of the commissioning framework. This action focuses on strengthening least restrictive rehabilitation interventions, maximising best use of resource and will support the maintenance of the centralised list.
- *Development of Rehabilitation Specification and Key Performance Indicators* - by Quarter 3/Quarter 4, 2026/27 it is planned that there will be an overarching C&M specification for Mental Health Rehabilitation, with robust key performance indicators to monitor outcomes.
- *Wider community pathway development* -the strategic group will harness mental health rehabilitation clinical, operational and strategic expertise to support the development of forensic, LDA, Complex Emotional Relational Needs and Acquired Brain Injury community pathways to prevent commissioning rehabilitation inpatient placements that are outside of the commissioning framework. This will include the development of joint working protocols and further scaffolding of community rehabilitation services, alongside community system partners such as local authorities and the voluntary community faith and social enterprise (VCFSE) sector.

4.5 CWP and Mersey Care are also collaborating to standardise their mental health rehabilitation offer and address any unwarranted variation in clinical or operational delivery. Building on the evidence within CWP's business case for Mental Health Intensive Support Team (MHIST expansion), including the improved offer for people with complex emotional and relational needs who are currently in hospital outside of C&M and the commissioning framework, opportunities are being explored to spread the approach throughout Cheshire

and Merseyside via stronger provider collaboration and potential budgetary responsibility.

5. Conclusion

- 5.1 There are many people who are placed in MHLDA inpatient care outside of C&M, largely outside locally commissioned pathways of care. NHS C&M is aware of all adult patients who have been placed outside of CWP and Mersey Care. Through the programmes of work described above, further improvements are required to establish collaborative centralised oversight and robust review.
- 5.2 NHS C&M is committed to delivering our three year their Inpatient Quality Transformation Plan, ending all adult out of area placements by March 2028 (adult Acute, PICU and Rehabilitation). NHS C&M is committed to only commissioning in line with the MHLDA Commissioning Framework by April 2027 and will ensure that there is dedicated capacity and focus to support this, working with partners from the C&M MH Programme, providers, local authorities and the VCFSE.

Meeting of the Board of NHS Cheshire and Merseyside

28 May 2026

ICB Financial Position – Month 1

Agenda Item No: ICB/05/26/17



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ICB Financial Position – Month 1

1. Purpose of the Report

- 1.1 This report provides an update to the Board on the financial performance of Cheshire and Merseyside ICB at Month 1 2026/27.

2. Executive Summary

- 1.2 Due to national system constraints, the 2026/27 ICB budgets cannot be uploaded into the financial ledger until May 2026 (Month 2).
- 1.3 As a result, the availability of robust financial data at Month 1 is limited, and reported performance is based on high-level assumptions and early intelligence.
- 1.4 In recognition of these constraints, NHS England has requested a reduced Month 1 financial submission. This focuses on:
- A high-level assessment of the overall financial position against plan; and
 - An update on Cost Reduction and Efficiency Scheme (CRES) delivery.

3. Financial Position as at Month 1

- 3.1 The ICB is reporting a breakeven position at Month 1, based on a number of planning assumptions and early indicators, summarised below.
- **Acute Services:** Elective activity is expected to be below plan, primarily due to the impact of industrial action.
 - **Adult Continuing Care (AACC) and Mental Health Packages:** Expenditure is broadly in line with plan, with the exception of a small shortfall in CRES delivery.
 - **Community Services:** Spend is in line with plan, reflecting the predominance of block contract arrangements.
 - **Mental Health Contracts:** Forecast remains in line with plan, on the basis that Indicative Activity Plans (IAPs) relating to ADHD are being finalised and incorporated within contracts.
 - **Prescribing:** Expenditure is reported in line with plan; however, April data will not be available until June 2026.
 - **Delegated Primary Medical Services:** Currently reported in line with plan, pending confirmation of national allocations associated with the revised GP contract.

- **Other Primary Care Services:** Financial plans are aligned to agreed contractual positions, including Local Enhanced Services, Out of Hours provision, and GPIT.
- **Pharmacy, Optometry and Dental (POD):** An underspend is currently reported, reflecting lower activity levels seen in the previous year. Final contract values and national uplifts are yet to be confirmed.
- **Running Costs and Programme Budgets:** Expenditure is reported in line with plan, supported by contract changes effective from 1 April and savings delivered through agreed voluntary redundancy schemes.
- **Provider Contracts for 2026/27:** Good progress has been made on the agreement of provider contract values and signing of contracts. There is one contract in mediation, and the outcome is anticipated shortly.

3.2 There is a small shortfall in CRES delivery at Month 1 (see Appendix 1), primarily relating to the phased delivery of unidentified schemes.

- 3.3 This shortfall is currently offset by timing differences, including:
- Delays in investment decisions; and
 - Early-year underspends across certain budget areas as described above.

4. Risks & Mitigations

4.1 The key financial risks at Month 1 remain consistent with those identified during the 2026/27 financial planning process.

- 4.2 They include risks relating to:
- Provider activity plans including Independent Sector do not deliver required RTT improvements which results in further funding required to deliver additional activity.
 - Non-Elective over-performance is above planned contingency.
 - Prescribing/High-Cost Drugs expenditure is above local horizon scanning e.g. in year price changes/Tirzepatide increases.
 - AACC/MH & Complex Packages of Care cost increase above local planning assumptions (complexity and price inflation).
 - ADHD continues to grow due to increase in demand including expansion of IS providers in the market under Right to Choose.
 - CRES schemes do not deliver efficiencies required in year.
 - Outcome of contract mediation.

4.3 Mitigating actions are in place. These include improved grip and control and oversight of the CRES programme, and a revised approach to contract

management and oversight that will be applied. The ICB continues to be scrutinised via Financial Performance Review Meetings (FPRM's) with PWC and NHSE. The Finance Committee is undertaking deep dives of areas of risk. Risk and mitigations will continue to be actively monitored and updated via the Executive Committee, Finance Committee and FPRM meetings..

5. Ask of the Board

5.1 The Board is asked to:

- Note the ICB financial position at month 1 (April 2026); and
- Acknowledge the level of uncertainty associated with early-year reporting and the reliance on planning assumptions at this stage.

6. Officer contact details for more information

Andrea McGee

Executive Director of Finance (Interim) Cheshire and Merseyside ICB
andrea.mcgee@cheshireandmerseyside.nhs.uk

Appendix 1: CRES Delivery at month 1 (April 2026)

Cheshire and Merseyside

| Programme / Workstream | CRES Development Status | | | | | Variance to CRES Target | Risk adjusted value based on Development status | YTD Plan M1 | YTD Actual M1 | YTD Variance M1 |
|--|-------------------------|-----------------|------------------|---------------|----------------|-------------------------|---|--------------|---------------|-----------------|
| | Implemented | Fully Developed | Plan in Progress | Opportunity | TOTAL | | | | | |
| | ADHD | - | 4,216 | 1,000 | - | | | | | |
| Contract and Investment Review | 620 | - | - | 10,333 | 10,953 | -0 | 3,203 | 71 | 52 | -19 |
| Digital | 50 | - | 454 | 547 | 1,051 | 51 | 414 | 2 | 4 | 3 |
| Estates | - | 768 | 1,228 | 250 | 2,246 | 0 | 1,252 | 72 | 0 | -72 |
| Grip & Control | 881 | 17,492 | - | - | 18,373 | 5,873 | 14,000 | 625 | 1,114 | 489 |
| Independent Sector Contract Management | 7,000 | 2,000 | - | - | 9,000 | 4,000 | 8,500 | 0 | 0 | 0 |
| Individual Patient Commissioning | - | 13,372 | 10,422 | - | 23,794 | -0 | 15,240 | 558 | 162 | -395 |
| Management Cost Reductions | 15,486 | 6,410 | - | - | 21,897 | 0 | 20,294 | 1,291 | 1,291 | 0 |
| Mental Health Redesign | - | 3,471 | - | - | 3,471 | -141 | 2,603 | 175 | 34 | -141 |
| Planned Care | 1,516 | - | 3,484 | - | 5,000 | 3,000 | 3,258 | 0 | 1,516 | 1,516 |
| Prescribing | 39,166 | 8,700 | - | - | 47,866 | 22,354 | 45,691 | 2,222 | 2,502 | 280 |
| Urgent & Emergency Care | - | - | 5,000 | - | 5,000 | 2,000 | 2,500 | 0 | 0 | 0 |
| Unidentified | - | - | - | - | 0 | -28,302 | 0 | 2,359 | 0 | -2,359 |
| Grand Total | 64,719 | 56,428 | 21,587 | 11,130 | 153,865 | 9,835 | 120,617 | 7,373 | 6,675 | -699 |

Meeting of the Board of NHS Cheshire and Merseyside

28 May 2026

Highlight report of the Chair of the Finance, Investment, and Contracting Committee (FICC)

Agenda Item No: ICB/05/26/18



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Highlight report of the Chair of the Finance, Investment, and Contracting (FICC) Committee

| | |
|---------------------------|---|
| Committee Chair | Sue Lorimer |
| Terms of Reference | https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/ |
| Date of meeting | 19 March 2026 and 23 April 2026 |

Key escalation and discussion points from the Committee meeting

Alert

Finance, Investment and Contracting Committee (FICC), 19th March 2026

- The Committee considered the complexity and risk within the 2026/27 contracting round, noting:
 - Significant misalignment between provider financial submissions and ICB contract offers, including unagreed income assumptions and growth expectations.
 - Resulting financial and reputational risk with NHSE, and reduced confidence in system alignment.
- The Committee supported a shift toward formal dispute and arbitration routes, where agreement cannot be reached, to provide clarity and discipline to contract negotiations.
- Non-Emergency Patient Transport (NEPTS) remained a critical risk area:
 - Procurement delays required urgent direct awards to NWAS and WMAS to maintain service continuity.
 - Additional financial support (revenue and capital) was required to stabilise WMAS provision.
- The Committee noted the scale of the financial challenge for 2026/27 with:
 - A CRES requirement of c.£140m–£150m, including management cost reductions. The Committee urged the team to finalise the CRES figure as it was not feasible to continue increasing it to balance off contracting pressures.
- Risks relating to independent sector activity and ADHD demand growth were highlighted as creating uncontrolled cost pressures requiring urgent intervention.

Finance, Investment and Contracting Committee (FICC), 23rd April 2026

- The Committee reviewed the 2026/27 financial plan, noting it remains balanced and compliant. Significant progress has been made in the identification, development and implementation of individual programmes but with residual



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CRES still requiring full identification. The Committee received verbal assurance that the full CRES value would be identified by the end of May. A series of CRES deep dives are in progress for FICC to support on-going delivery.

- A number of material risks relating to contracting and procurement were highlighted:
 - The Non-Emergency Patient Transport (NEPT) procurement required abandonment of a non-compliant 2-year award and replacement with a 12-month urgent contract to maintain patient safety.
 - Wider procurement weaknesses were highlighted, with internal audit commissioned to carry out a review.
- The ICB contract with Mersey and West Lancs NHS Foundation Trust is not agreed and is entering a formal dispute process, led by NHS England. The issues are linked to complex historic block contract funding associated with the merger of St Helens and Southport & Ormskirk, support for excess PFI costs, and residual top-ups.
- The ICB achieved its break-even control total at Month 12, but underlying pressures remain, particularly in prescribing and continuing care. A late deterioration in CRES delivery was noted.
- Changes to national reporting arrangements were discussed. Provider finance data will now be routed via NHSE, reducing availability of system-level position and potentially increasing system financial risk.

Advise

Finance, Investment and Contracting Committee (FICC), 19th March 2026

- The Committee reviewed procurement and contracting activity, noting:
 - A significant volume of procurement decisions, with remaining urgent decisions requiring tender waivers (reported via Audit Committee).
 - The ongoing need for contract rationalisation and improved contract management arrangements.
- Financial recovery and CRES delivery were presented, including:
 - Plans for improved delivery tracking through a new CRES toolkit and programme governance framework provided by PWC.
 - Delivery risks were highlighted due to workforce reductions and capacity within the Programme Office.
- The Committee reviewed a deep dive on All Age Continuing Care (AACC):



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- £21.8m savings target for 2026/27, with delivery dependent on service redesign, workforce stability and improved processes.
- The presentation highlighted significant operational challenges including vacancies, agency use, and variation across places.
- Committee members emphasised that left-shift funding must not be used as a mechanism to support provider deficits and should be linked to clear activity reduction within secondary care and transformation outcomes.
- The Committee supported stronger demand management approaches, particularly across planned and urgent care, to reduce reliance on secondary care activity.

Finance, Investment and Contracting Committee (FICC), 23rd April 2026

- The Committee considered contracting progress, noting:
 - 15 of 16 C&M contracts agreed awaiting signature.
 - 14 of 16 OOA contracts agreed awaiting signature.
 - Introduction of standard contract management principles to improve financial discipline, particularly around over-performance.
- The Committee reviewed the detail of the deconstruction of block contracts. Block contract deconstruction remains a major strategic priority to improve transparency, value for money, and alignment to activity, though it presents significant provider challenge and system risk. It was proposed that where it appears that there is significant activity underfunded within the current block arrangements, that some further investigative work is undertaken by the ICB.
- The Committee reviewed “unique” non-recurrent funding arrangements within 2026/27 contracts emphasising:
 - They must remain time-limited, transparent, and non-recurrent.
 - Strong governance and clear exit strategies are required.
- Feedback from PwC Financial Recovery Meetings (FPRMs) highlighted a misalignment between ICB and provider assumptions, particularly on RTT. Weaknesses in provider workforce planning and delivery. Enhanced scrutiny of high-risk providers will continue in Q1 of 2026/27.
- The Committee endorsed the process for the allocation of left-shift funding, stressing that investment must deliver measurable reductions in acute demand and be prioritised and aligned to the ICB strategy.
- The Committee received a report from the Systems Primary Care Committee. The underspend on Dental Services was discussed, and it was noted that this was not driven by financial issues but by workforce shortages and delivery



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constraints. The Committee supported the need to reduce reliance on Primary Care underspends given the strategic priorities around prevention, inequalities and left-shift. The Committee also noted an inconsistency in funding arrangements for digital services within GP practices and this had been escalated to the Executive Committee for review.

- The Committee received a presentation on the Specialised Commissioning financial plan. It was noted that almost all contracts for 26/27 were agreed although the Mersey and West Lancs NHS Foundation Trust contract remained unsigned.
- The Committee received a deep dive into the Prescribing CRES and members were pleased to see the excellent progress that had been made in this area.

Assure

Finance, Investment and Contracting Committee (FICC), 19th March 2026

- The Committee received assurance on ICB financial performance, noting:
 - Continued trajectory to deliver break-even position for 2025/26
 - Strong progress on savings delivery (£111m delivered YTD)
- Assurance was also received on:
 - Capital programme delivery, with spending on track and aligned to priorities.
 - Strengthened procurement governance, including reinstatement of the Procurement Decision Review Group (PDRG).
- ISFE2 implementation risks were noted. Assurance was given regarding new controls introduced to address identified issues and an increased confidence in financial reporting processes was reported.

Finance, Investment and Contracting Committee (FICC), 23rd April 2026

- The Committee received assurance that the ISFE2 financial system is now more reliable, with successful completion of year-end reporting. A recent internal audit review has given substantial assurance on the effectiveness of financial controls. It was agreed that routine ISFE2 reporting can now cease, with updates provided only on an exception basis.
- Assurance was also received on the development of improved contract oversight arrangements across finance, commissioning and contracting.



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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 |
| Financial Sustainability / Recovery | Extensive discussion on financial recovery, CRES identification and contracting risks. Actions include strengthened grip and control, continued PwC oversight, and enhanced programme governance. |

| Board Assurance Framework Risks | |
|---------------------------------|---|
| Risk Title | Key actions/discussion undertaken |
| BAF risk P13 | The Committee noted that the current risk framework does not yet fully reflect the scale of challenge, and agreed further work is required to strengthen risk articulation, escalation, and alignment to the BAF. |

Achievement of the ICB Annual Delivery Plan

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

| Service Programme / Focus Area | Key actions/discussion undertaken |
|---------------------------------|---|
| Financial planning and recovery | Oversight of 2026/27 financial plan, CRES delivery and financial recovery programme. |
| Contracting & Procurement | Agreement of majority of provider contracts, including the introduction of standard contract principles, and strengthened procurement governance. |
| System Transformation | Endorsement of left-shift investment approach to support demand reduction and strategic transformation. |

| Service Programme / Focus Area | Key actions/discussion undertaken |
|--------------------------------|---|
| Primary Care | Oversight of primary care financial risks and dental performance. |



Compassionate



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Working Together



Accountable

Meeting of the Board of NHS Cheshire and Merseyside

28 May 2026

Integrated Performance Report

Agenda Item No: ICB/05/26/19



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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 May 2026, see appendix one, provides an overview of key metrics drawn from the 2025/26 Operational plans, specifically covering Urgent Care, Planned Care, Diagnostics, Cancer, Mental Health, Learning Disabilities, Primary and Community Care, Health Inequalities and Improvement, Quality & Safety, Workforce and Finance.
- 2.2 For metrics that are not performing to plan, the integrated performance report provides further analysis of the issues, actions and risks to delivery in section 5 of the integrated performance report.

3. Ask of the Board and Recommendations

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

4. Reasons for Recommendations

- 4.1 The report is sent for assurance.

5. Background

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

6. [Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities](#)

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

Reviewing the quality and performance of services, providers and place enables the ICB to set system plans that support improvement against health inequalities.

Objective Two: Improving Population Health and Healthcare

Monitoring and management of quality and performance allows the ICB to identify where improvements have been made and address areas where further improvement is required.

Objective Three: Enhancing Productivity and Value for Money

The report supports the ICB to triangulate key aspects of service delivery, finance and workforce to improve productivity and ensure value for money.

Objective Four: Helping to support broader social and economic development

The report does not directly address this objective.

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

- 7.1 The integrated performance report monitors the organisational position of the ICB, against the annual delivery plan agreed with NHSE and national targets.

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

Theme One: Quality and Safety

The integrated performance report provides organisational visibility against three key quality and safety domains: safe and effective staffing, equity in access and equity of experience and outcomes.

Theme Two: Integration

The report addresses elements of partnership working across health and social care, particularly in relation to care pathways and transitions, and care provision, integration and continuity.

Theme Three: Leadership

The report supports the ICB leadership in decision making in relation to quality and performance issues.

9. Risks

- 9.1 The report provides a broad selection of key metrics and identifies areas where delivery is at risk. Exception reporting identifies the issues, mitigating actions and delivery against those metrics.
- 9.2 There is a risk that the system will not meet elective care recovery targets set out in the 2025/26 Operational Planning Guidance, including referral to treatment times, time to first appointment and 52-week RTT waiting time standards, due to constrained elective capacity, rising demand, workforce shortages and financial constraints. This may result in prolonged patient waits, increased clinical risk, poor patient experience, financial impact, and reputational harm. This corresponds to Board Assurance Framework Risk P14.
- 9.3 Additionally, there is a risk that the system will be unable to deliver timely and effective urgent and emergency care services due to rising demand, workforce pressures, capacity constraints, and delayed patient discharges. This may result in non-compliance with key NHS 2025/26 planning guidance standards, including the 4-hour ED target, 12-hour decision-to-admit (DTA) breaches, and ambulance handover delays. These risks may contribute to patient harm, regulatory scrutiny, and reputational damage. This maps to Board Assurance Framework Risk P15.

10. Finance

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

11. Communication and Engagement

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

12. Equality, Diversity and Inclusion

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

13. Climate Change / Sustainability

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

14. Next Steps and Responsible Person to take forward

- 14.1 Actions and feedback will be taken by Jude Adams, Interim Executive Director of Strategy and Transformation. Actions will be shared with, and followed up, by relevant teams. Feedback will support future reporting to the Q&P committee.

15. Officer contact details for more information

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

16. Appendices

Appendix One: Integrated Quality and Performance report

Integrated Performance Report

28th May 2026



Index

| | |
|--|------------|
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| Section 3: Provider / Trust Aggregate Position | Page 10-12 |
| Section 4: Place Aggregate Position | Page 13-15 |
| Section 5: Exception Report | Page 16-39 |

Provider Acronyms:

ACUTE TRUSTS

COCH COUNTESS OF CHESTER HOSPITAL NHS FT

ECT EAST CHESHIRE NHS TRUST

MCHT MID CHESHIRE HOSPITALS NHS FT

LUFT LIVERPOOL UNIVERSITY HOSPITALS NHS FT

MWL MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST

WHH WARRINGTON AND HALTON TEACHING HOSPITALS NHS FT

WUTH WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT

SPECIALIST TRUSTS

AHCH ALDER HEY CHILDREN'S HOSPITAL NHS FT

LHCH LIVERPOOL HEART AND CHEST HOSPITAL NHS FT

LWH LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

TCCC THE CLATTERBRIDGE CANCER CENTRE NHS FT

TWC THE WALTON CENTRE NHS FT

COMMUNITY AND MENTAL HEALTH TRUSTS

BCHC BRIDGEWATER COMMUNITY HEALTHCARE NHS FT

WCHC WIRRAL COMMUNITY HEALTH AND CARE NHS FT

MCFT MERSEY CARE NHS FT

CWP CHESHIRE AND WIRRAL PARTNERSHIP NHS FT

KEY SYSTEM PARTNERS

NWAS NORTH WEST AMBULANCE SERVICE NHS TRUST

CMCA CHESHIRE AND MERSEYSIDE CANCER ALLIANCE

OTHER

OOA OUT OF AREA AND OTHER PROVIDERS

Key:

Data formatting

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

C&M National Ranking against the 42 ICBs

| | |
|--------------------------------------|--|
| $\leq 11^{\text{th}}$ | C&M in top quartile nationally |
| 12^{th} to 31^{st} | C&M in interquartile range nationally |
| $\geq 32^{\text{nd}}$ | C&M in bottom quartile nationally |
| - | Ranking not appropriate/applied nationally |

C&M National Ranking against the 22 Cancer Alliances

| | |
|-------------------------------------|--|
| $\leq 5^{\text{th}}$ | C&M in top quartile nationally |
| 6^{th} to 17^{th} | C&M in interquartile range nationally |
| $\geq 18^{\text{th}}$ | C&M in bottom quartile nationally |
| - | Ranking not appropriate/applied nationally |

Notes on interpreting the data

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

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

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

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

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

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

Integrated Quality & Performance Report – Interpreting SPC Charts:

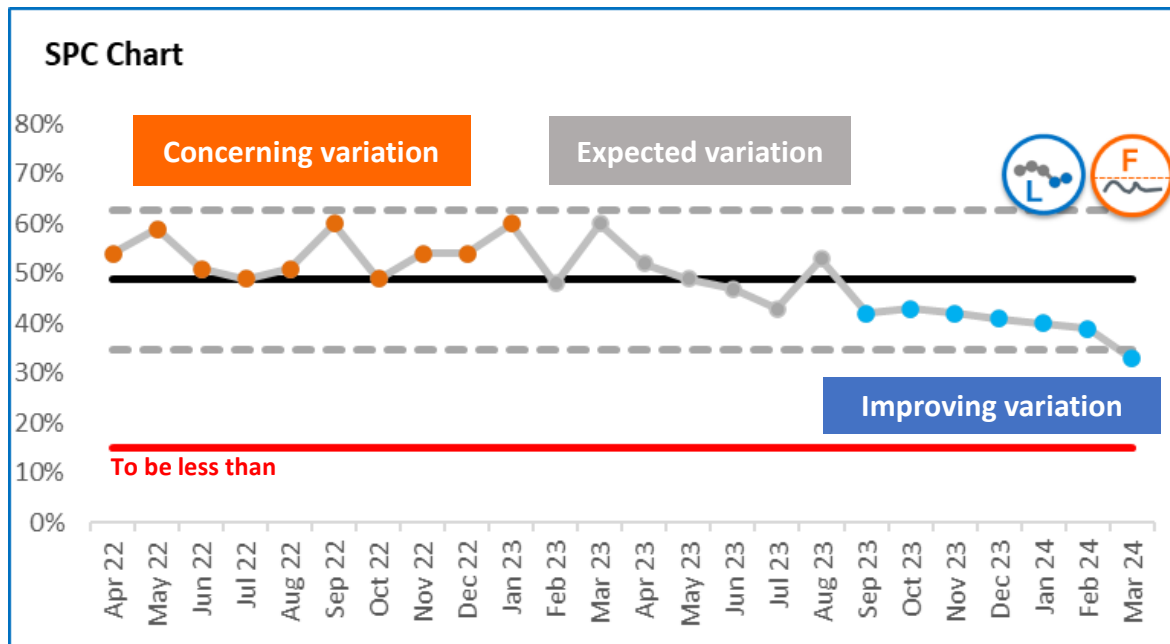
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

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

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

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

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



- UPL
- Average
- LPL
- Target

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

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

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

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

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

| Variation / performance icons | | | |
|-------------------------------|--|---|---|
| Icon | Technical description | What does this mean? | What should we do? |
| | Common cause variation, NO SIGNIFICANT CHANGE. | This system or process is 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

| Category | Metric | Latest period | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Apr-26 | Local Trajectory | National Target | Region value | National value | Latest Rank |
|--------------|---|---------------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|------------------|-----------------|--------------|----------------|-------------|
| Urgent care | 4-hour A&E waiting time (% waiting less than 4 hours) | Apr-26 | 72.7% | 73.7% | 73.0% | 71.9% | 72.8% | 72.5% | 71.9% | 72.4% | 71.5% | 71.5% | 71.6% | 73.8% | 74.7% | | 82% by Year end | 74.9% | 76.9% | 26/42 |
| | Ambulance category 2 mean response time | Apr-26 | 00:27:58 | 00:26:44 | 00:30:22 | 00:32:05 | 00:27:24 | 00:28:44 | 00:32:51 | 00:37:31 | 00:45:25 | 00:40:49 | 00:31:46 | 00:30:05 | 00:26:46 | | 00:25:00 | 00:23:01 | 00:24:44 | 24/42 |
| | Mean Ambulance Handover time (ED and Non ED) | Apr-26 | 00:34:23 | 00:31:57 | 00:32:58 | 00:31:04 | 00:25:02 | 00:27:41 | 00:31:48 | 00:34:37 | 00:38:39 | 00:49:33 | 00:37:08 | 00:32:41 | 00:31:11 | | 00:25:00 | 00:25:59 | 00:25:39 | 30/42 |
| | A&E 12 hour waits from arrival (Type 1 & 2) | Apr-26 | 15.9% | 16.6% | 16.8% | 17.0% | 16.3% | 17.6% | 17.2% | 17.1% | 17.4% | 18.7% | 18.3% | 16.3% | 13.1% | | 10.0% | 9.4% | 6.6% | 42/42 |
| | Adult G&A bed occupancy (all acutes) | Apr-26 | 96.4% | 96.5% | 95.8% | 95.6% | 94.9% | 96.1% | 95.7% | 96.2% | 94.3% | 96.0% | 96.2% | 95.7% | 95.3% | | 92.0% | 95.1% | 94.8% | 21/42 |
| | Percentage of beds occupied by patients no longer meeting the criteria to reside (Rolling 7-day average last week of month) | Apr-26 | 21.2% | 20.0% | 20.3% | 20.0% | 20.7% | 19.7% | 19.1% | 19.7% | 18.7% | 20.4% | 21.4% | 20.2% | 19.9% | | - | n/a | n/a | - |
| | Discharges - Average delay (exclude zero delay) | Mar-26 | 9.8 | 8.8 | 8.6 | 8.4 | 7.9 | 8.6 | 8.8 | 8.2 | 8.4 | 8.2 | 8.5 | 8.9 | | 9.0 | | 7.4 | 6.2 | 39/42 |
| | Percentage of patients discharged on discharge ready date | Mar-26 | 88.3% | 88.3% | 88.4% | 88.5% | 88.5% | 89.1% | 87.2% | 85.9% | 85.2% | 84.8% | 85.6% | 86.0% | | 86.7% | | 86.1% | 85.3% | 20/42 |
| Planned care | Total incomplete Referral to Treatment (RTT) pathways | Mar-26 | 354,386 | 350,979 | 355,722 | 362,412 | 366,066 | 367,700 | 367,494 | 355,626 | 349,685 | 346,862 | 343,407 | 328,547 | | 334,989 | - | 963,778 | 7,014,879 | - |
| | The % of people waiting less than 18 weeks on the waiting list (RTT) | Mar-26 | 58.0% | 59.1% | 59.0% | 58.7% | 58.4% | 59.2% | 59.4% | 59.1% | 58.7% | 58.8% | 60.7% | 64.5% | | 62.9% | 92.0% | 64.6% | 65.3% | 25/42 |
| | The % of people waiting more than 52 weeks on the waiting list (RTT) | Mar-26 | 3.5% | 3.7% | 3.9% | 3.9% | 3.9% | 3.6% | 3.3% | 2.9% | 2.4% | 2.2% | 1.9% | 1.1% | | 1.0% | | 1.3% | 1.3% | 25/42 |
| | Number of 52+ week RTT waits, of which children under 18 years. | Mar-26 | 972 | 983 | 1,031 | 1,098 | 1,114 | 899 | 992 | 947 | 847 | 731 | 767 | 501 | | 560 | - | n/a | n/a | - |
| | Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more | Mar-26 | 990 | 1,443 | 1,325 | 1,242 | 941 | 677 | 444 | 319 | 74 | 58 | 46 | 36 | | - | 0 by Sept 2024 | 107 | 4,302 | |
| | Patients waiting more than 6 weeks for a diagnostic test | Mar-26 | 10.1% | 12.0% | 11.4% | 11.2% | 14.2% | 12.4% | 9.5% | 9.2% | 10.2% | 10.7% | 7.1% | 9.8% | | 5.0% | 5.0% | 12.7% | 21.2% | 3/42 |
| Cancer | 2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer | Feb-26 | 76.1% | 75.0% | 73.8% | 75.4% | 76.2% | 72.7% | 72.3% | 74.2% | 74.6% | 71.1% | 73.5% | | | 74.8% | 85.0% | 71.8% | 68.6% | 9/42 |
| | 1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer | Feb-26 | 94.7% | 95.5% | 95.5% | 95.2% | 95.1% | 93.7% | 94.4% | 94.4% | 95.3% | 93.7% | 95.8% | | | 96.0% | 96.0% | 95.7% | 93.0% | 12/42 |
| | Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitely Excluded | Feb-26 | 75.4% | 71.8% | 73.6% | 71.7% | 70.5% | 70.6% | 73.6% | 74.8% | 75.3% | 71.6% | 80.7% | | | 79.6% | 77% by Year end | 81.3% | 80.5% | 21/42 |
| | Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028. (Rolling 12 months) | Dec-25 | 59.2% | 59.2% | 59.4% | 59.4% | 59.4% | 59.6% | 59.5% | 59.7% | 59.3% | | | | | 70.0% | 75% by 2028 | 59.0% | 59.7% | 26/42 |
| Community | Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours | Feb-26 | 86% | 86% | 86% | 87% | 87% | 88% | 85% | 84% | 85% | 85% | 85% | | | 70.0% | 70.0% | 88.0% | 84.0% | 21/42 |
| | Virtual Wards Utilisation | Mar-26 | 75.3% | 74.7% | 63.7% | 78.9% | 72.0% | 72.9% | 72.0% | 99.8% | 85.1% | 87.3% | 97.7% | 82.4% | | 80.0% | 80.0% | 69.9% | 83.5% | 18/42 |
| | Community Services Waiting List (Adults) | Feb-26 | 42,897 | 41,462 | 54,290 | 66,869 | 72,441 | 68,623 | 62,270 | 55,301 | 53,675 | 55,229 | 62,384 | | | | | 114,454 | 847,169 | - |
| | Community services Waiting List (CYP) | Feb-26 | 20,519 | 21,794 | 24,606 | 25,457 | 19,198 | 19,103 | 20,279 | 18,547 | 18,632 | 22,586 | 23,654 | | | | | 44,925 | 320,900 | - |
| | Community Services – Adults waiting over 52 weeks | Feb-26 | 95 | 71 | 237 | 424 | 613 | 449 | 410 | 231 | 219 | 176 | 229 | | | 0 | | 611 | 10,317 | - |
| Note/s | * from BIP sentinel metric run report | | | | | | | | | | | | | | | | | | | |

1. ICB Aggregate Position



Cheshire and Merseyside

| Category | Metric | Latest period | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Apr-26 | Local Trajectory | National Target | Region value | National value | Latest Rank |
|-----------------------------|---|---------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|---------|--------|------------------|-----------------|--------------|----------------|-------------|
| Mental Health | Referrals on the Early Intervention in Psychosis (EIP) pathway seen in 2 weeks | Feb-26 | 83.0% | 77.0% | 76.0% | 69.0% | 79.0% | 80.0% | 84% | 76% | 75% | 72% | 71% | 76% | | | 60.0% | 60.0% | 58.0% | 72.2% | 24/42 |
| | People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months | To Dec 25 | 62.0% | 56.0% | | | 53.0% | | | 54.0% | | | | | | - | 60.0% | 57.0% | 59.0% | 33/42 | |
| | Dementia Diagnosis Rate | Feb-26 | 67.6% | 67.6% | 67.6% | 67.8% | 68.0% | 68.2% | 68.1% | 68.4% | 68.4% | 68.2% | 68.3% | 68.1% | | | 66.7% | 66.7% | 70.2% | 66.1% | 14/42 |
| | CYP Eating Disorders Routine | Feb-26 | 86.0% | 92.0% | 93.0% | 93.0% | 93.0% | 94.0% | 93.0% | 92.0% | 92.0% | 91.0% | 89.0% | 81.0% | | | 95.0% | 95.0% | 77.0% | 81.3% | 3/42 |
| | Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact | Feb-26 | 34,625 | 35,450 | 35,185 | 35,485 | 35,090 | 35,105 | 35,220 | 35,940 | 36,195 | 36,410 | 37,245 | 37,725 | | | 37246 | - | 127990 | 875531 | - |
| | Number of people accessing specialist Community PMH and MMHS services | Feb-26 | 3,625 | 3,620 | 3,600 | 3,645 | 3,635 | 3,655 | 3,675 | 3,465 | 3,645 | 3,665 | 3,670 | 3,820 | | | 3420 | - | 8900 | 67170 | - |
| | Talking Therapies 1st to 2nd Treatment >90 days | Feb-26 | 31% | 36% | 31% | 30% | 19% | 15% | 17% | 15% | 12% | 13% | 16% | 19% | | | - | 10% | 33% | 23.9% | 6/42 |
| | Talking Therapies completing a course of treatment - % of plan achieved | Feb-26 | 91.0% | 102.0% | 97.0% | 104.0% | 98.0% | 95.0% | 97.0% | 99.0% | 100.0% | 100.0% | 100.0% | 108.0% | | | 100.0% | 100.0% | 98.0% | 90.0% | 18/42 |
| | Talking Therapies Reliable Recovery | Feb-26 | 49.0% | 48.0% | 48.0% | 48.0% | 47.0% | 47.0% | 44.0% | 47.0% | 47.0% | 47.0% | 46.0% | 47.0% | | | 48.0% | 48.0% | 44.0% | 47.3% | 25/42 |
| | Talking Therapies Reliable Improvement | Feb-26 | 68.0% | 67.0% | 68.0% | 68.0% | 67.0% | 66.0% | 64.0% | 67.0% | 66.0% | 66.0% | 65.0% | 67.0% | | | 67.0% | 67.0% | 66.0% | 67.7% | 26/42 |
| Learning Disabilities | Adult inpatients with a learning disability and/or autism (rounded to nearest 5) | Feb-26 | 80 | 80 | 75 | 75 | 75 | 75 | 75 | 75 | 75 | 75 | 70 | 70 | | | 46 | - | 220 | 1,825 | 15/42 |
| | Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register | Feb 26 YTD | 85.5% | 3.1% | 7.5% | 12.7% | 18.5% | 23.4% | 31.1% | 38.3% | 46.4% | 52.8% | 62.0% | 70.9% | | | 70.9% | 75% by Year end | 72.9% | 71.0% | 23/42 |
| Primary Care | Units of dental activity delivered as a proportion of all units of dental activity contracted | Mar-26 | 95.0% | 82.0% | 81.0% | 80.0% | 79.0% | 77.0% | 82.0% | 84.0% | 87.0% | 76.0% | 84.0% | 92.0% | 90.0% | | 80.0% | 100.0% | 91.0% | 89.0% | 18/44 |
| | Number of unique patients seen by an NHS Dentist – Adults (24 month) | Mar-26 | 937,773 | 940,716 | 941,167 | 941,865 | 944,188 | 944,511 | 946,089 | 947,758 | 947,371 | 950,458 | 951,752 | 952,540 | 954,250 | | 950,302 | | 2,688,288 | 18,368,383 | - |
| | Number of unique patients seen by an NHS Dentist – Children (12 month) | Mar-26 | 333,475 | 333,796 | 333,871 | 334,907 | 335,719 | 336,440 | 337,729 | 338,502 | 338,564 | 340,663 | 340,812 | 341,444 | 342,405 | | 346,638 | | 1,054,133 | 7,373,012 | - |
| | Appointments in General Practice & Primary Care networks | Feb 26 YTD | 1,342,136 | 1,237,198 | 1,220,981 | 1,272,114 | 1,377,472 | 1,167,168 | 1,364,319 | 1,688,291 | 1,337,024 | 1,326,865 | 1,425,232 | 1,322,413 | | | 1,354,605 | | - | - | - |
| | The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care. (rolling 12 months) | Jan-26 | 7.09% | 7.14% | 7.18% | 7.22% | 7.28% | 7.29% | 7.29% | 7.32% | 7.34% | 7.36% | 7.40% | | | | 10.0% | 10.0% | - | 7.62% (Dec 24) | - |
| | Total volume of antibiotic prescribing in primary care | Jan-26 | 0.97 | 0.95 | 0.94 | 0.94 | 0.93 | 0.92 | 0.92 | 0.92 | 0.91 | 0.91 | 0.91 | | | | 0.871 | 0.871 | - | 1.00 | - |
| Integrated care BCF metrics | Unplanned hospitalisation for chronic ambulatory care sensitive conditions (average of place rates) (New data source) | Dec-25 | 239 | 229 | 232 | 237 | 228 | 215 | 225 | 244 | 210 | 188 | | | | | - | - | - | 198.8 | - |
| | Percentage of people who are discharged from acute hospital to their usual place of residence (New data source) | Dec-25 | 80.5% | 82.3% | 82.3% | 83.1% | 82.3% | 83.0% | 82.0% | 82.5% | 81.0% | 80.9% | | | | | - | - | - | 80.2% | - |
| | 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) | Oct-25 | 127 | 149 | 148 | 144 | 151 | 164 | 154 | 145 | | | | | | | - | - | - | 133.8 | - |
| Note/s | | | | | | | | | | | | | | | | | | | | | |

1. ICB Aggregate Position

| Category | Metric | Latest period | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Apr-26 | Local Trajectory | National Target | Region value | National value | Latest Rank |
|-----------------------------------|--|---------------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|------------------|-----------------|--------------|----------------|-------------|
| Specialised Commissioning | Cardiac Treatment waiting list (LH&CH) ^ | Mar-26 | 376 | 363 | 383 | 403 | 402 | 402 | 398 | 395 | 408 | 369 | 461 | 378 | 368 | | 376 | | | | - |
| | Neurosurgery waiting list (TWC) ^ | Mar-26 | 967 | 974 | 950 | 993 | 1,006 | 1,021 | 989 | 1,023 | 958 | 860 | 1,082 | 939 | 915 | | 967 | | | | - |
| | Specialised Paediatric surgery waiting list (AHCH) ^ | Mar-26 | 248 | 238 | 221 | 203 | 180 | 180 | 207 | 225 | 216 | 193 | 244 | 222 | 225 | | 248 | | | | - |
| | Vascular waiting list (LUFT) ^ | Mar-26 | 180 | 160 | 183 | 182 | 213 | 214 | 197 | 176 | 167 | 173 | 161 | 172 | 198 | | 180 | | | | - |
| Health Inequalities & Improvement | % of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold | Q2 25/26 | 69.07% | 67.34% | | | 67.42% | | | | | | | | | | 77.0% | 80.0% | 68.60% | 68.7% | 29/42 |
| | CVD treated to cholesterol threshold LDL-cholesterol less than or equal to 2.0 mmol/l or non-HDL cholesterol less than or equal to 2.6 mmol/l) | Q2 25/26 | 46.0% | 45.6% | | | 46.7% | | | | | | | | | | | 50.0% | 48.2% | 48.93% | 30/42 |
| | Smoking at Time of Delivery V2 | Q3 25/26 | 5.9% | 5.4% | | | 4.8% | | | 5.4% | | | | | | | - | 6.0% | 5.4% | 4.70% | 31/42 |
| | Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems.(Aged 15+) ~ | Mar-26 | | | | 14.0% | 14.0% | 14.0% | 13.9% | 13.8% | 16.4% | 16.3% | 16.3% | 16.2% | 16.1% | | 12.0% | 12.0% | - | 12.7%^ | - |
| Continuing Healthcare | Standard Referrals completed within 28 days | Q3 25/26 | 76% | 71.70% | | | 70.40% | | | 63.90% | | | | | | | 80.0% | >80% | 78.0% | 77.0% | 34/42 |
| | Number eligible for Fast Track CHC per 50,000 population (snapshot at end of quarter) | Q3 25/26 | 27.04 | 23.78 | | | 23.85 | | | 27.19 | | | | | | | 18.00 | | 21.33 | 16.22 | 40/42 |
| | Number eligible for standard CHC per 50,000 population (snapshot at end of quarter) | Q3 25/26 | 54.67 | 54.27 | | | 53.8 | | | 52.71 | | | | | | | 34.00 | | 44.74 | 33.25 | 40/42 |
| Maternity | HIE (Hypoxic ischemic encephalopathy) grade 2 or 3 per 1,000 live births (>=37 weeks) | Q3 25/26 | 0.5 | 0.7 | | | 0.7 | | | 0.5 | | | | | | | 2.5 | 2.5 | 0.8 | | |
| | Still birth per 1,000 (rolling 12 months) (GP Reg MSDS) | Jan-26 | 2.49 | 2.41 | 2.43 | 2.49 | 2.44 | 2.54 | 2.56 | 2.60 | 2.65 | 2.69 | 2.51 | | | | - | 2.6* | - | 3.7 | - |
| Quality & Safety | Healthcare Acquired Infections: Clostridium Difficile - Place aggregation (All cases) | 12 months to Feb 26 | 1191 | 1155 | 1143 | 1133 | 1134 | 1129 | 1108 | 1090 | 1079 | 1049 | 1060 | 1064 | | | 843 | | 2907 | 17044 | |
| | Healthcare Acquired Infections: E.Coli Place aggregation (All cases) | 12 months to Feb 26 | 2330 | 2330 | 2326 | 2330 | 2297 | 2325 | 2334 | 2320 | 2346 | 2353 | 2385 | 2424 | | | 2001 | | 5967 | 44774 | |
| | Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation # | 12 months to Nov 25 | 0.986 | 0.989 | 0.996 | 0.989 | 0.989 | 1.000 | 1.005 | 0.998 | 0.999 | | | | | | 0.887 to 1.127 * | | - | 1.000 | - |
| | Never Events | Mar-26 | 2 | 0 | 5 | 3 | 2 | 0 | 3 | 1 | 2 | 3 | 5 | 1 | 4 | | 0 | 0 | - | - | - |
| Workforce / HR (ICS total) | Staff in post | Mar-26 | 74,600 | 74,524 | 74,471 | 74,458 | 74,346 | 74,372 | 74,426 | 74,646 | 74,572 | 74,337 | 74,281 | 74,352 | 74,326 | | 72,773 | - | | | |
| | Bank | Mar-26 | 5,459 | 5,216 | 4,852 | 4,566 | 4,782 | 4,830 | 4,762 | 4,616 | 4,600 | 4,278 | 4,545 | 4,995 | 5,159 | | 4,015 | - | | | |
| | Agency | Mar-26 | 749 | 638 | 620 | 602 | 555 | 513 | 490 | 474 | 420 | 408 | 416 | 424 | 460 | | 598 | - | | | |
| | Turnover | Feb-26 | 10.4% | 10.1% | 10.0% | 9.9% | 9.8% | 9.7% | 9.7% | 9.5% | 9.5% | 9.7% | 9.5% | 9.5% | | | 11.2% | - | | | |
| | Sickness## | Jan-25 | 6.1% | 6.1% | 6.1% | 6.1% | 6.1% | 6.2% | 6.2% | 6.2% | 6.3% | 6.3% | 6.2% | | | | 5.8% | - | | | |
| Note/s | ^ RAG rating based on 12 month comparison (Red = Higher, Green = Lower) # Banding changed Aug 23 to reflect SOF bandings for providers. Green = no providers higher than expected, Amber = 1-2 providers higher than expected, Red = more than 2 providers higher than expected ~ New methodology from June, data now reported in line with CIPHA ## latest rank, region and national values are one month behind latest data * Original NHS target was to halve the 2010 stillbirth rate of 5.1 per 1,000 by 2025. replaced with a reduction to 2.3 per 1,000 by 2030 | | | | | | | | | | | | | | | | | | | | |

2. ICB Aggregate Financial Position

ICB Overall Financial Position:

| Category | Metric | Latest period | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Plan (£m) | Dir. Of Travel | FOT (£m) Plan | FOT (£m) Current | FOT (£m) Variance |
|----------|--|---------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|-----------|----------------|---------------|------------------|-------------------|
| Finance | Financial position £m (ICS) ACTUAL | Feb-26 | -45.9 | - | -37.4 | -51.7 | -78.4 | -110.4 | -124.8 | -138.0 | -159.0 | -173.2 | -200.4 | -177.8 | -178.0 | 0 | ↘ | 0.0 | -178.0 | -178.0 |
| | Financial position £ms (ICS) VARIANCE | Feb-26 | -45.9 | - | 0.2 | 1.4 | -17.3 | -35.6 | -42.6 | -59.4 | -76.7 | -86.3 | -118.4 | -98.4 | -178.0 | | ↘ | | | |
| | Efficiencies £ms (ICS) ACTUAL | Feb-26 | 417.1 | - | 61.0 | 98.1 | 147.8 | 180.7 | 226.1 | 264.3 | 312.4 | 364.5 | 420.4 | 472.7 | 542.6 | 572.5 | ↗ | 572.5 | 542.6 | -29.9 |
| | Efficiencies £ms (ICS) VARIANCE | Feb-26 | -22.8 | - | -1.9 | 1.0 | 9.3 | 0.0 | 2.2 | -9.6 | -11.7 | -11.0 | -14.3 | -21.2 | -29.9 | | ↘ | | | |
| | Capital £ms (ICS) ACTUAL | Feb-26 | 327.0 | - | - | - | | | | | | | | | | - | - | 236.8 | 236.6 | -0.2 |
| | Capital £ms (ICS) VARIANCE | | -16.7 | - | - | - | | | | | | | | | | - | - | N/A | N/A | |

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

| Category | Metric | Latest period | Mar-25 | Apr-25 | May-25 | Jun-25 | Jul-25 | Aug-25 | Sep-25 | Oct-25 | Nov-25 | Dec-25 | Jan-26 | Feb-26 | Mar-26 | Vs Target expenditure (Current) | Vs Target expenditure (Previous) | Dir. Of Travel |
|----------|---|---------------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|---------------------------------|----------------------------------|----------------|
| Finance | Mental Health Investment Standard met/not met (MHIS) | Jan-26 | Yes | - | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | ↔ |
| | BCF achievement (Places achieving expenditure target) | Jan-26 | 9/9 | - | 9/9 | 9/9 | 9/9 | 9/9 | 9/9 | 9/9 | 9/9 | 9/9 | 9/9 | 9/9 | 9/9 | 9/9 | 9/9 | ↔ |

3. Provider / Trust Aggregate Position

| Category | Metric | Latest period | Providers | | | | | | | | | | | | | | | | | Net OOA/ Other/ ICB | ICB * |
|--------------|---|---------------|--------------------------------|-------------|-----------|-----------|-------------------|-------------------------|-------------|-------------------|--------|-----------|--------|--------|-----------------------|-------|-----------|-------------|--------------|---------------------|-------|
| | | | Cheshire & Wirral Acute Trusts | | | | | Merseyside Acute Trusts | | Specialist Trusts | | | | | Community & MH Trusts | | | | | | |
| | | | COCH | ECT | MCHT | WUTH | NCM ^{##} | LUFT | MWL | AHCH | LHCH | LWH | TCCC | TWC | BCHC | WCHC | MCFT | CWP | | | |
| NHS SOF | Segment*** | 25/26 Q3 | ④ | ④ | ④ | ④ | ④ | ④ | ③ | ① | ① | ③ | ① | ① | ③ | ① | ② | ③ | | | |
| | Segment movement from previous quarter | 25/26 Q3 | → | → | → | → | → | → | → | → | → | → | → | → | → | → | → | | | | |
| | NHSE Capability Assessment [§] (NEW) | 25/26 Q3 | Red | Amber/Green | Amber/Red | Amber/Red | Amber/Red | Red | Amber/Green | Green | Green | Amber/Red | Green | Green | Amber/Green | Green | Amber/Red | Amber/Green | NWAS - Green | | |
| Urgent care | 4-hour A&E waiting time % waiting less than 4 hours ^{\$\$} (New Note) | Apr-26 | 64.8% | 53.0% | 66.5% | 73.8% | 76.4% | 74.2% | 77.9% | 92.3% | | 81.9% | - | - | - | - | - | - | - | 74.7% | |
| | Mean Ambulance Handover time (ED and Non ED) | Apr-26 | 00:25:59 | 00:23:14 | 00:21:14 | 00:29:05 | 00:32:59 | 00:33:10 | 00:37:38 | 00:23:08 | | | | | | | | | | 00:31:11 | |
| | A&E 12 hour waits from arrival | Apr-26 | 15.5% | 16.0% | 12.9% | 20.3% | 17.0% | 16.2% | 18.7% | # | - | # | - | - | - | - | - | - | - | 13.1% | |
| | Adult G&A bed occupancy | Apr-26 | 97.8% | 98.9% | 96.0% | 92.9% | 96.5% | 95.6% | 97.5% | - | 81.2% | 60.8% | 89.0% | 90.9% | | | | | - | 95.3% | |
| | Percentage of beds occupied by patients no longer meeting the criteria to reside (NEW - rolling 7-day average last week of month) | Apr-26 | 21.5% | 21.8% | 21.0% | 21.7% | 17.5% | 22.3% | 20.9% | | | | | | | | | | - | 19.9% | |
| | Discharges - Average delay (exclude zero delay) | Mar-26 | 12.0 | 9.0 | ** | 7.6 | 10.1 | 6.6 | 11.9 | 0.0 | 5.4 | 1.7 | 2.0 | 0.0 | | | | | | 8.9 | |
| | Percentage of patients discharged on discharge ready date | Mar-26 | 84.9% | 81.4% | ** | 89.7% | 80.8% | 83.2% | 86.4% | 100.0% | 97.0% | 92.4% | 99.4% | 100.0% | | | | | | 86.0% | |
| Planned care | Total incomplete Referral to Treatment (RTT) pathways | Mar-26 | 27,662 | 16,262 | 30,569 | 43,525 | 33,113 | 59,668 | 76,787 | 15,751 | 5,331 | 11,638 | 722 | 12,179 | | | 53 | - | 328,547 | | |
| | The % of people waiting less than 18 weeks on the waiting list (RTT) | Mar-26 | 64.3% | 60.1% | 62.5% | 64.8% | 65.3% | 62.1% | 66.5% | 68.5% | 80.9% | 60.1% | 96.4% | 66.4% | | | 100.0% | | 64.5% | | |
| | The % of people waiting more than 52 weeks on the waiting list (RTT) | Mar-26 | 0.9% | 2.1% | 1.3% | 0.8% | 0.7% | 0.9% | 1.3% | 1.3% | 0.2% | 2.4% | 0.0% | 0.6% | | | 0.0% | | 1.1% | | |
| | Number of 52+ week RTT waits, of which children under 18 years. | Mar-26 | 42 | 26 | 12 | 72 | 14 | 20 | 109 | 203 | 0 | 3 | 0 | 0 | | | | | 501 | | |
| | Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more | Mar-26 | 1 | 16 | 1 | 0 | 4 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | | | 0 | | 36 | | |
| | Patients waiting more than 6 weeks for a diagnostic test | Mar-26 | 16.0% | 13.9% | 8.3% | 6.4% | 2.8% | 11.0% | 13.3% | 2.6% | 4.4% | 11.0% | 0.4% | 0.0% | 5.5% | 0.0% | - | - | - | 9.8% | |
| 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 | Feb-26 | 76.6% | 74.5% | 60.1% | 74.7% | 79.7% | 68.2% | 80.3% | 100.0% | 78.0% | 63.8% | 86.7% | 100.0% | 76.7% | | | - | 73.5% | | |
| | 1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer | Feb-26 | 93.7% | 100.0% | 89.9% | 92.0% | 98.6% | 88.7% | 96.0% | 100.0% | 100.0% | 89.2% | 99.5% | 100.0% | 95.8% | | | - | 95.8% | | |
| | Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded | Feb-26 | 83.8% | 80.2% | 80.3% | 76.9% | 78.6% | 82.5% | 81.3% | 100.0% | 57.9% | 72.0% | 100.0% | 100.0% | 89.3% | | | - | 80.7% | | |
| | Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028 (calendar YTD) | Dec-25 | 58.9% | 65.5% | 62.0% | 59.5% | 49.0% | 58.8% | 57.0% | 33.3% | 55.9% | 75.7% | 74.6% | - | 96.9% | - | | | 59.3% | | |
| Note/s | <p>* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6, 7 and 8 for the ICB's latest position on the above metrics</p> <p>** Indicates that provider did not meet to DQ criteria and is excluded from the analysis □</p> <p>*** NHS SOF Segments - Highest = 1 (Consistently high performing) , 2 (Requires some improvement or support), 3 (Experiencing significant challenges and requires more intensive support), 4 (Mandated intensive support due to serious problems or risks to care quality)</p> <p># - Numbers suppressed due to small numbers</p> <p>§ - NHSE Capability Assessment: GREEN = No concerns evident, High confidence in the trust's ability to deliver on its priorities. AMBER/GREEN = Some concerns emerging, Trust has prepared plan(s) to address any problems, Historical issues/track record mean NHS England does not(yet) have full confidence in the board. AMBER/RED = Issues with self-assessment or subsequent issues across multiple domains, Failure to deliver on agreed plans to address a material issue, Potentially in breach of licence. RED = Material or long-running concerns at the organisation that management has been unable to grip, NHS trust in breach of licence or likely to be.</p> <p>\$\$ - Following a decision by NHS England from April 2026 Widnes UTC activity will no longer be attributed 50/50 MWL and WHH and will all be attributed to WHH. it is expected that this will have the effect of reducing 4-hour performance at MWL by 1.5% and increasing 4-hour performance at WHH by 3.5%</p> <p>## - NCM = North Cheshire and Mersey - previously reported as WHH Warrington & Halton Hospitals</p> | | | | | | | | | | | | | | | | | | | | |

3. Provider / Trust Aggregate Position

| Category | Metric | Latest period | Providers | | | | | | | | | | | | | | | | | | |
|-----------------------|--|---------------|--------------------------------------|-------|--------|----------------------------------|-------|-------------------------|-------|-------------------|------|-----|------|-----|-----------------------|-------|--------|-------|---------------------|--------|-------|
| | | | Cheshire & Wirral Acute Trusts | | | | | Merseyside Acute Trusts | | Specialist Trusts | | | | | Community & MH Trusts | | | | Net OOA/ Other/ ICB | ICB * | |
| | | | COCH | ECT | MCHT | WUTH | WHH | LUFT | MWL | AHCH | LHCH | LWH | TCCC | TWC | BCHC | WCHC | MCFT | CWP | | | |
| Community | Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours | Feb-26 | 84.0% | 89.0% | 86% | Community Service Providers only | | | | | | | | | 97.0% | 84.0% | 83.0% | 65% | 78% | 85.0% | |
| | Virtual Wards Utilisation ~ | Mar-26 | 100.0% | 60.0% | 100.0% | 80.0% | 45.0% | 73.0% | 72.2% | 100.0% | | | | | | | | | 82.4% | | |
| | Community Services Waiting List (Adults) | Mar-26 | 0 | 4,393 | 6,541 | 475 | - | - | 201 | 0 | 133 | - | - | - | 3,860 | 5,958 | 17,499 | 5,958 | 17366 | 62,384 | |
| | Community services Waiting List (CYP) | Mar-26 | 1,411 | 674 | 3,284 | 3,658 | - | - | 511 | 4,921 | 0 | - | - | - | 5,427 | 468 | 862 | 468 | 1970 | 23,654 | |
| | Community Services – Adults waiting over 52 weeks | Mar-26 | 0 | 6 | 0 | 0 | - | - | 0 | 0 | 0 | - | - | - | 52 | 0 | 0 | 0 | 171 | 229 | |
| Mental Health | Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks | Feb-26 | Mental Health service providers only | | | | | | | | | | | | 73.0% | 82.0% | - | 76% | | | |
| | CYP Eating Disorders Routine | Feb-26 | | | | | | | 77% | | | | | | | | 85.0% | 91.0% | | 81.0% | |
| | Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact | Feb-26 | | | | 1695 | | | | 5125 | | | | | 1630 | | 9260 | 8925 | 11090 | 37,725 | |
| | Number of people accessing specialist Community PMH and MMHS services | Feb-26 | | | | | | | | | | | | | | | 2550 | 1330 | | 3820 | |
| | Talking Therapies completing a course of treatment - % of LTP trajectory | Feb-26 | Just number available / no target | | | | | | | | | | | | | | | | | 108.0% | |
| | Talking Therapies Reliable Recovery | Feb-26 | | | | | | | | | | | | | | | | 49.0% | | | 47.0% |
| | Talking Therapies Reliable Improvement | Feb-26 | | | | | | | | | | | | | | | | 67.0% | | | 67.0% |
| Learning Disabilities | Inpatients with a learning disability and/or autism (rounded to nearest 5) | Feb-26 | | | | | | | # | | | | | | | | 55 | 25 | | 70 | |
| Note/s | * The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6, 7 and 8 for the ICB's latest position on the above metrics # Value suppressed due to small numbers □ ~ NHSE published and MWL local BIP data are different, NHSE published MWL data includes 20 paediatric hospital at home beds which is not included in local BIP published data □ | | | | | | | | | | | | | | | | | | | | |

3. Provider / Trust Aggregate Position

| Category | Metric | Latest period | Providers | | | | | | | | | | | | | | | | | |
|--------------------------------|--|---------------------|--------------------------------|--------|--------|--------|--------|-------------------------|--------|-------------------|-------|--------|-------|-------|-----------------------|-------|--------|-------|---------------------|-----------|
| | | | Cheshire & Wirral Acute Trusts | | | | | Merseyside Acute Trusts | | Specialist Trusts | | | | | Community & MH Trusts | | | | Net OOA/ Other/ ICB | ICB/ICS * |
| | | | COCH | ECT | MCHT | WUTH | WHH | LUFT | MWL | AHCH | LHCH | LWH | TCCC | TWC | BCHC | WCHC | MCFT | CWP | | |
| Maternity | HIE (Hypoxic ischemic encephalopathy) grade 2 or 3 per 1,000 live births (>=37 weeks) | 25/26 Q3 | 0.0 | 0.0 | 0.0 | 1.5 | 1.6 | | 0.0 | | | 0.0 | | | | | | | | 0.5 |
| | Still birth per 1,000 (rolling 12 months) | Jan-26 | 3.81 | 0.00 | 3.13 | 5.04 | 3.73 | - | 2.55 | - | - | 3.99 | - | - | | | | | | 2.51 |
| Quality & Safety | Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation (Healthcare Associated) | 12 months to Feb 26 | 68 | 20 | 36 | 136 | 81 | 177 | 107 | 16 | 4 | 2 | 20 | 16 | | | | | | 683 |
| | Healthcare Acquired Infections: E.Coli (Healthcare associated) | 12 months to Feb 26 | 58 | 26 | 53 | 108 | 80 | 267 | 155 | 13 | 6 | 6 | 26 | 12 | | | | | | 810 |
| | Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation** # | 12 months to Nov 25 | 0.8840 | 1.2826 | 1.0090 | 1.0546 | 1.0355 | 0.9521 | 0.9956 | | | | | | | | | | | 0.999 |
| | Never Events (rolling 12 month total) | 12 Months to Mar 26 | 4 | 2 | 3 | 4 | 4 | 3 | 4 | 3 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 29 |
| Workforce / HR (Trust Figures) | Staff in post | Mar-26 | 4,480 | 2,437 | 5,169 | 5,891 | 4,271 | 14,237 | 9,515 | 4,166 | 1,919 | 1,717 | 1,880 | 1,524 | 1,288 | 1,432 | 10,472 | 3,928 | - | 74,352 |
| | Bank | Mar-26 | 355 | 221 | 451 | 369 | 422 | 982 | 758 | 117 | 78 | 77 | 14 | 76 | 35 | 48 | 964 | 192 | - | 4,995 |
| | Agency | Mar-26 | 27 | 40 | 93 | 29 | 50 | 97 | 60 | 1 | 3 | 5 | 3 | 6 | 1 | 0 | 32 | 15 | - | 424 |
| | Turnover | Fab-26 | 9.7% | 10.7% | 8.9% | 9.4% | 9.1% | 8.2% | 8.4% | 10.5% | 6.9% | 11.1% | 9.9% | 11.5% | 13.0% | 20.5% | 10.3% | 9.5% | - | 9.5% |
| | Sickness | Jan-26 | 5.8% | 5.8% | 5.5% | 6.0% | 6.7% | 6.6% | 4.8% | 6.8% | 5.6% | 8.6% | 5.5% | 6.6% | 8.7% | 7.7% | 8.3% | 7.0% | - | 6.3% |
| Finance | Overall Financial position - YTD Surplus / (Deficit) (£m) (including deficit support funding) | Mar-26 | -14.41 | -21.13 | -16.28 | -45.30 | -36.10 | -60.97 | -10.73 | 7.16 | 9.61 | -15.72 | 0.89 | 6.96 | -4.43 | 5.10 | 13.27 | 4.05 | 0.00 | -178.02 |
| | Overall Financial position - YTD Surplus / (Deficit) (£m) (excluding deficit support funding) | Mar-26 | -34.04 | -23.72 | -39.32 | -49.53 | -40.68 | -72.09 | -40.95 | 7.16 | 9.61 | -31.03 | 0.89 | 6.96 | -4.43 | 5.10 | 13.27 | 4.05 | 0.00 | -288.74 |
| | Overall Financial position - YTD Variance from plan (£m) (including deficit support funding) | Mar-26 | 0.00 | -13.50 | 0.10 | -40.10 | -25.70 | -48.90 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.10 | -2.90 | 4.20 | -1.00 | 0.00 | -50.30 | -178.00 |
| | Efficiencies - YTD Variance from plan (£m) | Mar-26 | -10.95 | 0.00 | 0.09 | 0.01 | 0.00 | -12.22 | 1.96 | 0.00 | -0.80 | 0.00 | 0.23 | -0.00 | 0.26 | 1.46 | -0.58 | 0.00 | -9.40 | -29.95 |
| | Capital - YTD Variance from plan £m | Mar-26 | 1.17 | 0.47 | 1.93 | -0.91 | -0.39 | -1.28 | -4.98 | -6.10 | 0.43 | -0.08 | -0.58 | -1.49 | -2.11 | -2.15 | 8.71 | -0.90 | 0.20 | -8.05 |
| Note/s | <p>* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6, 7 and 8 for the ICB's latest position on the above metrics</p> <p>** The SHMI banding gives an indication for each non-specialist trust on whether the observed number of deaths in hospital, or within 30 days of discharge from hospital, was as expected when compared to the national baseline, as the UCL and LCL vary from trusts to trust. This "banding" is different to the "rate" used for the ICB on slide 5, therefore a comparison cannot be drawn between the two.</p> <p># Banding changed Aug 23 to reflect SOF rating by NHSE. 'As expected' rating is RAG rated Green, 'Higher than expected' is RAG rated Red.</p> | | | | | | | | | | | | | | | | | | | |

4. Place Aggregate Position

| Category | Metric | Latest period | Sub ICB Place | | | | | | | | | ICB * | Local Trajectory | National Target | |
|--------------|---|---------------|-------------------|---------|----------|------------|------------|-----------|----------|----------|--------------|----------|------------------|-----------------|-----------------|
| | | | Cheshire & Wirral | | | | Merseyside | | | | | | | | |
| | | | Cheshire | | Wirral | Warrington | Liverpool | St Helens | Knowsley | Halton | Sefton | | | | |
| | | | East ** | West ** | | | | | | | South Sefton | | | | S/port & Formby |
| Urgent Care | 4-hour A&E waiting time % waiting less than 4 hours | Mar-26 | 59.0% | 62.0% | 32.4% | 60.6% | 76.1% | 75.4% | 81.9% | 74.7% | 74.1% | 73.8% | 0.0% | 78% by Year end | |
| | Ambulance category 2 mean response time (Ave last 7 days of month) | Mar-26 | 00:30:03 | | 00:30:29 | 00:32:27 | 00:29:41 | 00:37:05 | 00:30:01 | 00:35:50 | 00:30:35 | 00:30:05 | | 00:30:00 | |
| | A&E 12 hour waits from arrival | Mar-26 | 18.1% | | 18.2% | 21.8% | 12.0% | 21.8% | 15.2% | 25.9% | 15.5% | 16.3% | 0.0% | - | |
| | Discharges - Average delay (exclude zero delay) | Feb-26 | 8.4 | 9.4 | 6.2 | 8.5 | 6.8 | 14.8 | 9.2 | 10.1 | 5.9 | 8.5 | 9.0 | | |
| | Percentage of patients discharged on discharge ready date | Feb-26 | 87.9% | 85.7% | 90.3% | 82.4% | 85.0% | 87.4% | 86.5% | 86.5% | 80.9% | 85.6% | 87% | | |
| Planned Care | Total incomplete Referral to Treatment (RTT) pathways | Mar-26 | 95,844 | | 47,998 | 27,484 | 50,585 | 28,807 | 22,504 | 20,193 | 35,132 | 328,547 | 334,989 | - | |
| | The % of people waiting less than 18 weeks on the waiting list (RTT) | Mar-26 | 63.7% | | 65.2% | 66.9% | 62.3% | 67.6% | 64.7% | 63.6% | 62.3% | 67.7% | 64.5% | 62.9% | |
| | The % of people waiting more than 52 weeks on the waiting list (RTT) | Mar-26 | 1.2% | | 0.8% | 0.9% | 1.1% | 1.1% | 1.5% | 1.2% | 1.0% | 1.1% | 1.0% | | |
| | Patients waiting more than 6 weeks for a diagnostic test | Mar-26 | 12.7% | | 6.3% | 3.1% | 10.1% | 5.0% | 7.2% | 8.5% | 15.2% | 9.8% | 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 | Feb-26 | 65.8% | 71.3% | 76.1% | 78.1% | 70.8% | 76.6% | 72.2% | 86.5% | 73.6% | 73.5% | 74.7% | 85.0% | |
| | 1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer | Feb-26 | 94.6% | 92.7% | 95.6% | 95.6% | 96.3% | 98.6% | 96.3% | 98.4% | 93.8% | 95.8% | 96.0% | 96.0% | |
| | Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded | Feb-26 | 80.3% | 82.5% | 76.8% | 80.9% | 80.9% | 84.2% | 81.3% | 84.2% | 79.9% | 80.7% | 79.2% | 77% by Year end | |
| | Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028 (calendar YTD) | Dec 25 YTD | 61.2% | | 61.0% | 56.4% | 59.0% | 57.4% | 56.6% | 53.7% | 57.9% | 60.2% | 59.3% | 75% by 2028 | |
| Community | Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours | Jan-26 | 84.0% | 74.0% | 85.0% | 97.0% | 83.0% | 81.0% | 88.0% | 97.0% | 78.0% | 85.0% | 70.0% | 70.0% | |
| | Virtual Wards Utilisation Number only | Mar-26 | 74 | 77 | 42 | 29 | 58 | 42 | 9 | 7 | 15 | 353 | | | |
| | Community Services Waiting List (Adults) - data only available at ICB/Provider level | | | | | | | | | | | | 62,384 | | |
| | Community services Waiting List (CYP) - data only available at ICB/Provider level | | | | | | | | | | | | 23,654 | | |
| | Community Services – Adults waiting over 52 weeks - data only available at ICB/Provider level | | | | | | | | | | | | 229 | | |
| Note/s | * The latest period for ICB performance may be different to that of the places due to variances in processing data at different levels. Please see slides 6, 7 and 8 for the ICB's latest position on the above metrics ** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT. # Wirral A&E figure affected by missing data submissions | | | | | | | | | | | | | | |

4. Place Aggregate Position

| Category | Metric | Latest period | Sub ICB Place | | | | | | | | | ICB * | Local Trajectory | National Target | |
|-----------------------|---|---------------|-------------------|---------|---------|------------|------------|-----------|----------|--------|--------------|-------|------------------|-----------------|-----------------|
| | | | Cheshire & Wirral | | | | Merseyside | | | | | | | | |
| | | | Cheshire | | Wirral | Warrington | Liverpool | St Helens | Knowsley | Halton | Sefton | | | | |
| | | | East ** | West ** | | | | | | | South Sefton | | | | S/port & Formby |
| Mental Health | Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks | Feb-26 | 88.0% | | 69.0% | | 67.0% | 92.0% | 58.0% | 100.0% | 67.0% | 86.0% | 76.0% | 60.0% | 60.0% |
| | People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months | To Dec 2025 | 51.0% | | 55.0% | 59.0% | 51.0% | 52.0% | 55.0% | 68.0% | 49.0% | 66.0% | 54.0% | - | 60.0% |
| | Dementia Diagnosis Rate | Feb-26 | 68.2% | | 66.2% | 72.1% | 69.5% | 66.6% | 66.3% | 67.9% | 67.60% | | 68.1% | 66.7% | 66.7% |
| | CYP Eating Disorders Routine | Feb-26 | 91.0% | | | 93.0% | 66.0% | 85.0% | 95.0% | 100.0% | 77.0% | 93.0% | 81.0% | 95.0% | 95.0% |
| | Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact | Feb-26 | 6700 | | 4755 | 3870 | 9770 | 4045 | 2950 | 1750 | 2505 | 1620 | 37725 | 37246 | - |
| | Number of people accessing specialist Community PMH and MMHS services | Feb-26 | 1045 | | 390 | 330 | 755 | 325 | 325 | 220 | 270 | 165 | 3820 | 3420 | - |
| | Talking Therapies 1st to 2nd Treatment >90 days | Feb-26 | 17% | | 17% | 38% | 5% | 7% | 16% | 22% | 63% | 52% | 19% | | <=10% |
| | Talking Therapies completing a course of treatment | Feb-26 | 8950 | | 3730 | 2250 | 5930 | 2610 | 1670 | 1035 | 1680 | 1220 | 108.0% | 100.0% | 100.0% |
| | Talking Therapies Reliable Recovery | Feb-26 | 52.0% | | 45% | 51.0% | 47.0% | 50.0% | 49.0% | 48.0% | 28.0% | 32.0% | 47.0% | 48.0% | 48.0% |
| | Talking Therapies Reliable Improvement | Feb-26 | 71.0% | | 62.0% | 73.0% | 67.0% | 68.0% | 62.0% | 65.0% | 59.0% | 52.0% | 67.0% | 67.0% | 67.0% |
| Learning Disabilities | Adult inpatients with a learning disability and/or autism (rounded to nearest 5) | Dec-25 | 20 | | 5 | 5 | 15 | 5 | 5 | 5 | 10 | | 70 | 46 | - |
| | Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register | Feb 26 YTD | 71.8% | | 69.2% | 63.2% | 74.8% | 64.7% | 80.3% | 67.2% | 69.2% | | 70.9% | 70.9% | 75% by Year end |
| Primary Care | Appointments in General Practice & Primary Care networks @ | Feb 26 YTD | 368,996 | | 212,895 | 112,774 | 263,211 | 87,598 | 86,979 | 57,177 | 132,783 | | 1,322,413 | 1,354,605 | |
| | The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care. (rolling 12 months) | Jan-26 | 6.29% | 7.51% | 9.32% | 6.33% | 7.65% | 6.41% | 6.82% | 6.64% | 7.96% | | 7.40% | 10.0% | 10.0% |
| | Total volume of antibiotic prescribing in primary care | Jan-26 | 0.76 | 0.84 | 1.01 | 0.80 | 0.90 | 1.06 | 1.09 | 0.95 | 0.93 | | 0.91 | 0.871 | 0.871 |
| Note/s | * The latest period for ICB performance may be different to that of the places 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 for Place based on last year postion, Green for greater than last year | | | | | | | | | | | | | | |

4. Place Aggregate Position

| Category | Metric | Latest period | Sub ICB Place | | | | | | | | | ICB * | Local Trajectory | National Target | |
|-----------------------------------|---|---------------------|-------------------|---------|--------|------------|------------|-----------|----------|--------|--------------|-------|------------------|-----------------|-----------------|
| | | | Cheshire & Wirral | | | | Merseyside | | | | | | | | |
| | | | Cheshire | | Wirral | Warrington | Liverpool | St Helens | Knowsley | Halton | Sefton | | | | |
| | | | East ** | West ** | | | | | | | South Sefton | | | | S/port & Formby |
| Integrated care BCF metrics *** | Unplanned hospitalisation for chronic ambulatory care sensitive conditions Per 100,000 (New data source) | Dec-25 | 189.7 | 267.8 | 168.7 | 269.4 | 281.9 | 64.4 | 124.3 | 177.3 | 147.4 | 187.9 | - | - | |
| | Percentage of people who are discharged from acute hospital to their usual place of residence (New data source) | Dec-25 | 73.0% | 73.8% | 84.0% | 82.7% | 82.1% | 81.9% | 84.1% | 85.3% | 81.5% | 80.9% | - | - | |
| | Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 (New data source) | Oct-25 | 152.8 | 105.9 | 114.7 | 128.9 | 192.2 | 128.8 | 195.3 | 118.2 | 169.5 | 145.1 | - | - | |
| Health Inequalities & Improvement | % of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold | Q2 25/26 | 68.4% | | 66.0% | 67.9% | 67.7% | 66.9% | 67.2% | 70.3% | 64.8% | 67.4% | 77.0% | 80.0% | |
| | CVD treated to cholesterol threshold: LDL-cholesterol less than or equal to 2.0 mmol/l or non-HDL cholesterol less than or equal to 2.6 mmol/l) | Q2 25/26 | 47.9% | | 49.5% | 45.8% | 46.2% | 44.2% | 47.4% | 47.1% | 43.1% | 46.7% | | 50% | |
| | Smoking at Time of Delivery | Q3 25/26 | 4.5% | | 5.4% | 2.6% | 6.7% | 8.0% | 5.9% | 6.1% | 6.8% | 5.4% | | <6% | |
| | Smoking prevalence (aged 15+) - As reported on CIPHA from GP Systems | Mar-26 | 13.5% | | 16.1% | 16.1% | 18.6% | 15.8% | 18.5% | 19.0% | 16.7% | 15.6% | 16.1% | 12% | 12% |
| Continuing Healthcare | Standard Referrals completed within 28 days | Q3 25/26 | 57.0% | | 62.0% | 83.0% | 57.0% | 98.0% | 94.0% | 80.0% | 51.0% | 66.0% | 63.90% | >80% | >80% |
| | Number eligible for Fast Track CHC per 50,000 population (snapshot at end of quarter) | Q3 25/26 | 16.98 | | 27.89 | 22.38 | 32.78 | 27.02 | 10.23 | 20.57 | 51.19 | 71.46 | 27.19 | 18 | |
| | Number eligible for standard CHC per 50,000 population (snapshot at end of quarter) | Q3 25/26 | 62.1 | | 64.0 | 41.5 | 46.9 | 36.7 | 32.5 | 43.4 | 58.1 | 64.0 | 52.71 | 34 | |
| Quality & Safety | Still birth per 1,000 - (rolling 12 mths) (GP Reg MSDS) | Jan-26 | 0.94 | 2.40 | 4.36 | 2.85 | 3.94 | 1.99 | 0.00 | 0.00 | 2.49 | 2.51 | | | |
| | Healthcare Acquired Infections: Clostridium Difficile - (All cases) | 12 months to Feb 26 | 215 | | 192 | 109 | 215 | 72 | 64 | 63 | 134 | 1064 | 843 | - | |
| | Healthcare Acquired Infections: E.Coli - (All cases) | 12 months to Feb 26 | 687 | | 301 | 180 | 477 | 206 | 170 | 109 | 294 | 2424 | 2001 | | |
| Finance | Overall Financial position Variance (£m) | Mar-26 | -8.5 | -3.8 | -7.1 | -2.5 | -16.3 | -2.4 | -8.0 | -4.2 | 0.1 | 2.4 | 0.0 | 0.0 | |
| | Efficiencies (Variance) | Mar-26 | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | 0.0 | 0.0 | |
| | Mental Health Investment Standard met/not met (MHIS) | Mar-26 | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | Yes | Yes | |
| | BCF achievement (Places achieving expenditure target) | Mar-26 | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y | 9/9 | 9/9 | |
| Note/s | <p>* The latest period for ICB performance may be different to that of the places due to variances in processing data at different levels. Please see slides 6,7 and 8 for the ICB's latest position on the above metrics</p> <p>** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT.</p> <p>*** Local trajectories set by Place as part of their BCF submissions to NHSE, therefore RAG rating will vary for Places with lower/higher trajectories</p> | | | | | | | | | | | | | | |

5. Exception Report – Urgent Care

A&E 4 hour waits from arrival

Latest ICB Performance (Apr-26)

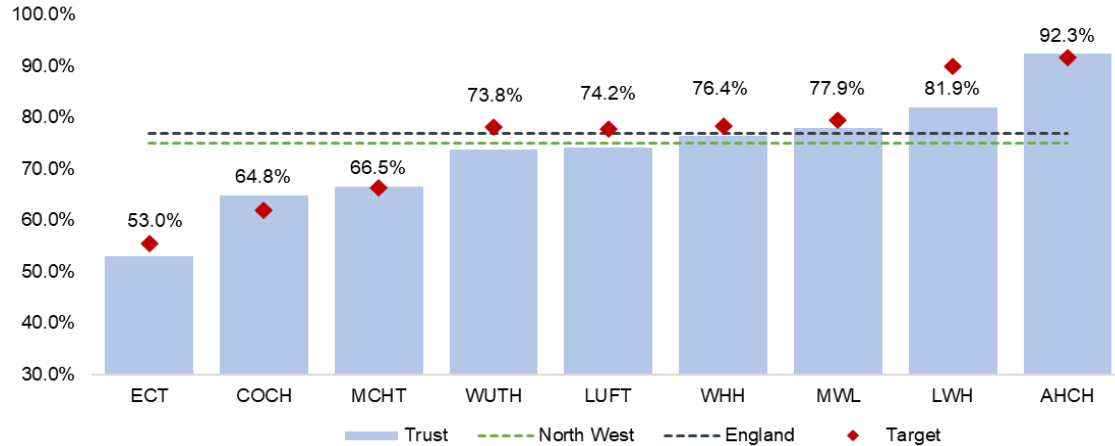
74.7%

National Ranking

26/42

Provider Breakdown (Apr-26)

Improved



A&E 12 hour waits from arrival (Type 1 & 2)

Latest ICB Performance (Apr-26)

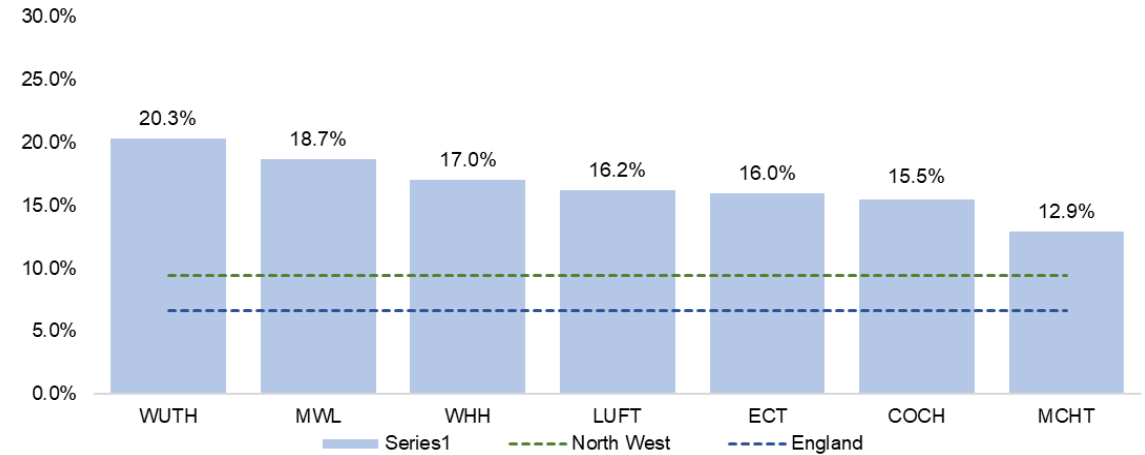
13.1%

National Ranking

42/42

Provider Breakdown (Apr-26)

Improved



Issue

- A&E 4-hour performance is 74.7% in April 2026, with a national ranking of 26/42 ICBs. This represents an improvement; however, system performance remains below the 78% national ambition and variation across providers continues.
- Performance has improved in a number of providers, with particularly strong performance seen at AHCH (92.3%), LWH (81.9%) and MWL (77.9%). ECT remains the lowest performing site at 53.0%, although improvement work continues to be embedded locally.
- A&E 12-hour waits from arrival have improved slightly to 13.1%, however the national ranking is 42/42. Whilst limited improvement is evident across most organisations, Cheshire and Merseyside continues to experience high occupancy, delayed discharges and long lengths of stay, impacting timely flow through emergency departments.

Action

- ECT continue to demonstrate the strongest trajectory of improvement from a low baseline, with sustained operational oversight through executive review, daily performance meetings and strengthened ED flow processes.
- WUTH and COCH have continued to see sustained improvement in 4-hour performance through focused operational grip, enhanced flow oversight and reinforcing urgent care performance as a whole-system responsibility.
- MWL have continued to perform above the North West average, supported through senior clinical decision-making, specialty engagement at the front door and strengthened MDT flow processes.
- LWH and AHCH remain the strongest performers across the system for 4-hour delivery, supported through dedicated flow teams, specialty in-reach and sustained focus on timely admissions and discharge.
- MCHT has the lowest proportion of 12-hour waits at 12.9%, with WUTH, MWL and WHH also demonstrating reductions in prolonged waits through strengthened oversight of long-waits.
- Whilst improvement is evident in 12-hour performance across the system, Cheshire and Merseyside continues to have a significant gap against both regional and national benchmarking.

Delivery

- Continued improvements in front-door streaming, Same Day Emergency Care (SDEC) utilisation and operational flow processes are supporting improvements in 4-hour performance across a number of providers.
- The ICB UEC team and SCC continue to provide daily operational oversight through SHREWD, system escalation calls and targeted support to organisations experiencing sustained pressure.
- Trusts continue to undertake daily reviews of all 12-hour waits, supported by executive escalation, senior clinical oversight and strengthened discharge coordination processes to improve patient flow.

5. Exception Report – Urgent Care

Ambulance category 2 mean response time

Latest ICB Performance (Apr-26)

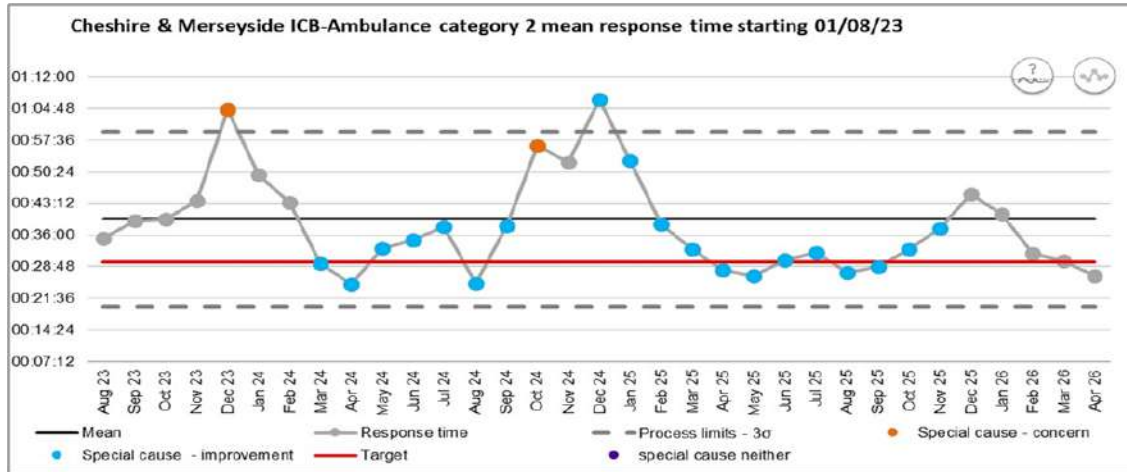
00:26:46

National Ranking

24/42

ICB Trend (Apr-26)

Improved



Issue

- Cat 2 mean response time for April 2026 is **00:26:46**, with a national ranking of **24/42**.
- Performance has continued to improve and is now operating **within the national 30-minute standard**, reflecting sustained recovery following winter pressures.
- Improvement has been supported by reductions in ambulance handover delays and strengthened system flow; however, variation in demand and hospital pressures continues to impact ambulance availability and turnaround at times.

Actions

- Sustained system-wide focus on ambulance handovers within 45 minutes, with strengthened escalation for >30 and >45 minute breaches through daily operational oversight.
- Continued use of real-time performance monitoring via SHREWD and OPEL escalation processes to support rapid intervention across providers and NWS.
- SCC colleagues continue to work with providers and NWS through daily operational calls and the Ambulance Improvement Group to reduce variation and maintain improvement.
- Ongoing programmes of work linked to admission avoidance, discharge, bed occupancy, and ED congestion to support ambulance flow across the wider system footprint.

Delivery

- The improvement in Cat 2 response times reflects increased operational grip, stronger whole-system coordination, and the positive impact of actions focused on patient flow and ambulance turnaround.

Mean Ambulance Handover time (ED and Non ED)

Latest ICB Performance (Apr-26)

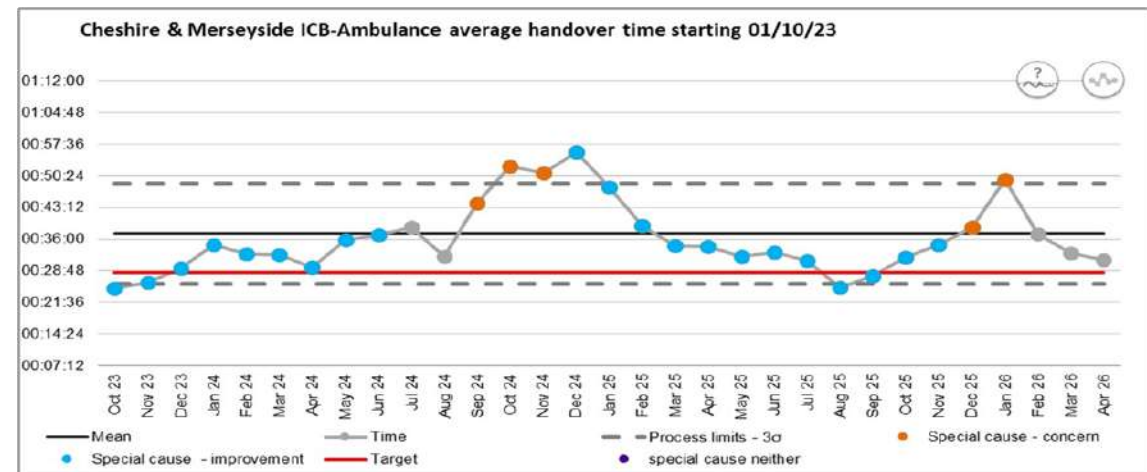
00:31:11

National Ranking

30/42

ICB Trend (Apr-26)

Improved



Issue

- Mean ambulance handover time for April 2026 is 00:31:11, with a national ranking of 30/42
- Performance has improved from the previous reporting cycle, with handover times continuing to reduce following winter escalation periods; however, performance remains above the 15-minute national expectation.
- Variation persists across sites, particularly during periods of ED congestion, high occupancy, and increased acuity.

Actions

- All Trusts have plans in place to reduce and eradicate corridor care. As flow improves through ED, we see an improvement in ambulance handover times
- NWS Integrated Contact Centre colleagues continue to liaise directly with providers to reduce delays and mitigate operational risk where possible.

Delivery

- Improvements in ambulance handover performance reflect strengthened operational oversight, improved coordination across system partners, and a sustained focus on reducing variation across sites.
- Continued delivery of flow and discharge initiatives is supporting gradual improvement in ambulance turnaround and reducing prolonged handover delays.

5. Exception Report – Urgent Care

Adult G&A bed occupancy

Latest ICB Performance (Apr-26)

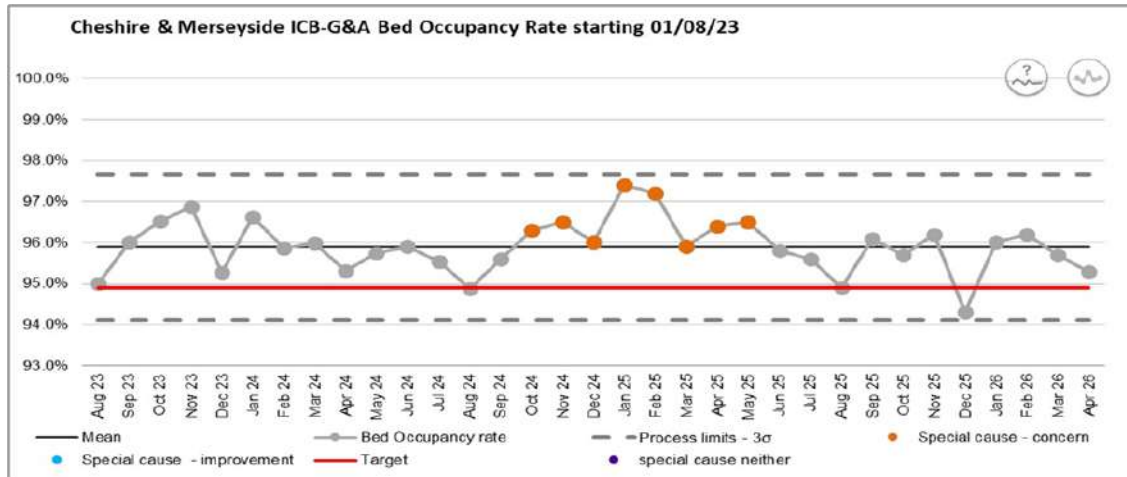
95.3%

National Ranking

21/42

ICB Trend (Apr-26)

Improved



Issue

- Adult G&A bed occupancy for April 2026 is 95.3%, with a national ranking of 21/42. This represents an improvement and continues the gradual reduction seen following peak winter pressures.
- Occupancy remains above the recommended 92–93% threshold, continuing to impact patient flow, ED crowding, and ambulance handover performance.
- System pressures continue to be driven by high acuity, delayed discharges, and variation in discharge productivity and flow across sites.

Actions

- System partners continue to maintain a strong focus on reducing bed occupancy through improved discharge flow, escalation management, and operational grip.
- Additional improvement activities in place in the lead up to Bank holidays to support flow (MADE and RESET at the front door).
- Locality and provider teams continue to work collaboratively to address barriers to discharge, including pathways impacted by non-NHS delays and repatriation challenges
- Continued focus on reducing long length of stay and improving flow through the first 72 hours of admission remains a key system priority

Delivery

- Despite improvement, occupancy remains significantly above optimal levels and continues to present operational risk across urgent and emergency care services.

Percentage of beds occupied by patients no longer meeting the criteria to reside

Latest ICB Performance (Apr-26)

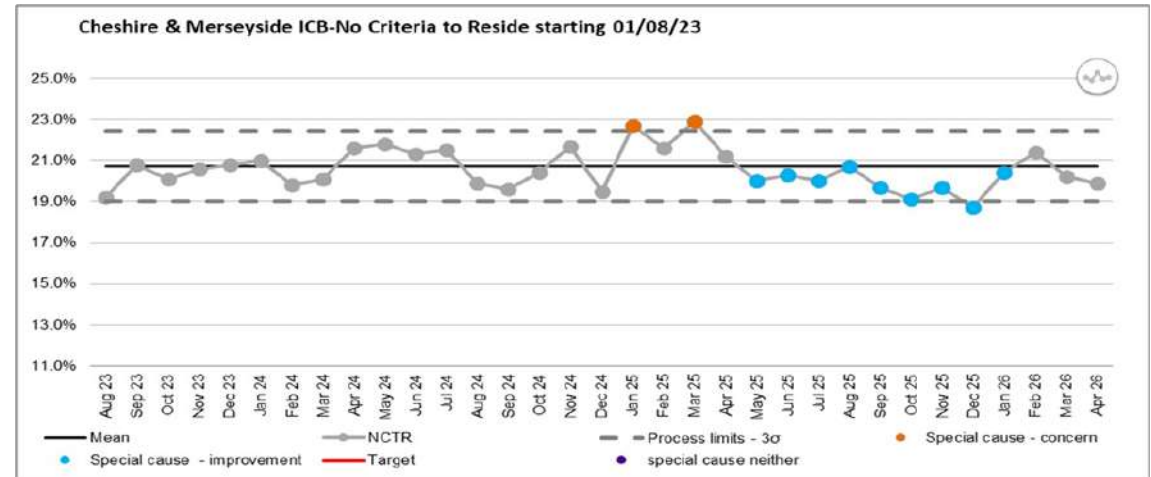
19.9%

National Ranking

n/a

ICB Trend (Apr-26)

Improved



Issue

- Performance remains above the C&M ambition of 12%. Delays linked to onward care, community capacity, housing, and wider non-NHS barriers continue to impact timely discharge and patient flow.
- Elevated NCTR levels contribute to high bed occupancy, reduced inpatient capacity, and front-door congestion across acute sites.

Actions

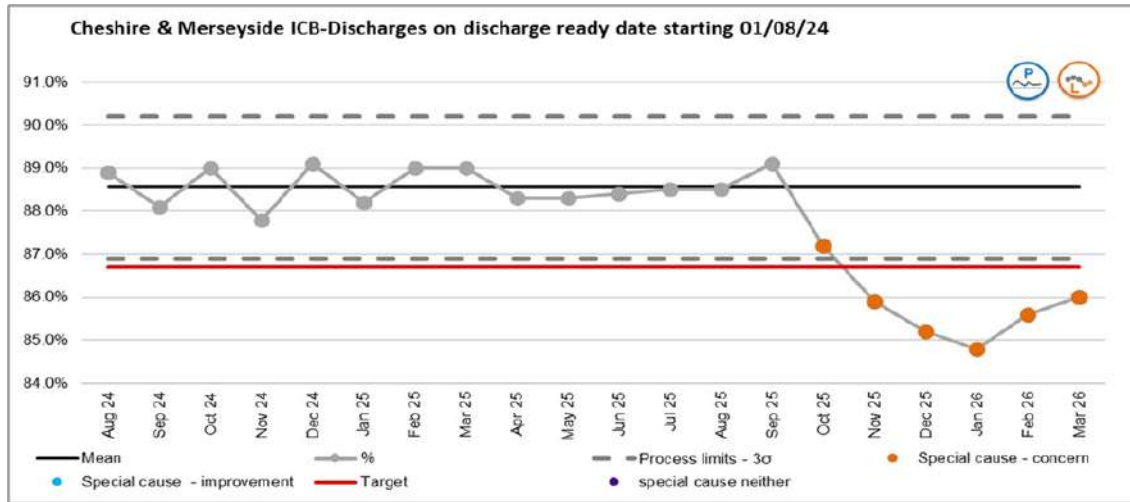
- ICB colleagues continue to support NCTR escalation meetings and discharge improvement activity.
- ICB has reviewed Better Care Fund plans ahead of submission to look at impact of BCF investment on discharge delays. ICB are to develop a new BCF review framework to support BCF planning throughout the year .
- Focussed programme of work across Cheshire to develop and reduce variation across Care Transfer Hubs for the 3 acute trusts .
- Community bed-based review is underway to understand capacity and to improve efficiency and flow .

Delivery

- Improved performance reflects continued operational focus on discharge and flow, alongside strengthened coordination between acute, community, local authority, and regional partners.
- Further improvement is required to reduce variation across the system and support sustainable reductions in occupancy and emergency care pressures.

5. Exception Report – Urgent Care

| Percentage of patients discharged on discharge ready date | | | |
|---|-------|------------------|--------------|
| Latest ICB Performance (Mar-26) | 86.0% | National Ranking | 20/42 |
| ICB Trend (Mar-26) | | | Deteriorated |



Issue

- Performance for March 2026 is 86.0%, with a national ranking of 20/42. This is a deterioration from previous months. Reduced performance reflects ongoing high bed occupancy, increasing complexity within discharge pathways, and continued pressure across community and social care capacity
- Delays linked to care transfer hub processes, domiciliary care availability, pathway capacity, and assessment turnaround continue to impact timely discharge and wider system flow.

Actions

- System partners continue to progress actions from recent MADE/RESET and flow improvement work focused on discharge reliability, early discharge planning, and same-day discharge performance.
- ICB has reviewed Better Care Fund plans ahead of submission to look at impact of BCF investment on discharge delays. ICB are to develop a new BCF review framework to support BCF planning.
- As part of BCF, Places ensuring that improvement trajectories for pathway 1,2 and 3 are agreed and reviewed to monitor improvement plans to support discharge pathways

Delivery

- Improvement in discharge reliability remains critical to reducing occupancy, lowering NCTR levels, improving ambulance handovers, and supporting front-door resilience ahead of further seasonal pressure.

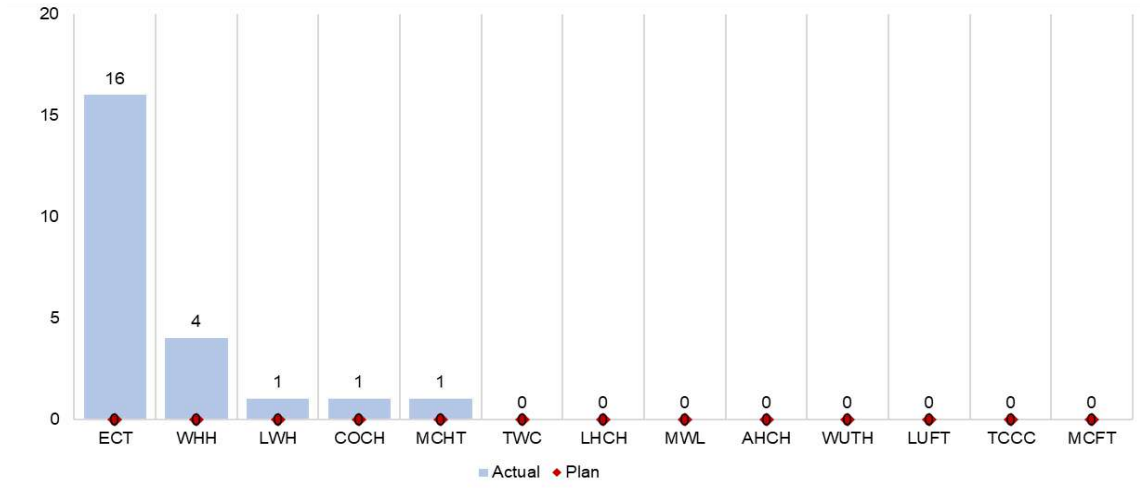
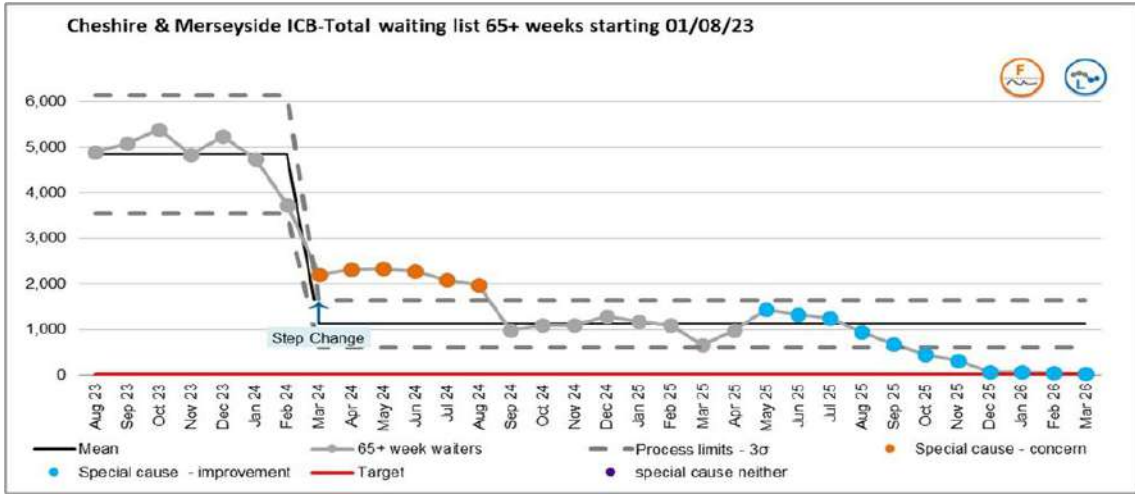
5. Exception Report – Planned Care

ICB incomplete RTT pathways of 65 weeks or more

| | | | |
|---------------------------------|-----------|------------------|-----------------|
| Latest ICB Performance (Mar-26) | 36 | National Ranking | n/a |
| ICB Trend (Mar-26) | | | Improved |

Trust incomplete RTT pathways of 65 weeks or more

| | | | |
|---------------------------------|-----------|------------------|-----------------|
| Latest ICB Performance (Mar-26) | 36 | National Ranking | n/a |
| Provider Breakdown (Mar-26) | | | Improved |



Issue

- There were 13 patients waiting 65wks+ as of March 26 month end, which is a significant improvement from the position reported over the previous months.
- The largest proportion is at East Cheshire Hospital Trust (07)
- Data quality and accurate forecasting to underpin improvement work has been a challenge. Significant improvements have been made across all providers.

Action

- Weekly Performance & Delivery meeting continue which all providers attend to update on their current position, escalate issues and request mutual aid. This has delivered significant improvements in 65wk performance during previous months.
- 6 Trusts are currently in NHSE Tiering with improvement plans in place and regular oversight meetings. CMPC & ICB representatives attend and provide support where required.
- The elective programme is working closely with providers to ensure that mutual aid and operational tactical measures are explored and expedited.
- CMPC continues to prioritise validation activity with current performance reporting at 12-weeks 72.88%, 26-weeks 88.62% (6 providers reporting above national ambition of 90%) and 52-weeks 96.67%, (with 9 providers reporting above the national ambition of 90%)
- The delivery of the C&M Q4 activity sprint with additional capacity initiatives has supported further improvements in 65wk breaches and supported future mitigation of upcoming breaches.
- 65-weeks breaches in C&M have been reduced from a position of 1,311 in July 2025 to 13 at the end of March 2026, and the ICB are now at 16/42 nationally with quartile 2 performance in the latest published data.

Delivery

- There is a continued focus on eradicating 65 week waits alongside delivery of 52- and 18-weeks performance.
- This will be monitored via the CMPC system Performance and Delivery meetings, COO Group and Delivery Board. CMPC continues to report into region on current performance and plans for immediate recovery.
- 65-weeks continues to be a key focus area in the weekly System Performance and Delivery meetings chaired by the programme Lead COO.

5. Exception Report – Planned Care

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

Latest ICB Performance (Mar-26)

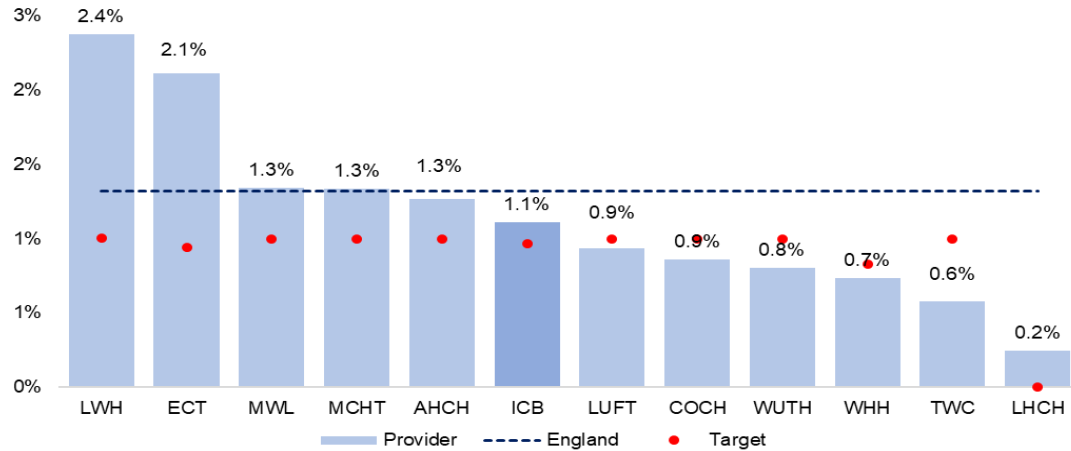
1.1%

National Ranking

25/42

Provider Breakdown (Mar-26)

Improved



Issue

- While the current performance is slightly behind plan, performance has improved significantly against the national target of 1%.
- Liverpool Women's is furthest off plan (+2.08%) due to cessation of insourcing earlier in the year, however, significant improvement has been made since a deterioration to c.10%.
- East Cheshire continues to experience challenges with delivery of the target following deployment of the new trust-wide EPR systems.

Action

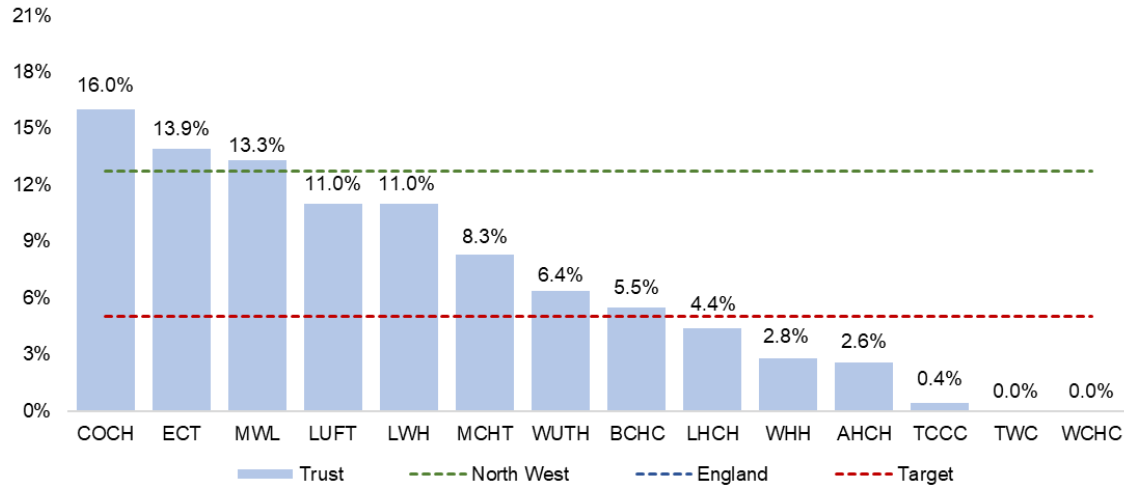
- 6 Trusts are currently in NHSE Tiering with associated improvement plans and regular oversight meetings. The CMPC Elective team hold two-weekly calls with all providers to review performance and to provide support for any escalated actions.
- The C&M Q4 plan with additional NHSE funding to support increased clinical triage of patients waiting >27wks is underway across multiple specialties and is achieving between 20 to 30% removals and supported delivery of the 52-week national target and reduce patient waiting times.
- A System Capacity Management Process is being implemented to increase utilisation of elective hubs and inter-organisational support. Additional regional funding will be used to provide increased capacity across the system to help reduce long waiters and WL size.

Delivery

- Delivered via C&M Clinical Operational Group, monitored via CMPC COO Group & Delivery Board.

5. Exception Report – Diagnostics & Cancer

| Patients waiting more than 6 weeks for a diagnostic test | | | |
|--|------|------------------|--------------|
| Latest ICB Performance (Mar-26) | 9.8% | National Ranking | 3/42 |
| Provider Breakdown (Mar-26) | | | Deteriorated |



Issue

- C&M did not achieve the 5% target but remained within the top 3 ICS nationally for diagnostic performance. 7 of the C&M NHS Providers achieved or exceeded the 5% target with 3 diagnostic tests (Sleep Studies, Barium Enema and CT) exceeding the target.
- March Performance was impacted by an increase in test demand due to Elective Sprint activity (RTT) which increased referrals for tests without an accompanying increase in diagnostic capacity.

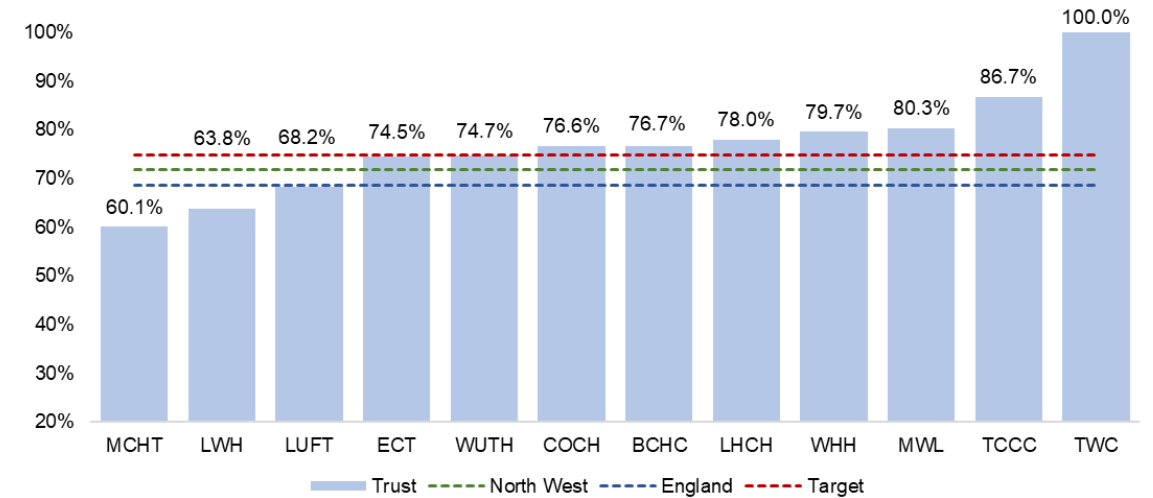
Action

- Action plans in place with Providers to increase referrals to the Halton Endoscopy Hub, to utilise NHS capacity to offer patients earlier access to an Endoscopy test. Work underway with the Hub to mitigate patients declining due to travel / transport issues.
- Continue to exhaust and maximise Mutual Aid for Imaging tests via CDCs.
- Awaiting outcome of NHSE capital bid funding which, if approved, will increase test capacity including expansion of existing CDC sites and new CDC sites.

Delivery

- C&M planning to meet the 96.6% target for March 2027.

| 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 (Feb-26) | 73.5% | National Ranking | 9/42 |
| Provider Breakdown (Feb-26) | | | Improved |



Issue

- C&M not yet achieving the 85% 62-day combined standard required. The interim target is 75% by March 2026. Current performance of 73.5% is significantly ahead of England (68.6%) and represents good performance and progress towards the end of year ambition.

Action

- Capacity and demand exercises for 25/26 are addressing delays and short-term investment is being made by the Cancer Alliance in key areas however, this is limited due to reduced alliance funding in 2025/26.
- An operational improvement plan was submitted to NHSE as part of alliance assurance.
- Q4 additional funding secured via region deployed across C&M.

Delivery

- C&M expects to meet the 75% and 85% ahead of England as a whole and expects to achieve the end of year trajectory position for 62-day performance.

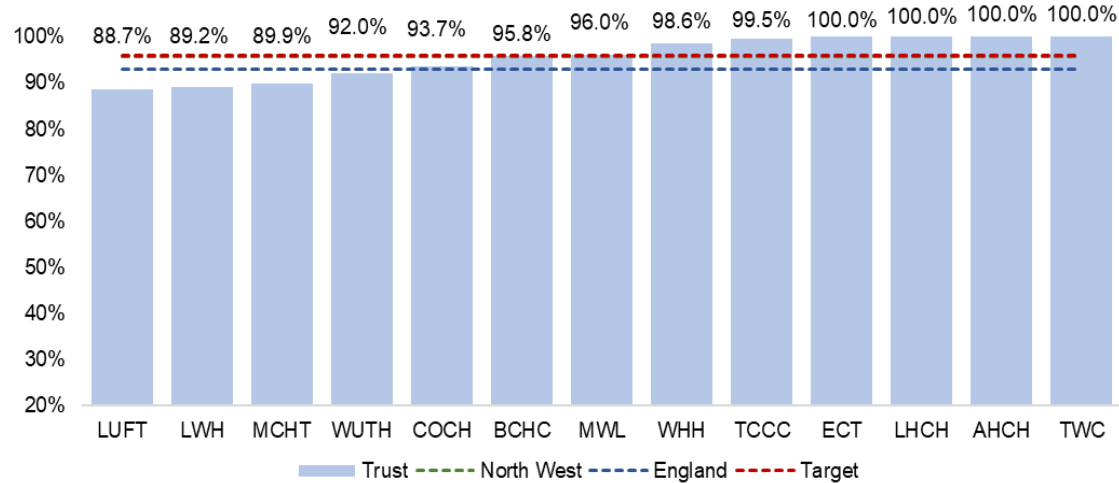
5. Exception Report – Cancer & Community

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

Latest ICB Performance (Feb-26) **95.8%** National Ranking **12/42**

Provider Breakdown (Feb-26)

Improved



Issue

- C&M not yet achieving the 96% 31-day combined standard required. However, the figure of 95.8% is ahead of England (93%) and represents good performance 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.
- Significant improvements have been made at Wirral and Mid Cheshire in recent months.

Delivery

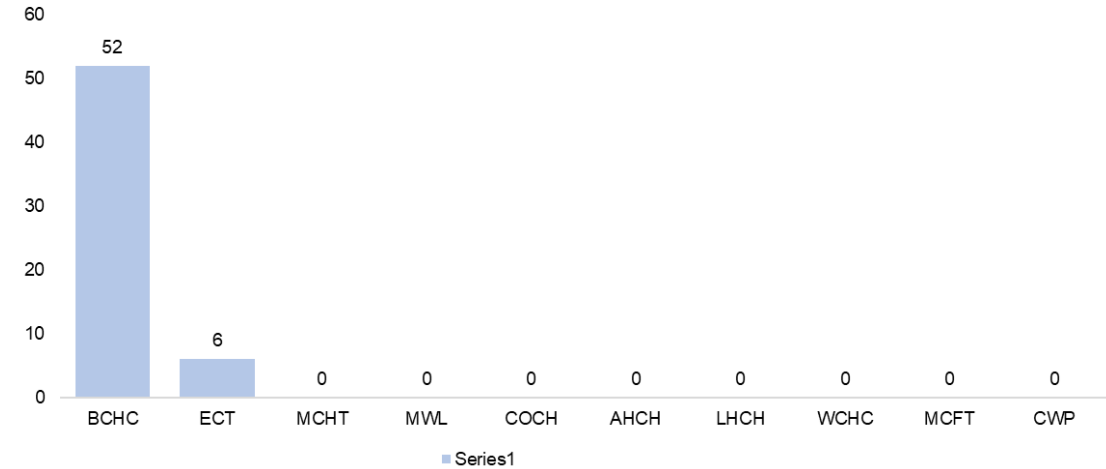
- C&M expects to meet the 96% ahead of England as a whole. 31-day breaches are identified and are targeted consistently with improvement plans.

Community Services – Adults waiting over 52 weeks

Latest ICB Performance (Feb-26) **229 *** National Ranking **n/a**

Provider Breakdown (Feb-26)

Deteriorated



Issue/Action

- Dermatology:** As of April 1st, 2026, there were two patients waiting over 52 weeks. The service remains on track to achieve a zero >52-week position,
- Podiatry – Warrington:** A zero >52-week waiting position has been achieved.
- Podiatry – Halton:** The service continues to reduce waits over 52 weeks, with a focused action plan in place to bring remaining long waiters below the threshold and is progressing towards a sustained zero >52-week position.

Delivery

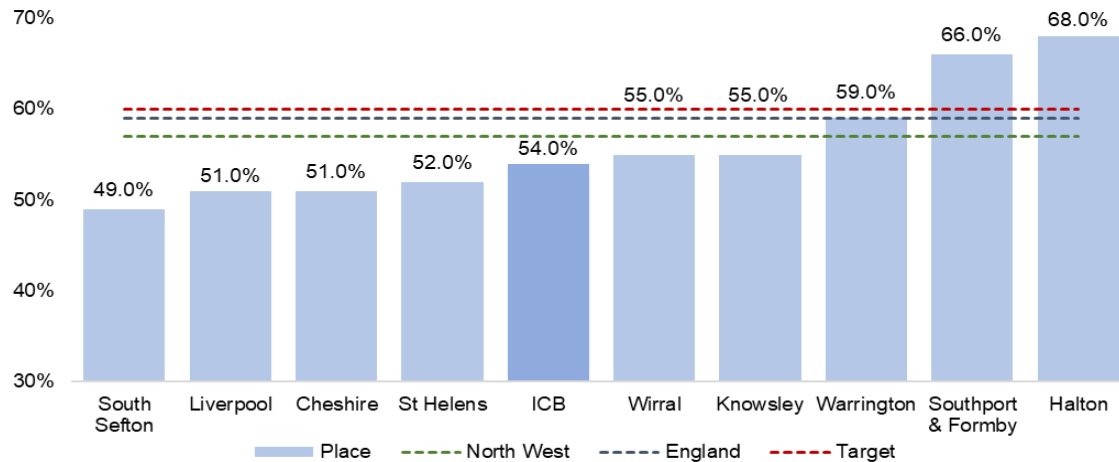
- Recovery plans remain in place across services, and sustained progress is being made to ensure no patients wait over 52 weeks.

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

5. Exception Report – Mental Health

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

| | | | |
|-----------------------------------|--------------|------------------|---------------------|
| Latest ICB Performance (Q3-25/26) | 54.0% | National Ranking | 33/42 |
| Place Breakdown (Q3-25/26) | | | Deteriorated |



Issue

- ICB performance is below the minimum 60% target. National ambition is to work towards 75% of people with SMI receiving all 6 physical health checks.

Action

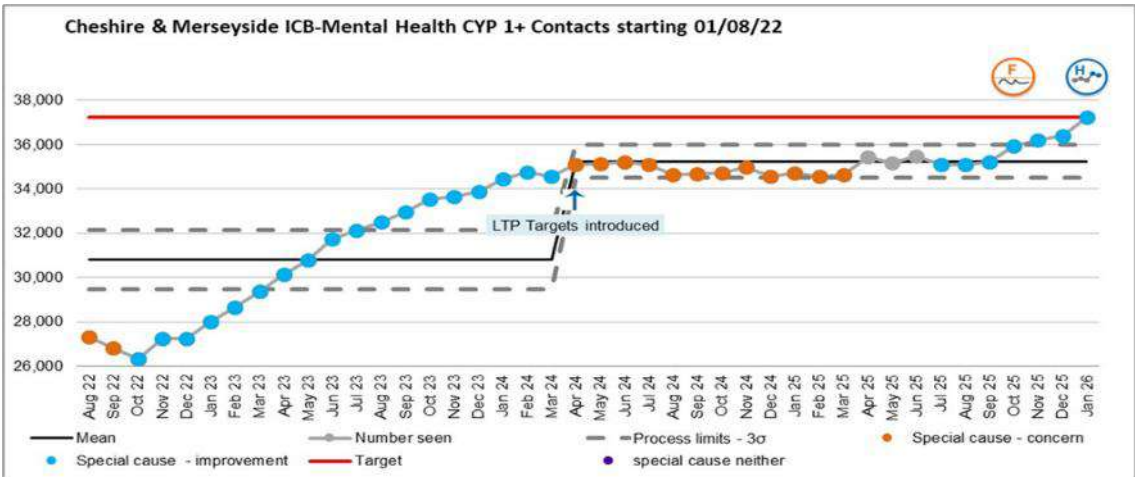
- Places to consider continuation of existing outreach schemes which promote and encourage uptake of physical health checks and note the risk of adverse impact if serving notice.
- Consideration given to how monitoring of physical health in SMI will be incorporated in business-as-usual processes to satisfy requirements of the NHS Oversight Framework.

Delivery

- Only 1 place met the minimum 60% target this quarter compared with 6 out of 9 places in Q4 of 2024/25.
- Compared with the same quarter 3 position last year, there has been a 2% increase in the number of SMI patients receiving all 6 health checks
- Historic trends generally indicate below plan performance in the first 3 quarters of the year with significant numbers of health checks undertaken in quarter 4. Forecast out-turn is therefore expected to meet the national standard of 60%.

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

| | | | |
|---------------------------------|---------------|------------------|-----------------|
| Latest ICB Performance (Jan-26) | 37,245 | National Ranking | n/a |
| ICB Trend (Jan-26) | | | Improved |



Issue

- There has been a further 2% improvement in planned access rates since Dec 25, however rates remain circa 345 below target at 99% 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. Month on month data illustrates progress towards target.

Action

- Request made for “in-month access” report to be added to BIP as 12-month rolling activity can be misleading. Aim to identify in-month changes more quickly and address areas of concern. However, capacity within the ICB limits progress.
- ICB place leads to develop a VCSE data improvement plan to address gaps in non-NHS funded activity, recognising digital and infrastructure variation across the sector. However, capacity to support VCSE onboarding limits progress.

Delivery

- There has been an incremental increase in overall C&M access rates in recent months as some VCSFE providers are onboarded to MHSDS and starting to flow data nationally.
- Further incremental increase is anticipated in quarter 4 but may not be sufficient to achieve target
- The establishment of new MH Support Teams in Schools in 2026/27 will further contribute to improved access rates and achievement of national targets is expected by March 2027.

5. Exception Report – Mental Health

CYP Eating Disorders Routine

Latest ICB Performance (Jan-26)

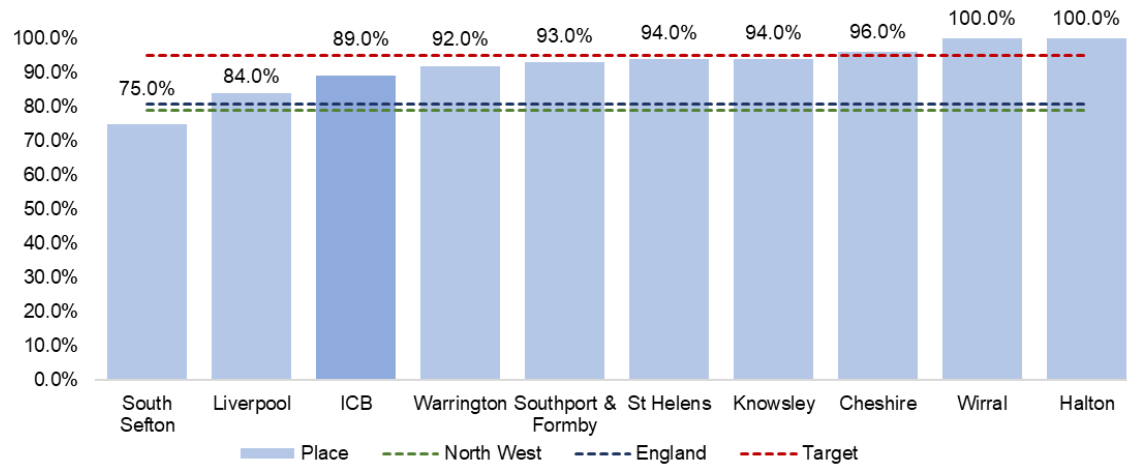
89.0%

National Ranking

3/42

Place Breakdown (Jan-26)

Deteriorated



Issue

- Although C&M waiting time standards for Routine waiting times has decreased by 3% from October 25 to January 26, the standard remains significantly better when compared to the England Routine average of 80.7%.

Action

- The C&M Mental Health programme are exploring opportunities with providers to conduct short term task and finish groups to support data requirements against the new nationally released technical guidance and metric definitions for Eating Disorder Services, released in January 2026. This work follows co-produced re-design of community ED services for CYP, aligning to recently published national guidance (NHSE).
- The ICB commissioners are now working alongside providers to establish implementation plans to strategically work towards the new model over time.

Delivery

- Performance is expected to improve based on 3 key changes within the new technical guidance:
 - only CYP up to the age of 17 years will be included, 18 year olds will not longer be counted within the metric.
 - there is increased clarity around clock start criteria for CEDS specifically.
 - Referrals to single points of access or MHSTS have been removed from the metric.

Talking Therapies 1st to 2nd Treatment >90 days

Latest ICB Performance (Jan-26)

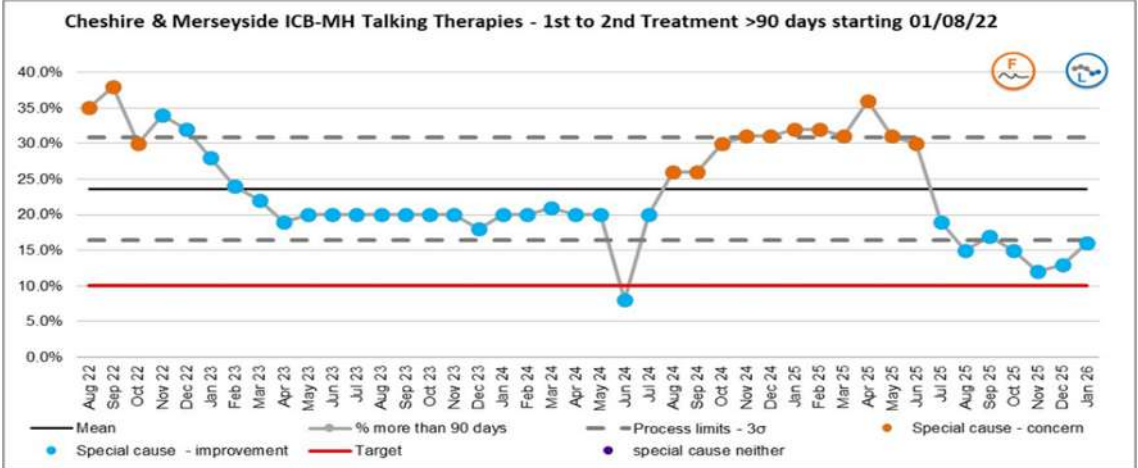
16.0%

National Ranking

6/42

ICB Trend (Jan-26)

Deteriorated



Issue

- The proportion of people who wait more than 90 days between 1st and 2nd treatment should not exceed 10%. Significant reductions have been reported in recent months, with nationally published data indicating delivery of 16%, however, this may not be accurate.
- Wirral Talking Therapy provider, Everyturn MH, had a system migration in Jul 2025 and data may still be affected. This will impact on the overall ICB position for ~12 months.

Action

- Significant improvement work has taken place over recent months in Cheshire East, Cheshire West and Central Cheshire.
- Review of waiting lists, DNA's and readiness for therapy resources supporting reduction in waiting times.

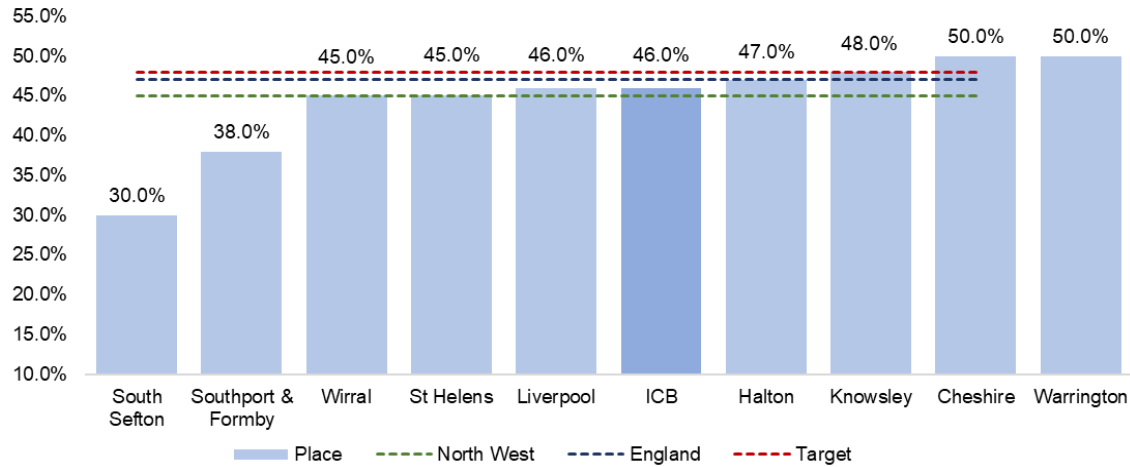
Delivery

- The percentage of people reported as waiting >90 days between treatment varies between 45% and 8% across Cheshire and Merseyside's 5 local providers.
- At place level variances are between 45% in Warrington & 33% Sefton (both services provided by MHM) and 8% in Wirral.
- Shared learning via C&M Talking Therapies Steering Group underway to understand variation and inform quality improvements.

5. Exception Report – Mental Health

Talking Therapies Reliable Recovery

| | | | |
|---------------------------------|--------------|------------------|---------------------|
| Latest ICB Performance (Jan-26) | 46.0% | National Ranking | 25/42 |
| Place breakdown (Jan-26) | | | Deteriorated |



Issue

- Nationally reported data indicates that reliable recovery rates have remained at 46% this month against a national target of 50%. However, Wirral Talking Therapy provider, Everyturn MH did not submit data in July and Aug. Sep to Dec reliable recovery reported for Wirral is lower than anticipated and this is impacting on the overall ICB rates.

Action

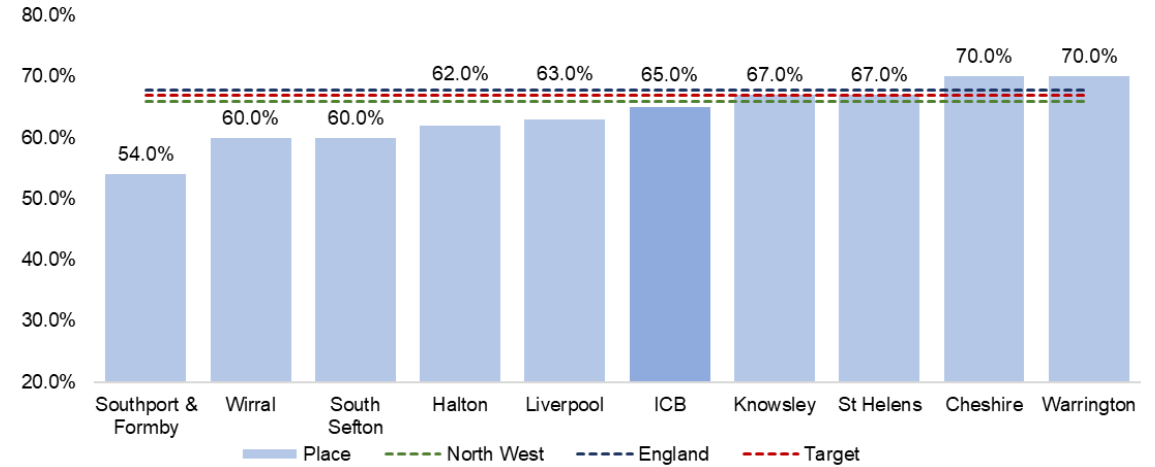
- Shared learning via C&M Talking Therapies Steering Group underway to understand variation and inform quality improvements.
- Wirral data submissions have resumed following system migration.
- The C&M equality of access project aims to improve reliable recovery and reliable improvement by ensuring consistent, equitable access across all communities.
- Increased workforce will facilitate increased session numbers to improve reliable recovery and work towards national ambition of 53% reliable recovery by 2028/29.

Delivery

- Despite an overall ICB position of 46%, performance varies widely across Cheshire—from 38% in Cheshire East to above-target levels of 52% in Central Cheshire and 55% in Cheshire West.
- Reliable recovery rates are forecast to remain below national standard by year end with rates delivered in 2026/27.

Talking Therapies Reliable Improvement

| | | | |
|---------------------------------|--------------|------------------|---------------------|
| Latest ICB Performance (Jan-26) | 65.0% | National Ranking | 26/42 |
| Place breakdown (Jan-26) | | | Deteriorated |



Issue

- Nationally reported data indicates that reliable improvement rate is below the national target of 68%. The Wirral provider, Everyturn MH, has recently migrated to a new system and did not submit data in July and Aug. Submissions made between Sep and Dec 25 may not be accurate for Everyturn and this is impacting on the overall ICB rates.

Action

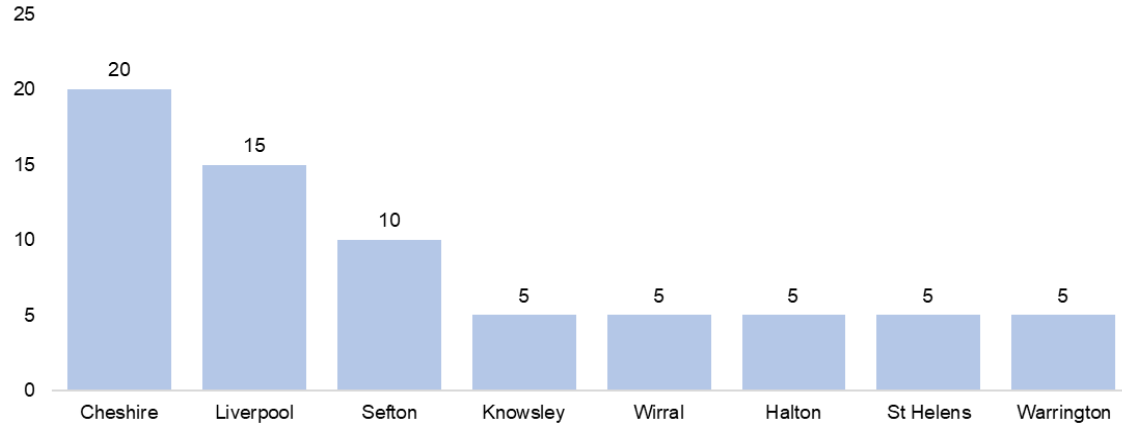
- Wirral data submissions have resumed following system migration but likely to impact on performance for a number of months as unable to resubmit missing/inaccurate data
- Shared learning via C&M Talking Therapies Steering Group underway to understand variation and inform quality improvements.
- The C&M equality of access project aims to improve reliable recovery and reliable improvement by ensuring consistent, equitable access across all communities.

Delivery

- CWP, Big Life Group, and Mental Health Matters for Warrington all achieved reliable improvement rates in this month.
- Mersey Care achieved 64% across 4 place teams (varied rates between the 4 teams, 62%-67%).
- Everyturn, Wirral achieved 60% (possible Data Quality challenges post system migration).
- Mental Health Matters delivered 57% for Sefton place.

5. Exception Report – Learning Disabilities

| Adult inpatients with a learning disability and/or autism | | | |
|---|-----|------------------|-----------|
| Latest ICB Performance (Feb-26) | 70* | National Ranking | 15/42 |
| Place Breakdown* (Feb-26) | | | No change |



Issue

- There were 70 adult inpatients, of which 44 are NHSE Specialised Commissioning (Spec Comm), and 26 ICB commissioned. The target for C&M (ICB and Spec Comm) is 46 LD/A or fewer by the end of Q4 2026.

Action

- The Transforming Care Partnership (TCP) has scrutinised those clinically ready for discharge. Of those 70 adults, 10 individuals are currently on Section 17 Leave. It is expected that some of the existing section 17 leave individuals will be discharged in Q4 pending MOJ Clearance and transition progress. 36 people have been discharged since April 2025.
- Data quality checks continue to be completed on Assuring Transformation to ensure accuracy.
- 2-weekly C&M system calls ongoing to address Delayed Discharges with Mersey Care and CWP.
- Housing Navigators continues to work to find voids which can accommodate delayed discharges.
- Desktop reviews with Place Commissioners and Prospect Case Managers to address section 17 leave progress and those identified for discharge.
- Transforming Care Lead is linking into Provider MADE calls for autistic adults who are inpatients
- The decommissioning of Alderley Unit will mean further discharges/transfer of care in Q3 and Q4.

Delivery

- C&M ICB and NHSE aim to reduce the number of inpatients, where appropriate, by the end of Q4 2025/26, where the target is 46 for LD/A and 28 for people with Autism. A variance of 14 in ASC now.
- C&M ICB have moved from the 4th quartile to the 2nd quartile in performance, being 1 of only 18 who have achieved the inpatient rate of 37 inpatients per million population.

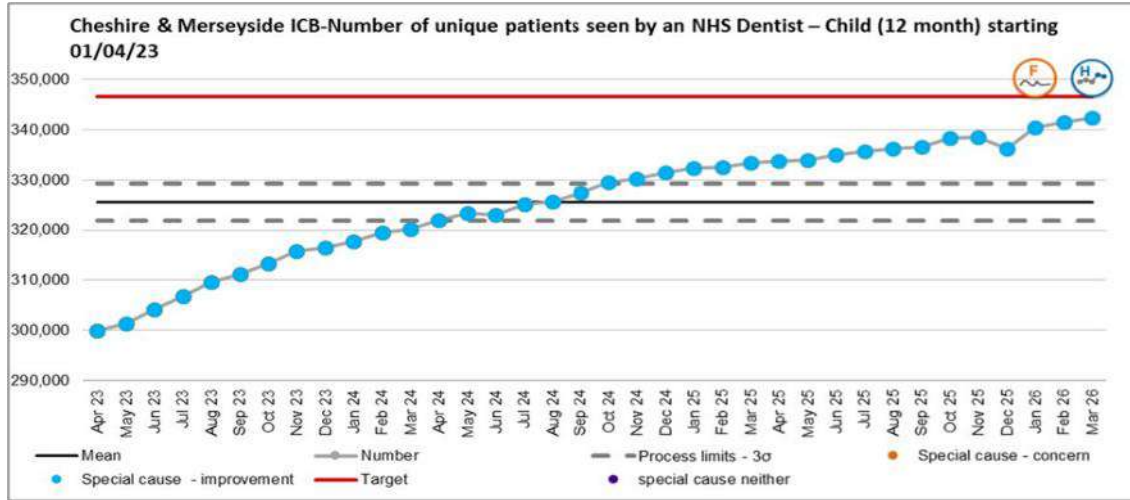
* Data rounded up/down to nearest 5: therefore, Place subtotals may not add up to the ICB total

5. Exception Report – Primary Care

Number of unique patients seen by an NHS Dentist – Children (12 month)

Latest ICB Performance (Mar-26) **342,405** National Ranking **n/a**

ICB Trend (Mar-26) **Improved**



Issue

- C&M is currently below target. We expect to see a year end flurry of activity that may take performance closer to the target. Overall, we have seen a continued increase in access during 25/26 and since April 2023.

Action

- Local Access Quality Scheme focussed on providing access for children and will continue to operate across C&M up to Q2 subject to review.
- Neighbourhood Dental Health Proof of Concept in Liverpool remains in place. This provides access for children from a number of local authority areas and from vulnerable groups.
- Commissioners will be assessing impact of contract reforms to inform plans from Q2 to year end.

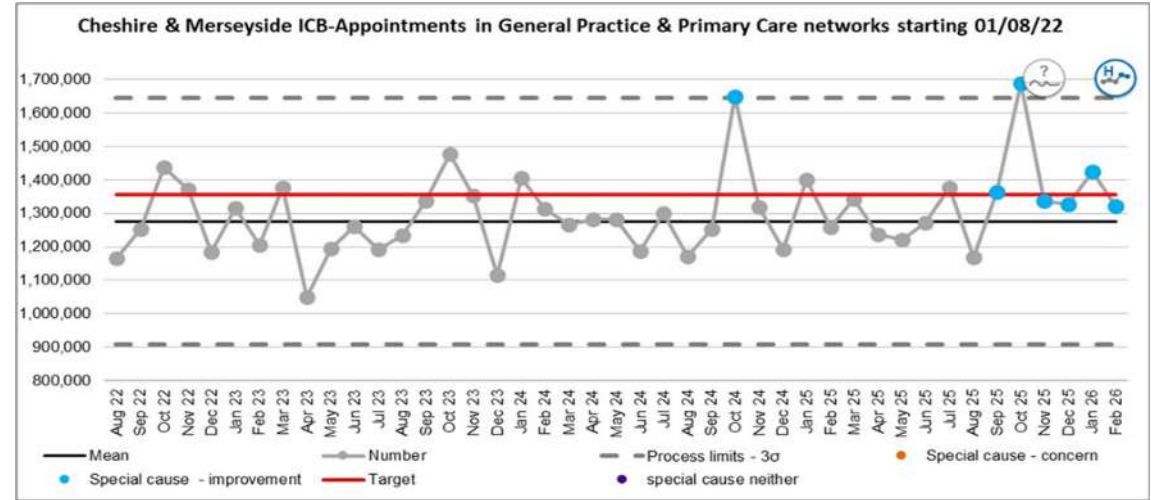
Delivery

- Commissioners are using flexible commissioning arrangements to improve activity and working with national team to understand 26/27 contract reforms.
- By year end we would expect to see the performance back on track with previous trend as a data reporting issue confirmed by the BSA in January had been resolved.

Appointments in General Practice & Primary Care networks

Latest ICB Performance (Feb-26) **1,322,413** National Ranking **n/a**

ICB Trend (Feb-26) **Deteriorated**



Issue

- Appointment numbers are close to the national target expectations and overall recent trend remains above the mean.

Action

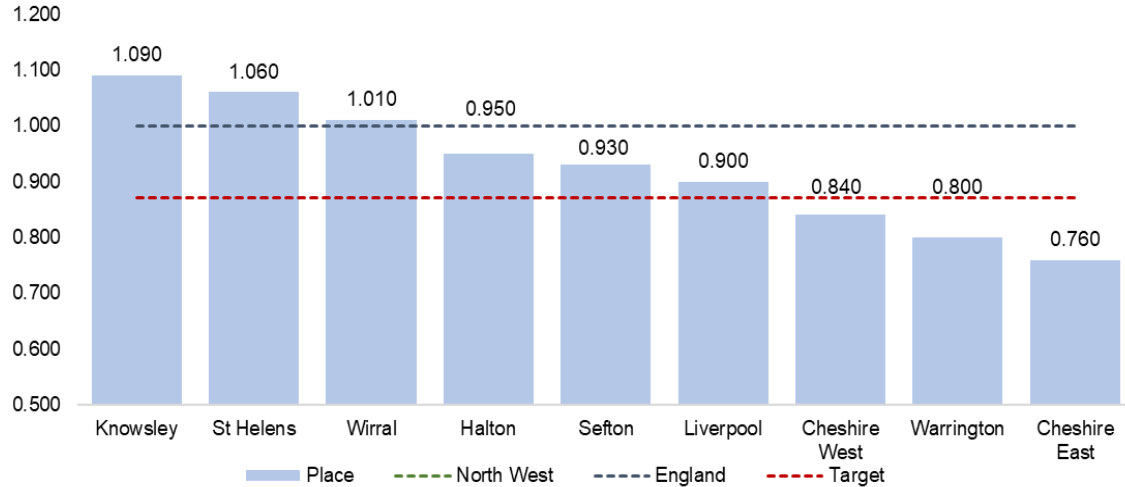
- Continue to maximise available appointments across core and enhanced (noting number of GP appointments is not a core contract requirement).
- Continue to use associated measurements such as number of appt per 1,000 patients via the national GP dashboard.
- Working with practices identified as outliers as part of the June 2025 plan variation to be refreshed as below, is ongoing.

Delivery

- Refresh of assumptions, measurements and variation as part of the PCAP (Primary Care Action Plan) expected by NHSE by end of May 2026 will include actions to support.

5. Exception Report – Primary Care

| Total volume of antibiotic prescribing in primary care | | | |
|--|-------------|------------------|------------------|
| Latest ICB Performance (Jan-26) | 0.91 | National Ranking | n/a |
| Place breakdown (Jan-26) | | | No change |



Issue

- C&M does not currently meet the target set for the volume of prescribing of antibiotics although performance continues to improve.

Action

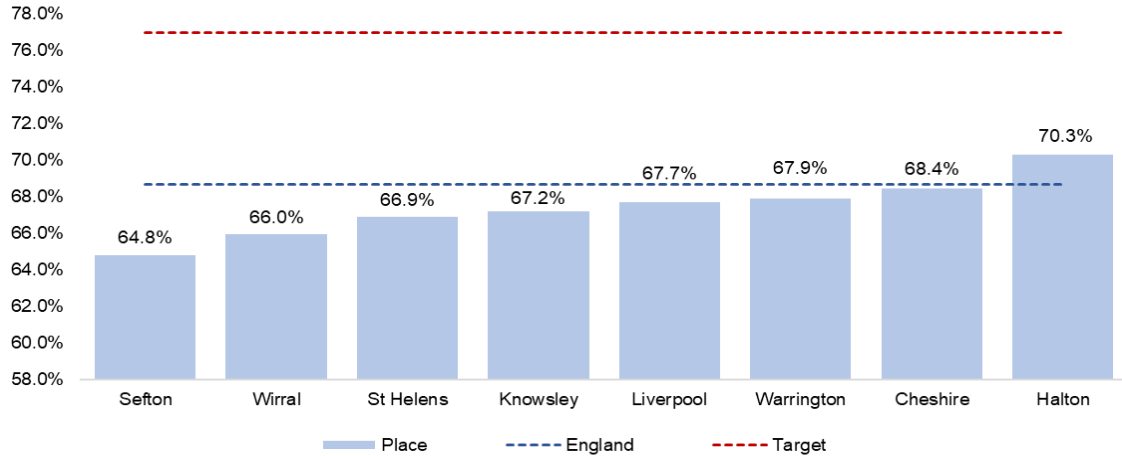
- All Places continue the cascade of education, public communication work, reviewing prescribing data and decisions in relation to antibiotic prescribing.
- Recruitment continues for two AMR Consultant Pharmacists to lead system-level AMS work.
- Baseline data at practice level shared across C&M for 5/7 prescribing in line with NHS C&M prescribing incentive scheme AMR element.
- Penicillin de-labelling work continues across the system and actions relating to penicillamine alert being actioned in line with NHS C&M ICB safety subgroup recommendations.
- Penicillamine alert to use the same format as the penicillin delabelling process to cascade information across the interface.

Delivery

- Analysis to continue with Q3 2025/26 data at Place and ICB level to inform areas to focus on at Place and C&M level.

5. Exception Report – Health Inequalities & Improvement

| % of patients (18+), with GP recorded hypertension, BP below appropriate treatment threshold | | | |
|--|--------|------------------|----------|
| Latest ICB Performance (Q2-25/26) | 67.42% | National Ranking | 29/42 |
| Place Breakdown (Q2-25/26) | | | Improved |



Issue

- There remains considerable variation between Places. C&M does not currently meet the national target ambition. However, performance has improved since last quarter.

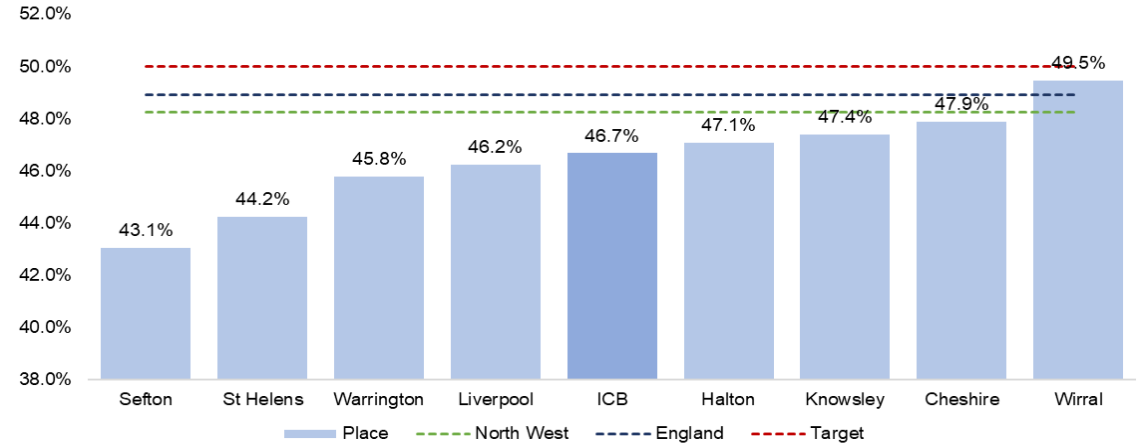
Action

- Hypertension case finding in optometry pilot continues with 60 opticians and representation from each Place. Over 1200 readings taken, with 28.2% being referred for further investigation, in line with estimated local prevalence. The national evaluation is out for consultation, ready to be shared Q4, and a blueprint for Local Optometry Committees is in development.
- Cycle 3 of the CLEAR CVD Prevention programme is underway, with the last 6 of the chosen PCNs. 26/27 will start with the 6 month and 1 year reviews for PCNs who underwent cycle 1.
- Happy Hearts (local CVD Prevention website) currently hosted by LHCH, will be brought under CHAMPS, focussing on professional resources to support CVD prevention risk factor management.
- A Clinical Pharmacist is leading on the development and dissemination of recommendations of the BP optimisation project, toolkits and resources will be hosted on Happy Hearts.
- EOI submitted to NHSE to become a CVD Prevention Accelerator Site with a focus on BP; 'Prevent it, Detect it, Treat it' will target all parts of the BP pathway. Awaiting bid outcome

Delivery

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

| CVD treated to cholesterol threshold: LDL-cholesterol less than or equal to 2.0 mmol/l or non-HDL cholesterol less than or equal to 2.6 mmol/l | | | |
|--|-------|------------------|----------|
| Latest ICB Performance (Q2-25/26) | 46.7% | National Ranking | 30/42 |
| Place Breakdown (Q2-25/26) | | | Improved |



Issue

- Considerable variation exists between Places and between ICBs. There is not currently a national target ambition for this metric. Performance has improved since last quarter.

Action

- Clinically led C&M Lipid Management group leads this work. A mapping exercise is being undertaken to understand the barriers and opportunities in both primary and secondary care to improve care and outcomes related to secondary prevention lipid management. Key recommendations will be disseminated Q4, with the lipid management group leading on developing an approach to change.
- Continued development of a suite of user-friendly resources and educational opportunities for primary care colleagues to better support Lipid management. The third in a series of webinars is planned for February on FH, and the patient toolkit is ready to be launched when the Happy Hearts website is in a position to host it.
- Cycle 3 of the CLEAR CVD Prevention programme is underway, with the last 6 of the chosen PCNs. 26/27 will start with the 6 month and 1 year reviews for PCNs who underwent cycle 1.

Delivery

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

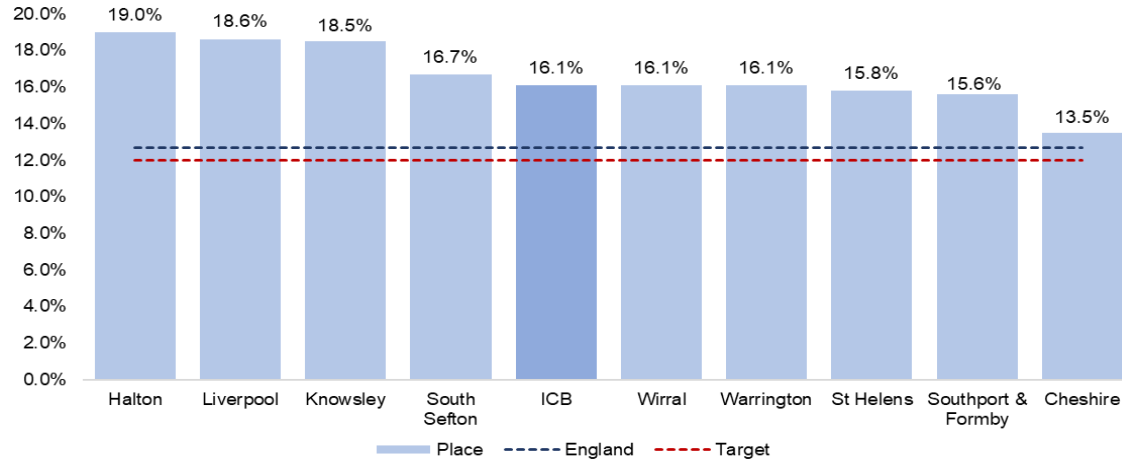
5. Exception Report – Health Inequalities & Improvement

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

| | | | |
|---------------------------------|----------------|------------------|-----|
| Latest ICB Performance (Mar-26) | 16.1% * | National Ranking | n/a |
|---------------------------------|----------------|------------------|-----|

Place Breakdown (Mar-26)

Improved



Issue

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

Action

- Two of three plan workshops have been completed as part of the smoking cessation service review. The next workshop will focus on options for improving the system.
- Mapping of the NHS digital systems is taking place to share with a potential digital provider who is exploring whether they can offer a solution to the electronic referral challenges between NHS Trusts and community providers.
- A communication campaign targeting routine and manual workers is due to be launched shortly.

Delivery

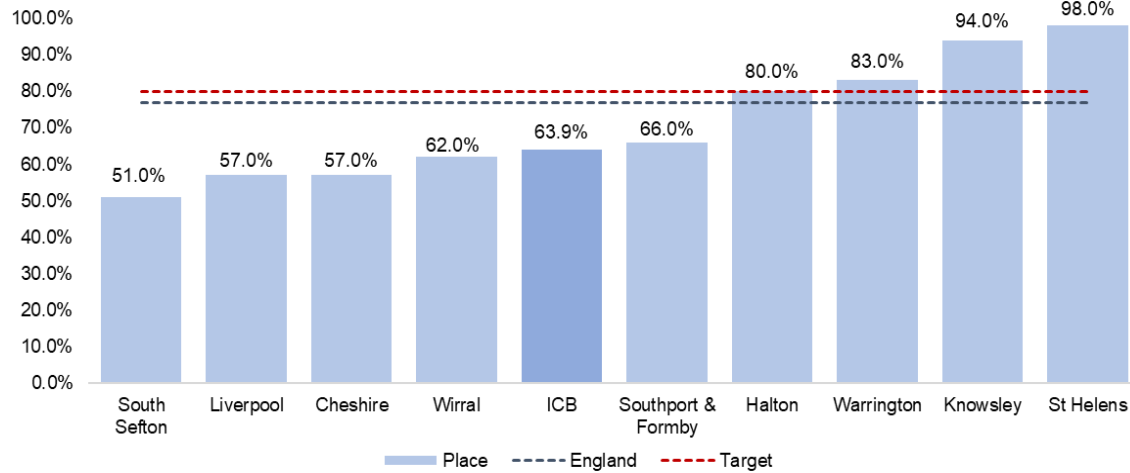
- It is anticipated that performance will continue to improve but the reduction in prevalence rate will be small with ongoing variation across Places. Supporting smokers to access specialist smoking cessation services to support them to quit should remain a key priority for all staff working in the NHS and implemented systematically across all providers.

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

5. Exception Report – Continuing Healthcare

Standard Referrals completed within 28 days

| | | | |
|-----------------------------------|--------------|------------------|---------------------|
| Latest ICB Performance (Q3-25/26) | 63.9% | National Ranking | 34/42 |
| Place Breakdown (Q3-25/26) | | | 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%. Place teams repeatedly report workforce issues being the driver for the inability to meet KPIs.

Action

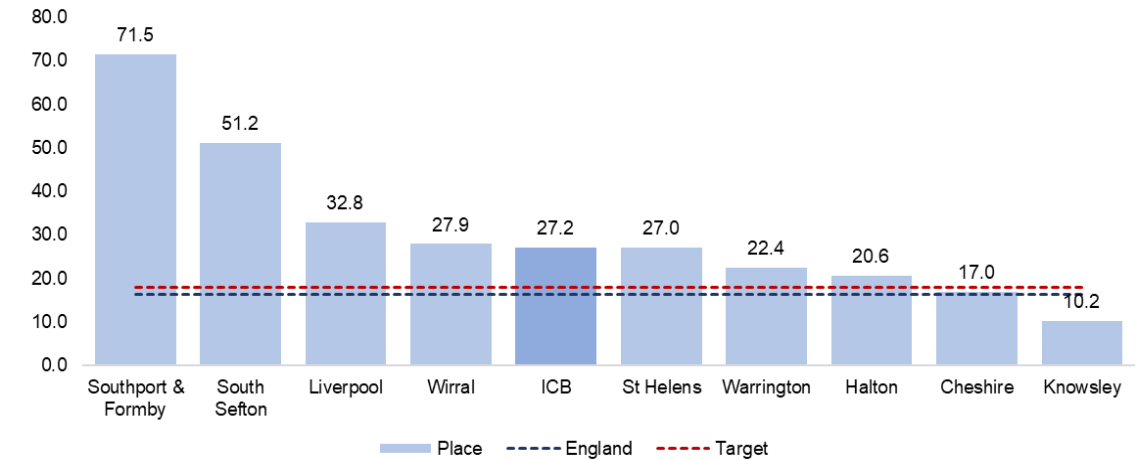
- A review of AACC delivery is being undertaken as part of the wider NHS/ICB service changes.
- Cheshire East and West continue to report a deteriorating position with performance due to the number of voids in the team (vacancy freeze/ staff absence/SW vacancies); further scrutiny of this is being monitored via NHS England.
- Additional scrutiny of the AACC delivery is in place via monthly Place Assurance Meetings.

Delivery

- The ICB delivery did not achieve the quarterly trajectory agreed with NHS England for Q3. The projection was $\geq 78\%$ to 80%. Workforce issues would suggest that an improvement is not anticipated until this is addressed. NB The NHSE workforce modelling tool illustrates that the team is under resourced for the current activity levels.

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

| | | | |
|-----------------------------------|--------------|------------------|---------------------|
| Latest ICB Performance (Q3-25/26) | 27.19 | National Ranking | 40/42 |
| Place Breakdown (Q3-25/26) | | | Deteriorated |



Issue

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

Action

- NHS C&M ICB are producing a suite of supportive policies and procedures to support teams in delivering consistent delivery and application of NHS CHC across the C&M system. Some are already operational and published whilst others are in various stages of ratification and development. Fast Track forms part of the AACC recovery scheme for AACC. PWC are specifically supporting a Fast Track Standard Operating Procedure.
- The ICB have approved a business case for Cheshire East and West so that up to 90% of Fast Track cases to support people in their own homes will now be a commissioned service rather than commissioned individually. This will improve the responsiveness and value for money of the service.

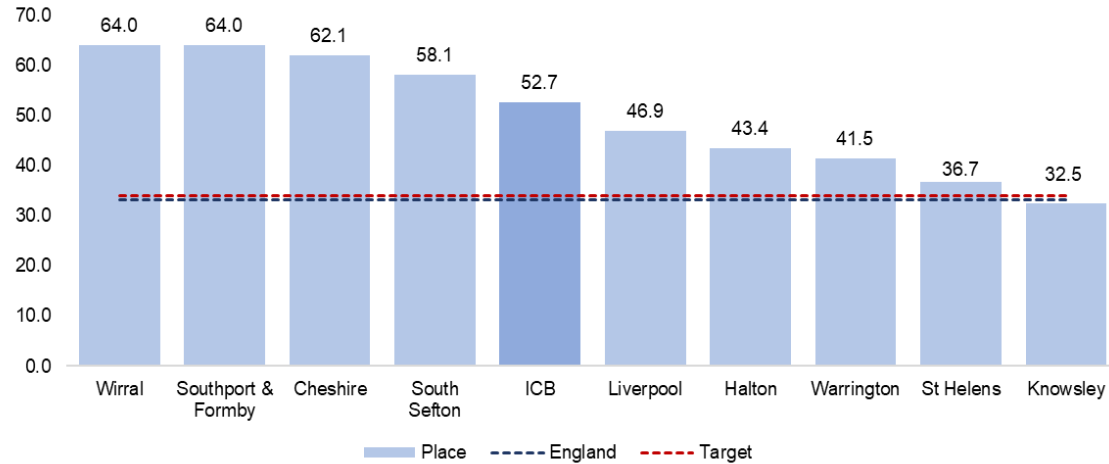
Delivery

- The Fast Track pilot in South Sefton continues to show positive results and is being rolled out for further testing in North Sefton. The findings are being shared across the wider AACC team in C&M for adoption and implementation with the intention that some improvement should be seen in early 2026/27.
- There is an overall deterioration for this metric within C&M.

*snapshot at end of quarter

5. Exception Report – Continuing Healthcare

| Number eligible for standard CHC per 50,000 population * | | | |
|--|------|------------------|----------|
| Latest ICB Performance (Q3-25/26) | 52.7 | National Ranking | 40/42 |
| Place Breakdown (Q3-25/26) | | | Improved |



Issue

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

Action

- The main outliers for this metric are Wirral, Southport and Formby, Cheshire and Sefton. Contract meetings are being held with the outsourced service in Wirral. A 'perfect week' is planned for Cheshire to better understand the referral sources and whether variation is warranted or not.

Delivery

- Delivery is anticipated to continue to improve through a consistent application of processes noting the historic and ongoing impact of formerly outsourced teams; any change would not be rapid due to the CHC processes. (Figures may also be impacted by demographics.)

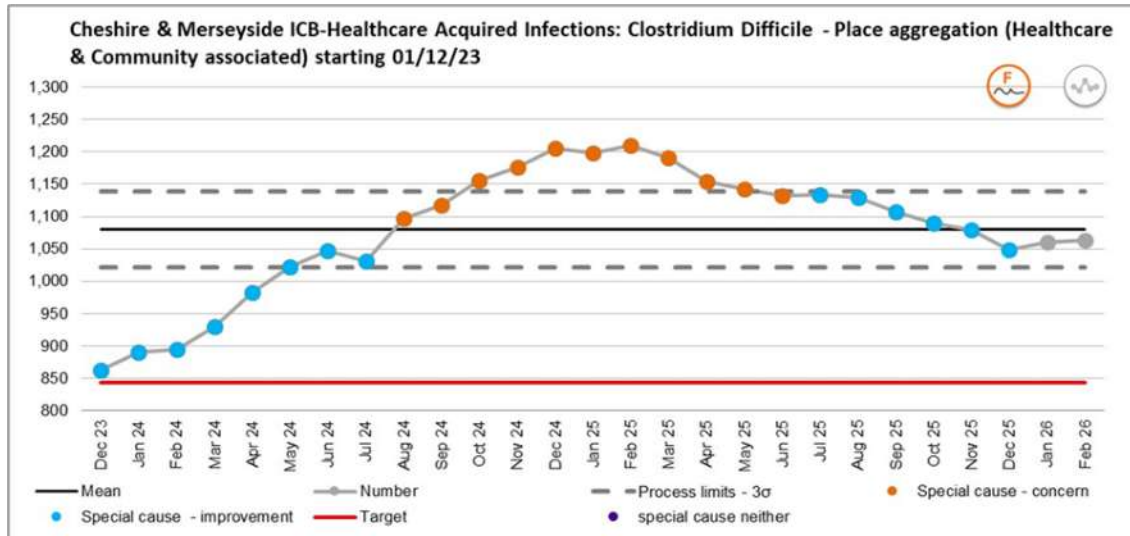
*snapshot at end of quarter

5. Exception Report – Quality

HCAI: Clostridium Difficile - Place aggregation (Healthcare & Community associated)

Latest ICB Performance (12 months to Jan-26) **1,064** National Ranking **n/a**

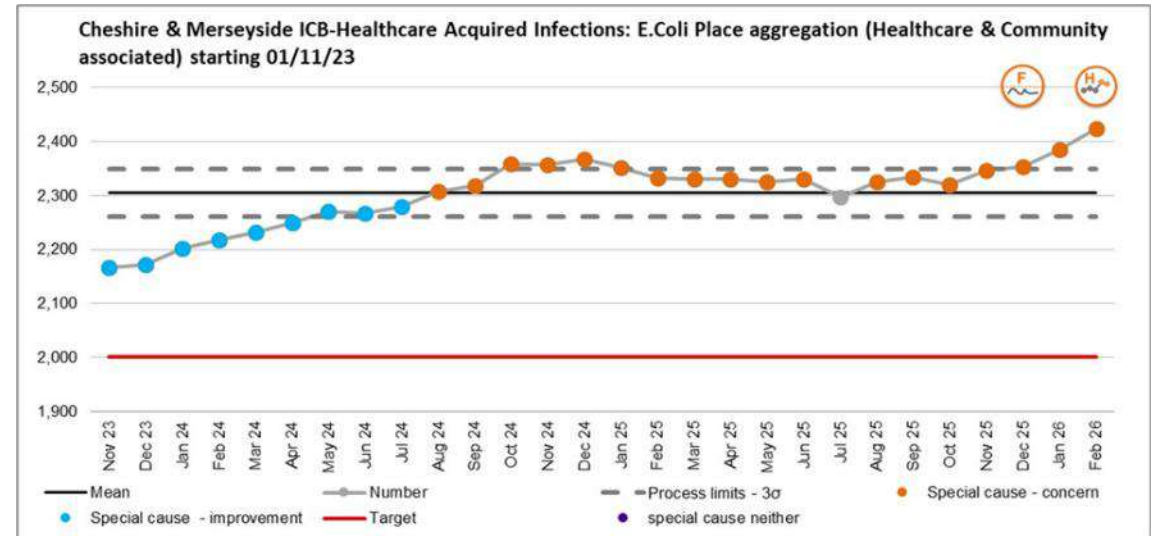
ICB Trend (rolling 12 months to Feb-26) **Deteriorated**



HCAI: E.Coli Place aggregation (Healthcare & Community associated)

Latest ICB Performance (12 months to Feb-26) **2,424** National Ranking **n/a**

ICB Trend (rolling 12 months to Feb-26) **Deteriorated**



Issue

- The C&M rate of CDI has plateaued. Despite sitting at an improved position, the WUTH position has significantly increased during Q4 and returned to an outlier status.
- The C&M rate of E. Coli has continued to increase month on month. Within the outlier reporting, annually LUFT and CCC remain high outliers.

Action

- The implementation and monitoring of the CDI tool kit continues to be a priority and has seen initial success, however recent rates have deteriorated at WUTH and WHH and slowed improvement at COCH. A review of implementation and sustainability of the C. Diff toolkit is required.
- The progress of the improvement plan at LUFT continues to be a focus at quality contract discussions.
- Further review or E. Coli insight is needed to revise an improvement plan.

Delivery

- The ICB tolerance for CDI has been exceeded overall and is outside tolerance at 10/12 providers; AHCH, ECT, LHCH, LWH, LUFT, MWL, TWC, CCC, WHH and WUTH.
- The ICB tolerance for E. Coli has been exceeded overall and is outside tolerance at 9/12 providers; AHCH, COCH, LWH, LUFT, MCHT, MWL, CCC, TWC and WUTH.

5. Exception Report – Quality

Never Events

Latest ICB Performance (Mar-26)

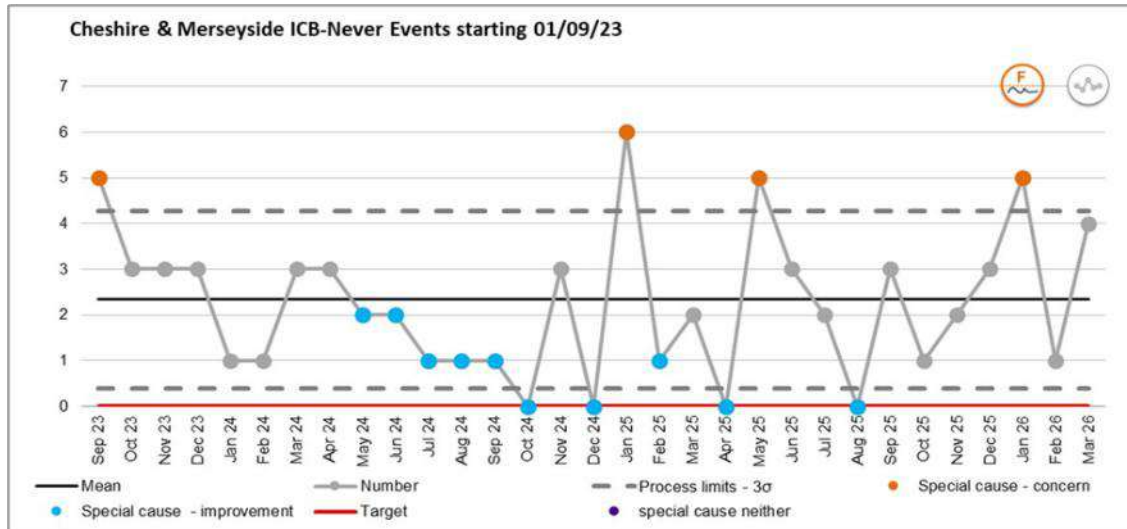
4

National Ranking

n/a

ICB Trend (Mar-26)

Deteriorated



Issue

- C&M continues to see a high rate of Never Events across the system with 10 reported in Quarter 4. The rolling 12-month position at 29 cases has increased from last update.
- The Never Events in February and March were related to wrong site surgery (3), wrong prothesis / implant, incorrect placement of a nasogastric tube and a retained guidewire following insertion of a nasogastric tube.
- Never events occurred at COCH (2), ECT and LUFT (2).

Action

- The ICB has reviewed assurance around surgical safety in line with National Safety Standards for Invasive Procedures. Several aspects of the submitted assurance was lacking and feedback has been provided, further assurance has been sought during Q4 to better understand compliance and areas for improvement. This additional assurance is currently being reviewed to formulate a further improvement plan. The issue is being reported through QPC.

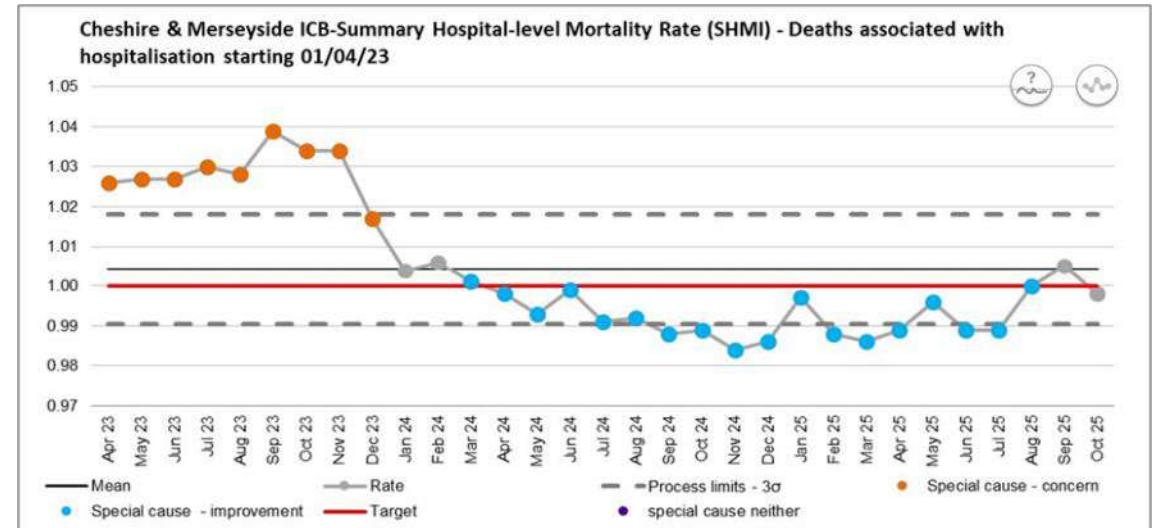
Delivery

- Current rates are deteriorating.

5. Exception Report – Quality

Summary Hospital-level Mortality Indicator (SHMI)

| | | | |
|---------------------------------|--------------|------------------|---------------------|
| Latest ICB Performance (Nov-25) | 0.999 | National Ranking | n/a |
| Provider Breakdown (Nov-25)* | | | Deteriorated |



Issue

- C&M trusts are within expected tolerances except ECT, with a current value of 1.2826 against the upper control limit for ECT of 1.1882.
- The SHMI data indicates higher rate of mortality in the community within 30 days of discharge, rather than a higher rate of mortality as an inpatient and also indicates statistically higher than expected rates of mortality with a diagnosis of pneumonia (specifically banded as higher than expected SHMI for this diagnosis code).

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.

Delivery

- Proportionately more patients die out of hospital than might be expected. The trust is being asked for detail behind this observation, and an audit of care for these patients is taking place to identify any learning.

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

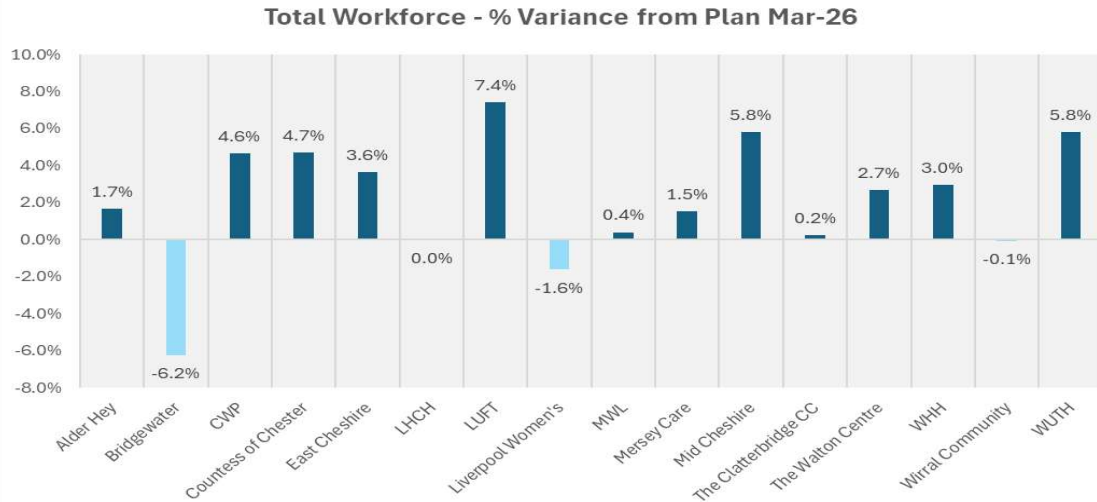
5. Exception Report – HR/Workforce

Total SiP (Substantive + Bank+ Agency) Variance from Plan % - via PFRs

C&M ICB Performance (Mar-26)

3.3%

Provider Breakdown (Mar-26)

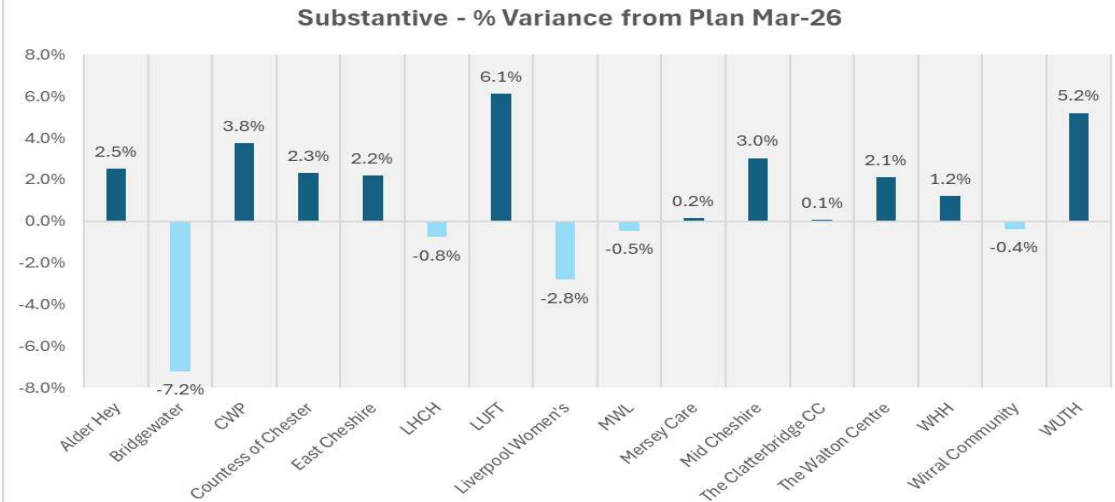


Substantive Variance from Plan % - via PFRs

C&M ICB Performance (Mar-26)

2.1%

Provider Breakdown (Mar-26)



Issue

- In Mar-26, twelve of the sixteen C&M Trusts reported their total workforce WTEs were above their planned figure as at M12, with a C&M variance above plan of 3.3% (2,559.7 WTE), versus 2.6% (1,981.2 WTE) higher than plan last month. These variances are based on the 2025/26 Workforce Operational Plan submissions with monthly forecasts for WTE for 25/26 as submitted to NHS England.
- Eleven of sixteen C&M Trusts reported substantive staff in post numbers higher than that forecast in their operational workforce plans. The total system performance was a variance from plan of 2.1%. At a system level, substantive staff utilisation decreased by -54 WTE / -0.1% from the previous month. Total workforce pay Year to Date variance was 2.5% above planned pay spend, equating to £94.8m.

Action

- As of the 1st April 2026, aligned to the NHS England Regional Blueprint & ICB Blue Print - greater scrutiny of workforce and pay costs data at organisational and system level by individual Trust provider will be carried out by the NHS England North West Regional team. Individual performance will be interrogated in terms of WTE numbers & assumptions for the coming quarter / financial year, and impact on specific professional groups in service pathways.

Delivery

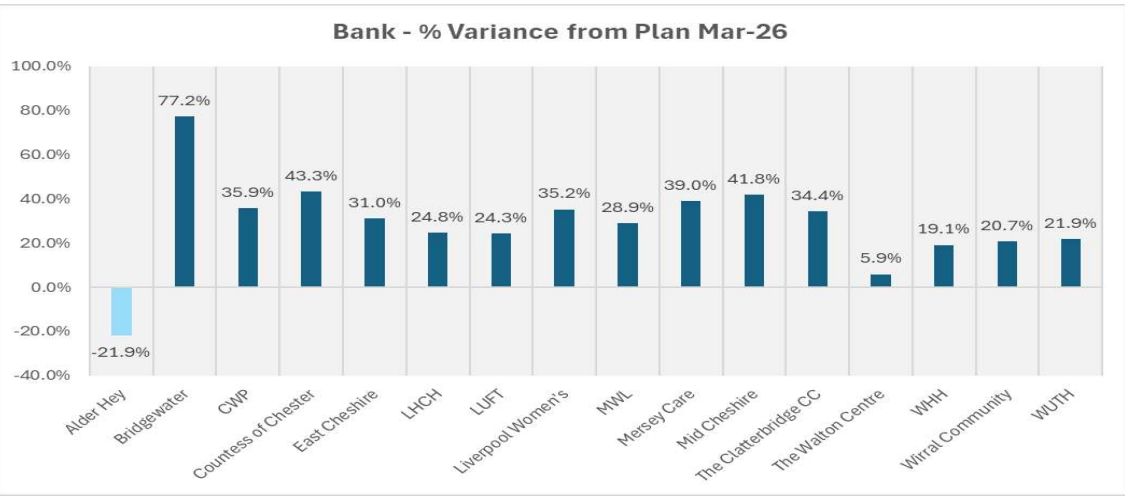
- NHS Trust Workforce Oversight will be conducted by the NHSE North West region for 26/27 – aligned to Trust submissions as part of the 26//27 – 28/29 Multi-Year Plan Submissions.

5. Exception Report – HR/Workforce

Bank Variance from Plan % - via PFR

| | |
|------------------------------|--------------|
| C&M ICB Performance (Mar-26) | 28.5% |
|------------------------------|--------------|

Provider Breakdown (Mar-26)



Issue

- Fifteen of sixteen C&M Trusts had Bank usage higher than that forecast in their operational workforce plans for the month of Mar-26. The total system performance was a variance from plan of 28.5% / 1,144.3 WTE.
- At a system level, the total bank usage increased by 364.4 WTE / 7.6% from the previous month. Bank spend of £28.3m in month (across all C&M Trust Providers)

Action

- All Trusts are reviewing their internal workforce resourcing processes & specific organisational actions around temporary staffing data, premium staffing costs (WTEs Utilised and Rates Charged) & cross-checks between financial & workforce returns, which continues to be a focus for all Trusts, as part of the 25/26 planning process & financial recovery.

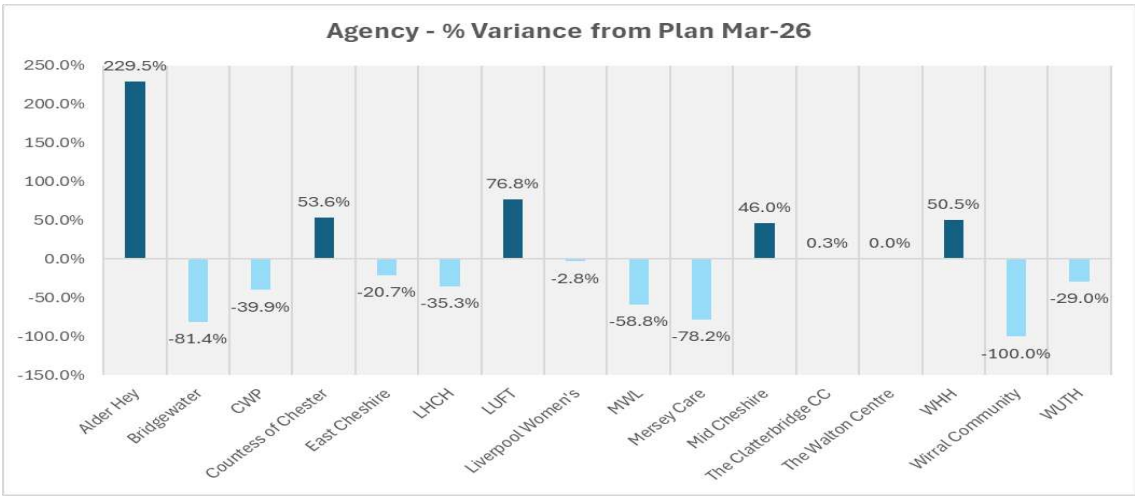
Delivery

- NHS Trust Workforce Oversight will be conducted by the NHSE North West region for 26/27 – aligned to Trust submissions as part of the 26//27 – 28/29 Multi-Year Plan Submissions.

Agency Variance from Plan % - via PFR

| | |
|------------------------------|---------------|
| C&M ICB Performance (Mar-26) | -23.0% |
|------------------------------|---------------|

Provider Breakdown (Mar-26)



Issue

- Nine of sixteen C&M Trusts had Agency usage lower than that forecast in their operational workforce plans for the month of March. The total system performance was a variance from plan of -23% / -137.8 WTE
- At system level, Agency usage increased by 35.6 WTE / 8.4% from the previous month; current month is -288.6 WTE from the Mar-25 baseline
- Agency spend of £3.8m in month

To note: small numbers/WTE for Planned v Agency usage at Alder Hey are skewing % change figures

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

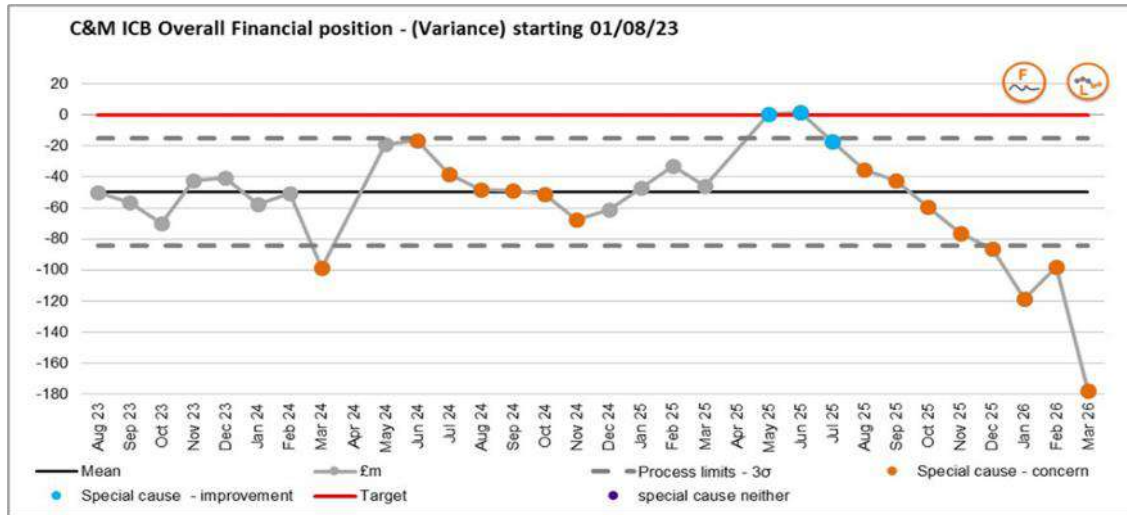
- NHS Trust Workforce Oversight will be conducted by the NHSE North West region for 26/27 – aligned to Trust submissions as part of the 26//27 – 28/29 Multi-Year Plan Submissions.

5. Exception Report – Finance

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

| | | | |
|---------------------------------|--------|------------------|-----|
| Latest ICS Performance (Mar-26) | -178.0 | National Ranking | n/a |
|---------------------------------|--------|------------------|-----|

ICS Trend (Mar-26)



Issue

- The system has reported a final position for the 2025/26 year as a £178m deficit against a breakeven system plan.
- The ICB reported a breakeven position (£50.4m overspend against plan), and providers reported a deficit of £178m (against their £50.4m deficit plan). Collectively the system has overspent against its initial plan by £178m
- This includes the impact of £67.6m of deficit support funding (DSF) being withheld by NHSE.
- This position was agreed with NHSE at month 11. It represents an improvement of £12.4m compared to the month 11 forecast due to the release of further DSF funding by NHSE.
- The ICB reports that it remained within its running cost allowance for 2025/26 and adhered to the mental health investment standard.

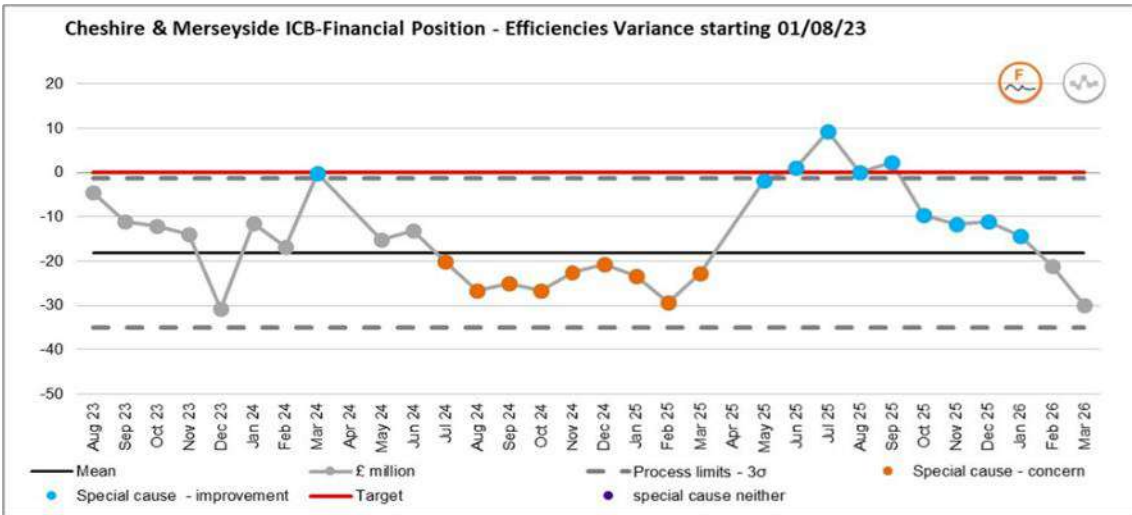
Action

- Accounts have now been submitted and are currently in the process of being audited

Efficiencies Variance (£m)

| | | | |
|---------------------------------|-------|------------------|-----|
| Latest ICS Performance (Mar-26) | -29.9 | National Ranking | n/a |
|---------------------------------|-------|------------------|-----|

ICS Trend (Mar-26)



Issue

- The system delivered £542.6m of efficiencies for the 2025/26 year against a plan of £572.4m therefore reporting a shortfall in delivery of £29.8m
- The ICB reports a shortfall of £9.3m on delivery, with providers delivering a shortfall of £20.5m
- The largest area of efficiency slippage for the ICB was linked to demand management of referrals.
- Providers delivered £120.4m of planned recurrent savings non-recurrently which impacts on planning for 2026/27.
- While the system reports that significant levels of efficiency savings have been delivered throughout the year, budgets have consistently overspent due to demand for services and other factors, therefore efficiency savings in some areas are not apparent and are offset by other pressures.

Action

- Efficiency achievement for 2025/27 has been reported internally to the FICC and externally to NHSE

Meeting of the Board of NHS Cheshire and Merseyside 28 May 2026

Highlight report of the Chair of the Quality & Performance Committee

Agenda Item No: ICB/05/26/20

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/ |
| Meeting Date(s) | 09 April 2026, 14 May 2026 |

Key escalation and discussion points from the Committee meeting

Alert

The Committee wishes to draw the Board’s attention to the following areas of current or emerging concern requiring continued oversight:

Urgent and Emergency Care performance in Cheshire remains a significant system-wide risk to performance and patient outcomes.

- The three Cheshire trusts have submitted 2026/27 operational plans that are non-compliant with national expectations, reflecting sustained demand, flow and workforce challenges. Of particular concern are 4-hour and 12-hour waits, for which Cheshire performance is a major contributor to poor patient outcomes, system-wide performance and national ranking.
- East Cheshire represents the most acute risk, with deteriorating performance and limited evidence of sustained improvement. Cheshire urgent and emergency care performance will remain under sustained Committee oversight.
- Further detailed analysis of flow, productivity and No Criteria to Reside metrics are underway, and additional proposals will be brought back as engagement with provider leadership progresses.

Safeguarding (Initial Health Assessment delays) System wide performance of this statutory duty for children in care continues to represent significant risks.

- The committee was informed of significant challenges to safeguarding; increasing recognition of complex lives agenda with demand linked to domestic abuse, exploitation, youth violence, suicide risk and self-neglect which places pressure on multiagency pathways.
- Although mitigations are in place, the Committee remains concerned about the cumulative impact of paediatric workforce shortages, statutory constraints on workforce models, and increasing complexity of safeguarding demand.
- The ICB has implemented a range of targeted interventions that are beginning to stabilise performance, particularly in relation to in-area Initial Health Assessments, periodic reviews of Health Assessments and multiagency responses to high-risk cases.
- The Committee also received assurance regarding ICB safeguarding leadership capacity in the context of organisational restructuring. It was confirmed that no statutory safeguarding posts have been removed, and job descriptions are being reviewed to strengthen clarity on accountability, escalation and governance

Advise

The Committee advises the Board of the following matters:

ECFT Oversight

ECFT continues to be an outlier for Standardised Hospital Mortality Indicator (SHMI). As a result of enhanced oversight discussions commencing in 2024, the Trust developed a comprehensive quality improvement plan that addressed:

- Acute Kidney Injury (AKI)
- Management of the Deteriorating patient
- Management of Community and Hospital Acquired pneumonia
- Sepsis
- Antimicrobial stewardship
- Pressure ulcer prevention
- Patient flow (with an emphasis on reducing length of stay)
- Reducing inappropriate admissions from care homes

The ICB (along with its regulatory partners) are to meet with the Trust in June 2026 to review the impact of its quality improvement plan and determine next steps

Quality and safety incidents within specific places and services, notably:

- Patient safety and conduct incidents in Warrington and Halton, including matters involving police investigation.
- Ongoing quality risks in Liverpool relating to all-age continuing care and mental health, learning disability and autism services.
- A significant digital quality incident in South Sefton primary care, relating to EMIS correspondence not being received or actioned since May 2024, with residual risk but no confirmed harm to date.

System Quality Group. The Committee reflected on the main thematic focus of the meeting, which was children and young people in crisis.

- Presentations outlined cases where children remained in acute hospital settings for prolonged periods, often in environments not designed to meet their needs. Members noted the adverse impact on children and families, staff wellbeing and wider service capacity, including disruption to other patients and the moral injury experienced by staff.
- Four priority areas identified by the System Quality Group (early identification to prevent crisis, staff support, proportionate after action reviews, and gateway process consistency) will be progressed through established governance and reported through QPC.

SEND

- The new funding model directs all monies to local authorities. The Committee's view is that a coordinated or joint commissioning approach is essential. A significant element of the reforms is the introduction of Experts at Hand, a national offer providing speech and language therapists, occupational therapists, and educational psychologists to all early years, primary, secondary and post-16 settings. The Committee recognised the potential benefits but expressed concern about workforce availability and the risk of destabilising existing NHS services. It was noted that clinicians are trained for individual assessment and treatment, whereas the new model requires whole-class and whole-school support, including environmental audits and cohort-level interventions.
- The Committee discussed the reported significant anxiety among parents and carers across Cheshire and Merseyside. The Parent Carer Forum reported widespread fear that children will lose statutory protections, particularly if individual support plans replace Education, Health and Care Plans (EHCPs) without equivalent rights of appeal.

Terms of Reference for the Quality and Performance Committee have been refreshed to reflect current operating arrangements and system governance. **The ToR are attached for approval by the Board.**

Patient Experience Work to strengthen system wide arrangements for patient experience and voice will continue following discussion of the King's Fund Healthwatch report, including the establishment of a small working group to bring forward proposals.

Assure

The Committee provides the following assurances to the Board:

Maternity safety Quality oversight through the LMNS and Joint Oversight and Support programme is robust, with evidence of sustained system-wide improvement.

- Liverpool Women's Hospital has exited enhanced oversight, and other trusts are subject to appropriate and proportionate levels of surveillance.
- Progress has been made in addressing historical maternity patient safety incident backlogs, with learning embedded through strengthened governance.
- Stillbirth rates across the system remain below national and regional averages, with continued improvement in risk assessment, escalation processes and support for women facing inequalities.
- (May) The Committee also noted positive performance in relation to continuity of carer pathways, particularly for Black, Asian and deprived communities, and strong referral rates into perinatal mental health services. Despite these strengths, the Committee discussed several areas where performance remains below expected levels. Breast milk at first feed continues to be lower than the national average, and although improvement work is underway, progress has been slow. Early booking before ten weeks remains a challenge, with Liverpool Women's and East Cheshire identified as the most affected providers.
- The Committee also considered a recent increase in stillbirths and hypoxic-ischaemic encephalopathy (HIE) at Liverpool Women's. LMNS colleagues are working with the North-West Operational Delivery Network to review the data, recognising that tertiary-level activity may influence the figures.
- A significant discussion centred on delays in induction of labour

Performance UEC and Cancer

- The Committee discussed the ongoing challenges in UEC performance across Cheshire and Merseyside. High numbers of 12-hour waits remain a significant concern, and ambulance response times continue to vary across providers. Members acknowledged that while some improvements have been made, the overall position remains fragile and requires sustained system-level intervention.
- The Committee noted positive progress in reducing long waits, particularly following the March sprint which targeted the longest waiters. Although the position has improved, members recognised that further work is required to maintain momentum and ensure that reductions are sustainable.
- Cancer performance remains strong across the system, with several key standards being met or exceeded. The Committee welcomed this continued stability and acknowledged the efforts of providers in maintaining performance despite wider system pressures.

Committee Risk Review

- The Committee reviewed the Quarter 4 risk register, which contained eleven risks, all of which had been previously reported. Members noted that while the risks were familiar, the organisation is in a period of transition, and the new operating model will require a refreshed approach to risk ownership, escalation and mitigation. The Committee acknowledged that several risks remain static due to long-standing structural issues, particularly workforce shortages and service capacity constraints.
- The Committee recognised Neurodevelopmental Pathways (ASD/ADHD) as one of the most significant risks, with long waits for assessment and treatment across

Cheshire and Merseyside. Most places have scored this risk at a high level, reflecting the persistent gap between demand and available clinical capacity. Despite recent efforts to reduce the longest waits, the overall position remains challenging.

- Delays in completing statutory health assessments continue to be driven by shortages in community paediatrics. The Committee noted that this risk is unlikely to improve without a system-wide workforce solution.

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 |
| All risks | Report on mitigations reviewed (see above) |

| Board Assurance Framework Risks | |
|---|--|
| Risk Title | Key actions/discussion undertaken |
| P4 potential for major quality failures | Review of Cheshire Trusts AED performance – further report requested. East Cheshire Trust review of improvement programme |

Achievement of the ICB Annual Delivery Plan

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

| Service Programme / Focus Area | Key actions/discussion undertaken |
|--|--|
| Urgent and Emergency Care | Analysis of System performance undertaken |
| Maternity | Review of performance |
| Safeguarding/Children and Young People | Update on Children Looked After health assessments |
| | SQG review of children and young people in crisis |

Appendices

Appendix One: Updated Terms of Reference

NHS Cheshire & Merseyside ICB

Quality & Performance Committee

Terms of Reference – May 2026



Compassionate



Inclusive



Working Together



Accountable

Document revision history

| Date | Version | Revision | Comment | Author / Editor |
|----------|---------|-------------------------------------|---|-----------------|
| 13.04.22 | 0.1 | ICB Quality Committee | Initial Draft | Michelle Creed |
| 11.05.22 | 0.2 | ICB Quality Committee | Revision consultation comments | Michelle Creed |
| 18.05.22 | 0.3 | ICB Quality Committee | Revision consultation comments | Ben Vinter |
| 07.06.22 | 0.4 | ICB Quality & Performance Committee | Revision to include Quality & Performance | Ben Vinter |
| 09.06.22 | 0.5 | ICB Quality & Performance Committee | Revision consultation comments | Michelle Creed |
| 31.07.23 | 0.6 | ICB Quality & Performance Committee | Revision consultation comments | Kerry Lloyd |
| 12.09.24 | 0.7 | ICB Quality & Performance Committee | Revision consultation comments | Kerry Lloyd |
| 12.09.24 | 0.8 | ICB Quality & Performance Committee | Revision post QPC review | Kerry Lloyd |
| 26.09.24 | 0.9 | ICB Quality & Performance Committee | Revision post QPC review | Tony Foy |
| 14.05.26 | 1.0 | ICB Quality & Performance Committee | Revision post QPC review | Tony Foy |

Review due: May 2027

1. Introduction

The Quality & Performance Committee (the “Committee”) has been established in accordance with the Integrated Care Board’s (ICBs) constitution.

These terms of reference, which must be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

The Committee is a non-executive committee of the Board and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Role and Purpose

The statutory duty of quality in the NHS mandates that organisations, particularly Integrated Care Boards (ICBs) and providers, continuously improve the safety, effectiveness, and patient experience of health services.

The Quality and Performance Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality (safe, effective, person-centred, well-led, sustainable and equitable), set out in the NQB Shared Commitment to Quality, NQB Guidance on risk management and escalation and duties enshrined in the Health and Care Act (2022) or successor legislation and guidance. This includes reducing inequalities in the quality, safety and experience of care.

The Committee has a responsibility on behalf of the Board in exercising its commissioning responsibilities to deliver the general duty with regards to reducing inequalities which is set out at section 14Z35 of the 2006 Act. This requires an ICB to have regard to the need to reduce inequalities with respect to people’s ability to access health services and reduce inequalities with respect to the outcomes achieved for those individuals by the provision of health services

The Committee exists to scrutinise and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care.

The Committee will focus on quality performance data and information and consider the levels of assurance that the ICB can take from data and local intelligence gathered from providers commissioned by the ICB or delivered in partnership across the ICS, actions to address any performance deficits and emerging issues of concern.

The Committee will provide regular assurance updates to the ICB in relation to activities and items within its remit:

Quality

- Ensure that there are robust processes in place for the effective management and consideration of quality, safety, and patient experience.
- Scrutinise structures in place to support quality planning, control and improvement, to be assured that the structures operate effectively, and timely action is taken to address areas of concern
- Oversee development of the ICB’s key quality priorities as set out in the 5-Year Strategic Plan, including priorities to address unwarranted variation/ inequalities in care, and recommend actions to Executives and the Board
- Oversee and monitor delivery of the ICB key statutory requirements



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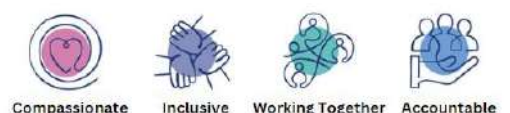
- Review and monitor those risks on the BAF and Corporate Risk Register which relate to quality, safety and patient experience, and significant operational risks which could impact on care.
- Oversee and scrutinise the ICB's response to all relevant (as applicable to quality) Directives, Regulations, national standard, policies, reports, reviews and best practice as issued by the DHSC, and other regulatory bodies or external agencies (e.g. CQC, NICE) to gain assurance that they are appropriately reviewed and actions are being undertaken, embedded and sustained
- Maintain an overview of changes in the methodology employed by regulators and changes in legislation/regulation and assure the ICB that these are disseminated and implemented across all sites
- Ensure that mechanisms are in place to review and monitor the effectiveness of the quality of care delivered by providers and partners where commissioned by the ICB
- Ensure processes are in place to enable the ICB to identify lessons learned from all relevant sources, including incidents, never events, complaints/patient experience and claims and ensure that learning is disseminated across the system and embedded in commissioning plans and actions
- Ensure that the ICB has effective and transparent mechanisms in place to monitor mortality and that it learns from death (including coronial inquests and PFD reports)
- Ensure that mechanisms are in place to systematically and effectively involve people that use services as equal partners in quality activities
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for adults and children (see Statutory Duties section) Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for infection prevention and control
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's statutory responsibilities for equality and diversity as it applies to people using commissioned services
- Scrutinise the robustness of the arrangements for and assure compliance with the ICB's responsibilities for medicines optimisation and safety
- Scrutinise the robustness of the arrangements for personalised commissioning including All Age Continuing Care and Funded Nursing Care

Performance

- Receive, review, and scrutinise the integrated performance reports for the ICB with a focus on promoting action to improve quality, safety, patient experience and outcomes.
- Ensure that contract quality performance is monitored in a way that is proportionate to risk
- Identify and scrutinise significant variations from plan of all Key Performance Indicators (KPIs) set out in the ICB's 5-Year Plan
- Scrutinise the appropriateness and robustness of any management actions to address identified performance issues in relation to the quality of services.
- Agree which of the underperforming contracts need to be brought to the attention of the Board
- Contribute to the ICB's contracting and procurement decisions with a focus on quality, safety and patient experience in line with statutory requirements.

Statutory and Regulatory Duties

In particular, the Committee will carry out regular reviews and provide assurance to the ICB on the delivery of the following duties:



- Statutory Duties in relation children including safeguarding, promoting welfare,); Working Together to Safeguard Children (2026)
- Statutory duties for SEN including the Children Acts (1989 and 2004), and the Children and Families Act (2014)
- Adult safeguarding and carers in the Care Act (2014) as amended by the Health and Care Act (2022)).
- National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care
- National Quality Board Guidance for ICBs

Risks

To deliver this, the responsibilities of the Committee will include:

- Ensuring the ICB is informed in a timely manner of significant risks, issues and mitigation plans relating to the quality and performance of commissioned services and strategic goals (in line with the remit of the Committee).

Other responsibilities

To undertake programme development and monitoring of specific outcomes in the ICB's 5-Year Plan.

3. Authority

The Committee is authorised by the Board to:

- Request further investigation or assurance on any area within its remit
- Obtain such internal information as is necessary and expedient to fulfil its functions
- Undertake, where necessary, detailed analysis into specific issues that will enable it to gain a greater level of understanding and assurance into specific issues that fall within its remit
- Bring matters to the attention of other committees to investigate or seek assurance where they fall within the remit of that committee
- Make recommendations to the ICB
- Escalate issues to the ICB
- Produce an annual work plan to discharge its responsibilities
- Approve the terms of reference of any sub-groups to the committee (e.g. System Quality Groups, Infection Prevention and Control, Local Maternity and Neonatal System,)
- Delegate responsibility for specific aspects of its duties to sub-groups. The terms of reference of any sub-groups shall be approved by the Committee.

For the avoidance of doubt, in the event of any conflict, the ICB Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation will prevail over these terms of reference other than the committee being permitted to meet in private.

4. Membership and Attendance

The Committee members shall be appointed by the Board in accordance with the ICB Constitution.

Membership of the Committee may be drawn from the ICB Board membership; the ICB executive leadership team; officers of the ICB; members or officers of other bodies in the wider health and social care system; other individuals/representatives as deemed appropriate.

The Committee members shall be:

- Non-Executive Member of the ICB (Chair)
- Non-Executive Member of the ICB (Deputy Chair)
- Executive Clinical Director
- Executive Director Health and Integrated Care Commissioning
- Up to two ICB Partner Members
- Chief Nursing Officer

Regular Attendees:

- Chief Pharmacist
- Director of Planning and Performance
- Healthwatch
- Director Integrated Nursing and Quality (rotation)
- Director System Quality and Governance (Safety Specialist)
- Director of Women's Health and Maternity Services
- Finance and Contracting representative (as required by an agenda item)

All Committee members may appoint a deputy (excluding Partner Members) to represent them at meetings of the Committee. Committee members should inform the Committee Chair of their intention to nominate a deputy to attend/act on their behalf and any such deputy should be suitably briefed and suitably qualified (in the case of clinical members).

The Committee may also request attendance by appropriate individuals to present agenda items and/or advise the Committee on issues.

Attendees

Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of matters.

5. Chair and Deputy-Chair

The Committee shall be chaired by a Non-Executive Member of the ICB. The Deputy Chair shall be a Non-Executive Member of the ICB.

If the Chair, or Deputy Chair, is unable to attend a meeting, they may designate an alternative ICB member to act as Chair.

If the Chair is unable to chair an item of business due to a conflict of interest, another member of the committee will be asked to chair that item.

6. Meetings

The Committee will meet in private.

The Committee will generally meet monthly and arrangements and notice for calling meetings are set out in the Standing Orders.

The Board, Chair or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

7. Quorum

A meeting of the Committee is quorate if 50% of the membership are present, to include at least one clinical member and one non-executive to act as chair

8. Decision-making and voting

Decisions should be taken in accordance with the Standing Orders.

The Committee will usually make decisions by consensus. Where this is not possible, the Chair may call a vote.

Only voting members, as identified in the "Membership" section of these terms of reference, may cast a vote.

A person attending a meeting as a representative of a Committee member shall have the same right to vote as the Committee member they are representing.

No member (or representative) with a conflict of interest in an item of business will be allowed to vote on that item.

Where there is a split vote, with no clear majority, the Chair will have the casting vote.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

9. Administrative Support

The Committee shall be supported with a secretariat function. Which will include ensuring that the agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.

Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary.

Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.

The Chair is supported to prepare and deliver reports to the Board.

The Committee is updated on pertinent issues/ areas of interest/ policy developments; and action points are taken forward between meetings.

10. Accountability and Reporting Arrangements

The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board.

The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

11. Behaviours and Conduct

Members will be expected to conduct business in line with the ICB values and objectives and the principles set out by the ICB.

Members of, and those attending, the Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

All members shall comply with the ICB's Managing Conflicts of Interest Policy at all times. In accordance with the ICBs' policy on managing conflicts of interest, Committee members should:

- Inform the chair of any interests they hold which relate to the business of the Committee.
- Inform the chair of any previously agreed treatment of the potential conflict / conflict of interest.
- Abide by the chair's ruling on the treatment of conflicts / potential conflicts of interest in relation to ongoing involvement in the work of the Committee.
- Inform the chair of any conflicts / potential conflicts of interest in any item of business to be discussed at a meeting. This should be done in advance of the meeting wherever possible.
- Declare conflicts / potential conflicts of interest in any item of business to be discussed at a meeting under the standing "declaration of interest" item.
- Abide by the chair's decision on appropriate treatment of a conflict / potential conflict of interest in any business to be discussed at a meeting.

As well as complying with requirements around declaring and managing potential conflicts of interest, Committee members should:

- Comply with the ICBs' policies on standards of business conduct which include upholding the Nolan Principles of Public Life;
- Attend meetings, having read all papers beforehand;
- Arrange an appropriate deputy to attend on their behalf, if necessary;
- Act as 'champions', disseminating information and good practice as appropriate;
- Comply with the ICB's administrative arrangements to support the Committee around identifying agenda items for discussion, the submission of reports etc.

Equality diversity and inclusion

Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

12. Monitoring Effectiveness and Compliance with Terms of Reference

The Committee will review its effectiveness at least annually

13. Review of Terms of Reference

These terms of reference will be reviewed annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Meeting of the Board of NHS Cheshire and Merseyside

28 May 2026

Highlight report of the Chair of the ICB Audit Committee

Agenda Item No: ICB/05/26/21

Highlight report of the Chair of the ICB Audit Committee

| | |
|---------------------------|---|
| Committee Chair | Mike Burrows |
| Terms of Reference | https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/ |
| Date of meeting | 21 April 2026 |

This report summarises the Audit Committee’s key alerts, advice and assurances arising from its April 2026 meeting, reflecting a period of significant organisational transition while maintaining robust assurance over governance, risk management and internal control.

| Key escalation and discussion points from the Committee meeting |
|--|
| Alert |
| <ul style="list-style-type: none"> <p>• Annual Report and Accounts 2025/26: The Audit Committee considered the draft ICB Annual Report and Accounts 2025/26 and received assurance on the arrangements in place to deliver a statutory-compliant and high-quality Annual Report in line with NHS England guidance and the Group Accounting Manual. The Committee reviewed the proposed structure, key timelines and governance arrangements, noting that further refinement is required ahead of finalisation, including incorporation of final out-turn performance data, audited financial information and the Head of Internal Audit Opinion. Particular scrutiny was applied to the draft Annual Governance Statement, with the Committee emphasising the importance of providing clear, balanced assurance on the effectiveness of governance, risk management and internal controls, reflecting the year’s significant organisational change and external scrutiny. No fundamental concerns were identified at this stage, and the Committee will undertake further review in May and in June prior to recommending the Annual Report and Accounts to the Board for approval</p> <p>• Standards of Business Conduct Policy: The Audit Committee reviewed the updated ICB Standards of Business Conduct Policy (Appendix One) and supported its recommendation to the Board for approval, noting that the policy had been comprehensively refreshed to reflect current NHS guidance and strengthened governance expectations. Key changes included clarifying the policy’s scope so that it applies not only to ICB employees but also to committee members and individuals acting on the ICB’s behalf, reinforcing expectations around personal conduct, social media use, and professional behaviour. The Committee noted that duplication with other core governance policies (including conflicts of interest, gifts and hospitality, and bribery) had been removed in favour of clear cross-referencing, improving coherence and usability. Particular attention was given to the inclusion of Fit and Proper Persons requirements and updated references to ethical standards, as well as the rationale for progressing a standalone Intellectual Property policy in line with recent national guidance. The Committee also provided constructive feedback on specific areas of clarity and training expectations, concluding that the revised policy is proportionate, clearer for staff and partners, and better aligned with current regulatory and assurance requirements.</p> |

The Audit Committee recommends that the Board approves the updated ICB Standards of Business Conduct Policy (Appendix One)

- draft Head of Internal Audit Opinion 2025/126 Report:** The Audit Committee reviewed and noted the draft Head of Internal Audit Opinion, which provides an overall **moderate assurance** on the effectiveness of governance, risk management and internal control for 2025/26, reflecting a year of significant organisational change and system pressure. The Committee noted that the opinion includes enhanced narrative context to explain the assurance judgement, including the impact of organisational transition, capacity constraints and the timing of audit delivery, with greater progress evident in the second half of the year. Members discussed the profile of assurance opinions issued, including a small number of moderate and one limited assurance review, recognising that these reflect known sector-wide risks (notably data security and third-party arrangements) rather than systemic control failure. The Committee highlighted the importance of the Opinion informing the Annual Governance Statement, supported clarification of references to prior-year caveats, and welcomed confirmation that no material change to the overall assurance level is anticipated ahead of final submission. The Board is alerted to the need to continue demonstrating grip on risk, delivery of audit actions and sustained improvement as the organisation stabilises.
- Internal Audit draft 2026/27 ICB Audit Plan:** The Audit Committee reviewed and **approved** the draft Internal Audit Plan for 2026/27, noting that it is risk-based, aligned to the refreshed ICB Board Assurance Framework and reflects engagement with Executive Directors on the ICB's principal risks and priorities. Members welcomed the proposed focus on core areas of governance, financial sustainability, strategic commissioning, quality and data security, including follow-up work on areas of known risk such as continuing healthcare, personal health budgets, primary care quality assurance and third-party data management. The Committee noted the inclusion of emerging risk areas, including digital and AI governance, and emphasised the importance of maintaining flexibility within the plan to respond to new or escalating risks during the year. Members highlighted the need to ensure appropriate coverage of organisational transition, workforce pressures and culture through other assurance routes, and were assured that the plan contains sufficient contingency to accommodate this. The Board is alerted that the plan has been approved subject to remaining responsive to system change and risk evolution during 2026/27.
- ICB Anti-Fraud Workplan 2026/27:** The Audit Committee reviewed and **approved** the Anti-Fraud Work Plan for 2026/27, noting that it aligns with NHS Counter Fraud Authority requirements and is proportionate to the ICB's risk profile. The Committee was advised that the plan maintains a strong focus on prevention, deterrence and response, including staff awareness and training, proactive risk-based exercises, policy assurance in key risk areas, and continued investigation activity where concerns are identified. Particular attention was drawn to targeted work in higher-risk areas such as personal health budgets and follow-up to national fraud alerts, alongside continued use of national systems to monitor and report outcomes. Members noted that the approach is consistent with



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other ICBs in the region and that no significant changes to scope or resourcing were proposed, subject to confirmation of national funding uplifts. The Board should be assured that appropriate counter-fraud arrangements are in place for the ICB for 2026/27 and that the plan provides a robust framework for protecting public funds.

Advise

- Internal Audit Progress Report:** The Audit Committee received and discussed the Internal Auditors' Progress Report, noting good overall progress against the approved internal audit plan during a period of significant organisational change. The Committee noted the range of assurance opinions issued, including substantial and moderate assurance reviews, and discussed the single limited assurance opinion, recognising that this reflected sector-wide challenges rather than isolated failings. Members emphasised the importance of maintaining strong follow-up arrangements, particularly where actions had been extended beyond original deadlines, and highlighted the need for clearer management narrative to explain reasons for slippage and expected completion dates. The Committee also discussed areas requiring continued focus, including equality, diversity and inclusion controls, third-party data management and cyber security, and took assurance that plans were in place to strengthen oversight and embed improvements during 2025/26. Overall, the Committee concluded that internal audit continues to provide robust, independent assurance while highlighting key risks and areas for management attention.
- Internal Audit Follow Up Report:** The Audit Committee considered the Internal Auditors' Follow-Up Report, noting overall reasonable progress in implementing agreed audit recommendations, while emphasising the need to strengthen management grip where actions had been extended beyond original deadlines. Members highlighted that, although there were no overdue high-risk actions, clearer narrative was required to explain why deadlines had been revised, when actions would be completed, and what controls were in place in the interim. The Committee stressed the importance of maintaining accountability during a period of organisational change, particularly where original action owners may have moved roles, and supported a more explicit approach to seeking approval for deadline extensions with a clear rationale. The Committee concluded that follow-up arrangements should remain a key area of focus, with enhanced reporting to provide assurance that agreed improvements are being delivered in a timely and sustainable way.
- Internal Audit Charter:** The Audit Committee reviewed and noted the Internal Audit Charter, which sets out how the internal audit service is delivered and confirms alignment with the Global Internal Audit Standards. Members noted that the Charter had been updated to reflect current professional requirements and that there were no substantive changes to the way internal audit operates or to its independence, scope or reporting arrangements. The Committee was advised that a recent external quality assessment had provided positive assurance on compliance with the standards, with further detail to be reported to a future meeting. The Committee was satisfied that the Charter appropriately supports the delivery of independent, objective assurance to the ICB and endorsed it for inclusion alongside the approved Internal Audit Plan.

- External Audit Sector Update Report:** The Audit Committee received and noted the External Audit sector update, including an update on progress with the 2025/26 audit, confirmation that the majority of planning and interim testing has been completed, and that work is progressing as expected towards reporting later in the year. The Committee noted confirmation that the ICB had met the Mental Health Investment Standard compliance requirements, with no issues identified, and that this would be the final year in which this work is reported as a standalone audit before being incorporated into the main financial audit process. Members also noted wider sector insights and emerging themes highlighted by the external auditors for consideration by management. No significant concerns were raised, and the Board is assured that external audit work remains on track, with further formal reports due to be presented in line with the agreed audit timetable

Assure

- Report on the Mental Health Investment Standard Compliance Statement:** The Audit Committee received and noted the report on compliance with the Mental Health Investment Standard (MHIS), and was advised that the ICB had met the MHIS requirements for the year with no issues identified. Members noted that the audit work had been completed and assurance provided, and that 2025/26 would be the final year in which the MHIS is subject to a standalone audit, with future assurance to be incorporated into the main financial statements audit process. No concerns or qualifications were raised, and the Board should be assured that the ICB remains compliant with national requirements for protecting and growing investment in mental health services

The next meeting of the Committee is scheduled for **09 June 2026**.

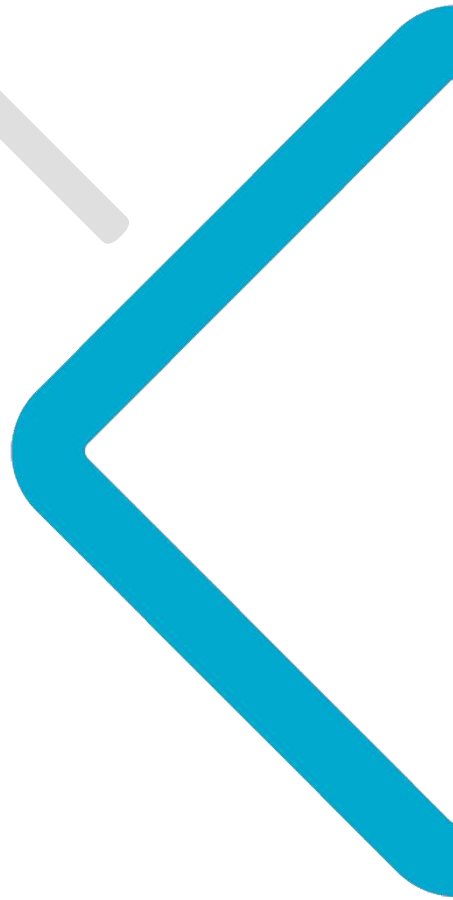
Appendices

Appendix One: Updated ICB Standards of Business Conduct Policy

Standards of Business Conduct Policy

v1.1

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Version Control

| Version Number | Author(s) | Date changes made | Outline of changes made to approved version |
|----------------|--------------------|-------------------|--|
| 1.0 | Ben Vinter | July 2022 | Original Version |
| 1.1 | Matthew Cunningham | April 2026 | <ul style="list-style-type: none"> • rewording of policy so now specifically targeted at staff employed by or working for and on behalf of the ICB rather than being written as a broad policy covering all staff within the ICS. • inclusion of personal responsibility statements and reference to Fit and Proper Persons regulations • removal of duplicate text found in other ICB policies around Conflicts of Interest, and Fraud, Bribery and Corruption and greater reference and signposting to these standalone ICB policies. • strengthening of reference to and content around Intellectual Property • strengthening of narrative around relationship of this policy to other key ICB governance policies • strengthening of and updating of information within the Personal Conduct section around Confidentiality, Gambling, Social Media • inclusion of requirements and expectations around training. • updated text within Appendix Two to reflect current version around Code of Ethics for the Chartered Institute of Procurement and Supply. |

| | | |
|--|---------------------------------|---------------------------|
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| | Approval date: | May 2026 |
| | Approved by: | ICB Board |
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| | Next policy review date: | April 2028 |

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Standards of Business Conduct Policy

1. Introduction

- 1.1 The Standards of Business Conduct policy describes the standards and public service values which underpin the work of the NHS and reflects current guidance and best practice which all staff working for or on behalf of NHS Cheshire and Merseyside (referred to in the policy as 'NHS C&M' or 'ICB') are expected to follow. See Section 3 for further information on those in scope of this policy.
- 1.2 As a publicly funded organisation, NHS C&M have a duty to set and maintain the highest standards of conduct and integrity. NHS C&M expects the highest standards of corporate behaviour and responsibility from all directly employed staff and those working on behalf of NHS C&M across the Cheshire and Merseyside Integrated Care System (ICS).
- 1.1 The NHS Constitution¹ sets out key responsibilities of all NHS staff. In addition, all NHS C&M colleagues, regardless of their role, are expected to act in the spirit set out in the seven principles of public life, or commonly referred to as the 'Nolan Principles' ([One](#)). The ICB actively encourages compliance with the Nolan Principles and all ICB colleagues have agreed to follow these principles by working within the terms of our constitution, which also sets out and promotes these principles.
- 1.2 The Code of Conduct and Code of Accountability in the NHS (2004)² sets out three public service values which are central to the on-going work and sustainability of both the ICS and NHS C&M:
- **Accountability** – everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
 - **Probity** – there should be an absolute standard of honesty in dealing with the assets of the NHS. Integrity should be the hallmark of all personal conduct in decisions affecting patients, officers, members and suppliers and in the use of information acquired during the course of their NHS duties, and
 - **Openness** – there should be sufficient transparency about NHS activities to promote confidence between each ICS, Integrated Care Body (e.g. NHS C&M) and staff, partners, patients and public.

2. Purpose

- 2.1 To provide guidance on the ethical standards which the ICB expects expected of an employee, as well as those individuals listed in section 3, in the conduct of NHS business.

3. Scope of Policy

- 3.1 This Policy applies to all staff working for or on behalf of NHS C&M, without exception, including and without limitation:
- all directly employees of NHS C&M -
 - Integrated Care Board (ICB) members (including in attendance and non-voting members)
 - Members of all NHS C&M committees and sub-committees
 - Agency, locum, self-employed contractors and other temporary staff engaged by NHS C&M under a contract of services
 - Students (including those on work experience), trainees and apprentices
 - Independent members of the ICB & Committees (not directly employed by NHS C&M)
 - Third parties acting on behalf of NHS C&M (including commissioned agencies and shared services)
- 3.2 Collectively, and for the purpose of this policy the above will simply be referred to as 'staff' throughout the document.
- 3.3 Throughout this policy, reference is made to NHS C&M policies and management structures. Where this policy applies to individuals or Associated Persons working on behalf of the ICB through agreed system or partnership arrangements, it will be applied proportionately alongside home-organisation policies while maintaining the ICB's expectations for integrity, transparency and accountability. This stipulation and expectation will be incorporated within any appointment, secondment or relevant partnership agreements between NHS C&M and the individual / individuals home organisation.

4. Policy Principles

4.1 Expectations of staff

- 4.1.1 Staff are expected at all times to:
- comply with the requirements of the NHS & NHS C&M³ Constitutions and be aware of the responsibilities outlined within them
 - act in good faith and in the interests of the C&M ICS – including NHS C&M and place-based partnerships
 - adherence to the 'Seven Principles of Public Life (the [Nolan Principles](#)), and the NHS Code of Conduct and Code of Accountability (2004), maintaining strict ethical standards.
- 4.1.2 All individuals covered by this policy are personally responsible for ensuring that their conduct meets the standards set out in this policy. A lack of awareness or misunderstanding of the policy will not be accepted as a justification for non-compliance.
- 4.1.3 In addition, every ICB Board member and staff member as described in the ICB's Fit and Proper Persons Test Policy must comply with the criteria of the "Fit and Proper Persons Regulations" and Framework and in accordance with the revised guidance issued by NHS England.

4.2 Failure to comply with the Standards of Business Conduct Policy

- 4.2.1 Failure to comply with the requirements set out in this policy may result in action being taken in accordance with the relevant organisational disciplinary procedure; such disciplinary action may include termination of employment (where applicable).
- 4.2.2 Where the failure to comply relates to an individual that is not a direct employee of NHS C&M, this may result in action being taken in accordance with the relevant engagement procedures (e.g., termination of a secondment agreement).

4.3 Relationship with other ICB Governance Policies

- 4.3.1 This policy sets out the overarching principles and standards of business conduct expected of all individuals working for or on behalf of the ICB. Where more detailed requirements are set out in specialist policies (including Conflicts of Interest, Gifts, Hospitality and Sponsorship, Anti-Fraud, Bribery and Corruption, Intellectual Property and Freedom to Speak Up), those policies must be followed. In the event of any inconsistency, the ICB's Constitution, Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation shall take precedence.

4.4 Raising Concerns and breaches

- 4.4.1 All staff should speak up about any genuine concerns in relation to compliance with this policy. Colleagues can raise these concerns directly with their own line manager or with the ICB's Corporate Governance team, ICB Conflicts of Interest Guardian⁴, Freedom to Speak Up Guardian⁵ or the ICBs Anti-Fraud Specialist at: investigation.team@miaa.nhs.uk

4.5 Standing Orders (SOs), Standing Financial Instructions (SFIs) and Scheme of Reservation & Delegation (SoRD)

- 4.5.1 All staff are required to carry out their duties in accordance with the ICBs Standing Orders (SOS), Standing Financial Instructions (SFIs) and the Scheme of Reservation & Delegation (SoRD) as these key documents set out the statutory and governance framework in which NHS C&M operates. There is considerable overlap with this policy and the provisions set out in these documents so staff must ensure that they refer to and act in accordance with them to ensure that correct, up to date processes are followed. In the event of doubt, staff should seek advice from their relevant line manager. The provisions of the SOs, SFIs and SoRD will always take primacy in the event of any conflicts arising with the content of this policy.

5. Management of Conflicts of Interest

- 5.1 A Conflict of Interest is defined as *“a set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement, or act, in the context of delivering, commissioning or assuring taxpayer-funded health and care*

services is, or could be, impaired or influenced by another interest they hold.”

- 5.2 All colleagues are expected to follow the ICBs Policies on Managing Conflicts of Interest which can be found at:
<https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/managing-conflicts-of-interest/>

6. Intellectual Property

- 6.1 Colleagues should declare patents and other intellectual property rights they hold relating to goods and services which are, or might reasonably be expected to be, procured or used by the ICB. Colleagues should declare these whether they are held as an individual or because of an association with a commercial or other organisation.
- 6.2 Any patents, designs, trademarks or copyright resulting from the work (for example research) of a colleague as part of their employment shall be the intellectual property the ICB.
- 6.3 Where the undertaking of external work, gaining patent or copyright or the involvement in innovative work, benefits or enhances our reputation or results in financial gain, the ICB will give consideration to rewarding colleagues subject to any relevant guidance for the management of intellectual property in the NHS issued by the Department of Health and Social Care.
- 6.4 Colleagues must seek prior permission through their manager before entering into any agreement with bodies about product development where this impacts on normal working time or uses our equipment and/or resources.
- 6.5 Where holding of patents and other intellectual property rights give rise to a conflict of interest, colleagues must follow the ICB conflicts of interest policy and declare this interest.

7. Personal Conduct and Corporate Responsibility

- 7.1 NHS C&M places the utmost importance upon the honesty, integrity and moral behaviour of its staff. It is the responsibility of all staff, irrespective of position or pay band to ensure they are not placed in a position which risks or appears to risk the reputation of the organisation, or the wider ICS, through actions which may be considered as an abuse of official position or by placing personal interests ahead of those of NHS C&M during the course of their duties. The following principles for personal conduct should be applied consistently by all staff:
- 7.2 All staff have a responsibility to respect and promote the corporate or collective decision of NHS C&M, even though this may conflict with their personal views. This applies particularly if NHS C&M are yet to decide on an issue or has decided in a way with which they personally disagree. Directors and officers may comment as they wish as individuals however, if they decide to do so, they

should make it clear that they are expressing their personal view and not the view of NHS C&M, or the wider ICS.

- 7.3 **Confidentiality** - Staff must, at all times, act in accordance with the General Data Protection Regulation and Data Protection Act 2018 and maintain the confidentiality of information of any type, including but not restricted to patient information; personal information relating to colleagues; commercial information.

This duty of confidence remains after staff members (however employed) leave the ICB. For the avoidance of doubt, this does not prevent the disclosure of information where there is a lawful basis for doing so (for example, consent). Staff should refer to the suite of ICB information governance and information technology policies for detailed information.

- 7.4 **Media interviews** and interactions with the media - All media enquiries should be directed to NHS Cheshire and Merseyside's communications team via media@cheshireandmerseyside.nhs.uk. This ensures enquiries are logged, tracked and responded to consistently and efficiently. When speaking as a member of NHS Cheshire and Merseyside, whether to the media, in a public forum or in a private or informal discussion, all staff should ensure that they reflect the current policies or view of the organisation. For any public forum or media interview, colleagues should work with the Head of Communications and team in advance. In the case of Board members, approval should be sought from the Chair and/or Chief Executive or their nominated deputies.

- 7.5 When this is not practicable, they should report their action to the Chair or Chief Executive or their nominated deputies, as soon as possible.

- 7.6 All staff must ensure their comments are well considered, sensible, well informed, made in good faith, in the public interest and without malice and that they enhance the reputation and status of NHS Cheshire and Merseyside and the wider ICS. All staff must follow the guidance for communication with the media; disciplinary action may be taken if this is not followed. The communications team will be able to support with the development of key messages.

- 7.7 **Use of Social Media** - Staff should refer to NHS Cheshire and Merseyside's Social Media Policy. The policy is designed to protect colleagues' interests and provide guidance on the potential consequences of behaviour and any content posted online, whether acting in a personal capacity or as a representative of NHS Cheshire and Merseyside. It also sets out clear expectations that where a member of staff identifies themselves as being associated with NHS Cheshire and Merseyside, or the NHS more broadly, discusses their work or colleagues, or is likely to encounter service users on social media platforms, they must behave appropriately. This includes acting in a manner consistent with their professional code of conduct (where applicable) and with NHS Cheshire and Merseyside values and behaviour policies.

- 7.8 **Political Activities** - Conferences or functions run by a party-political organisation should not be attended by NHS C&M staff in an official NHS C&M capacity except where prior permission has been granted by the Chief Executive. Staff should ensure that any political activity they undertake outside of their role does not identify them individually as an employee of NHS C&M. The ICB recognises that

- colleagues from local authorities who sit on our Board, committees or sub-committees may not be able to meet this expectation.
- 7.9 **Lending and borrowing of money** - Staff should refrain from the lending or borrowing of money between colleagues and peers, whether informally or as a business and particularly where the amounts are significant sums of money. It is a particularly serious breach of discipline for any staff member to use their position to place pressure on colleagues, business contact or member of the public to loan them money.
- 7.10 **Gambling** - No member of staff may bet or gamble whilst on duty, or on NHS Cheshire and Merseyside premises, or through the use of NHS systems or resources. The ICB recognises that limited, informal activities such as small lottery syndicates or sweepstakes (for example, those associated with national or international sporting events) may take place between immediate colleagues. Such activity is only acceptable where it is:
- Low-value and occasional in nature;
 - Confined to immediate colleagues and does not involve service users, suppliers or external partners;
 - Does not take place during working time or interfere with the performance of duties;
 - Does not create a perception of pressure, obligation or benefit linked to an individual's role or seniority; and
 - Is not connected to decision-making, procurement, commissioning or the use of NHS resources.
- 7.11 Informal lottery syndicates or sweepstakes that result in winnings do not of themselves constitute a breach of this policy, provided they are conducted appropriately and do not give rise to actual or perceived conflicts of interest.
- 7.12 Any gambling activity that could bring the ICB into disrepute, create a perception of financial impropriety, or undermine public confidence in the integrity of the organisation is not permitted
- 7.13 **Charitable collections** -
- **Individual** – whilst the ICB supports staff who wish to undertake charitable collections amongst immediate colleagues, no reference or implication should be drawn to suggest that the ICB, is supporting the charity. Permission is not required for informal collections amongst immediate colleagues on an occasion like retirement, marriage, birthday, or a new job.
 - **Organisational** – charitable collections which reference the ICB must be authorised and documented by a relevant Director in advance and reported to the Executive Director of Corporate Services and Governance, who will ensure a central record of collections is maintained.
- 7.14 **Individual Voluntary Arrangements, County Court Judgment (CCJ), Bankruptcy / Insolvency** - Any staff member who becomes bankrupt, insolvent, has an active CCJ, or made individual voluntary arrangements with organisations must inform their line manager and the HR team as soon as possible. Staff who are declared bankrupt or insolvent cannot be employed, or otherwise engaged, in posts that involve duties which might permit the misappropriation of public funds or involve the approval of orders or handling of money.

- 7.15 **Arrest or Conviction** - Any staff member who is arrested, subject to continuing criminal proceedings, or convicted of any criminal offence must inform their line manager and the HR Department as soon as is practicably possible.
- 7.16 **Trading on NHS C&M premises** - trading on ICB premises is strictly prohibited, whether for personal gain or on behalf of others; this includes flyers advertising services/ products or catalogues in common areas. This also applies to canvassing within offices by, on behalf of, external bodies or companies (including non-ICB interests of staff or their relatives). This provision excludes refreshment arrangements conducted solely by staff (e.g. tea and coffee funds).
- 7.17 **Initiatives** - approval from the appropriate line manager/head of service should be sought before entering into any obligation to undertake external work connected with the business of NHS C&M (e.g. writing articles for publication, speaking at conferences or events).
- 7.18 Staff are encouraged to contribute to professional learning, collaboration and knowledge exchange across the health and care system, including through participation in conferences, events and external forums. Where a member of staff is invited to speak, present or otherwise participate in an external event in connection with their role at NHS Cheshire and Merseyside, they must:
- seek prior approval from their line manager (and, where appropriate, the Communications Team) where the engagement could reasonably be perceived as representing the ICB;
 - be clear whether they are speaking on behalf of the ICB or in a personal/professional capacity, and make this distinction explicit where required;
 - declare any actual or potential conflicts of interest in accordance with the ICB's Conflicts of Interest Policy, including where event organisers, sponsors or hosts are commercial organisations; and
 - ensure that participation does not create a perception of undue benefit to third parties, personal gain, or endorsement of commercial interests.
- 7.19 Attendance at, or speaking at, events organised by commercial or external bodies - particularly where attendance fees are charged to delegates—must be handled with transparency and in line with the ICB's Gifts, Hospitality and Sponsorship, Conflicts of Interest and Communications policies.
- 7.20 Nothing in this policy is intended to discourage appropriate professional engagement or sharing of expertise, provided such activity is undertaken openly, with appropriate approval, and in a way that protects the reputation of the ICB and the wider Integrated Care System.
- 7.21 Where the undertaking of external work (including gaining patent, copyright or the involvement of innovative work) benefits or enhances NHS C&M's reputation or results in a financial gain for the organisation, please refer to Section 6: Intellectual Property.

- 7.22 Further guidance may be sought from the Corporate Governance or Communications teams where there is uncertainty about how an engagement should be handled.
- 7.23 **Contractors & Suppliers of Services** - NHS C&M will ensure that all services are procured in a manner that is open, transparent, non-discriminatory and fair to all potential providers and has in place a robust Procurement Policy. Staff who are in contact with suppliers and contractors (including external consultants) and particularly those who are authorised to sign purchase orders or enter into contracts for goods and services are expected to adhere to professional standards in line with those set out in the Codes of Ethics of the Chartered Institute of Purchasing and Supply (Appendix Two).
- 7.24 Staff involved in the awarding of contracts and tender processes must take no part in a selection process if a personal interest or conflict of interest is known. Such an interest must be declared in accordance with the NHS C&M Conflicts of Interest Policy⁴ as soon as it becomes apparent.
- 7.25 Details of all contracts, including the value of the contract will be published on the public-facing website as soon as contracts are agreed. Where NHS C&M decides to commission a service(s) via an Any Qualified Provider (AQP) arrangement, the type of service and agreed price for each service commissioned will be published on the website and will also be included in the Annual Report.

8. Fraud, Bribery & Corruption

- 8.1 Staff must be aware of and act in accordance with the NHS C&M Anti-Fraud, Bribery & Corruption Policy, and understand that in certain circumstances a breach of this policy could potentially result in criminal proceedings being brought against individuals, the organisation, and other linked organisations. Policy breaches could also result in civil legal challenge.
- 8.2 Staff members have a continuing obligation to inform the ICB of any investigation into their conduct by the police, professional body or similar, including the Fraud Act 2006, Bribery Act 2010 and the new corporate offence of 'failure to prevent fraud' contained within The Economic Crime and Corporate Transparency Act 2023 (ECCTA 2023)".
- 8.3 Any financial or other irregularities or impropriety which involve evidence or suspicion of fraud, bribery or corruption by any officer, will be reported to the Anti-Fraud Specialist and/or NHS Counter Fraud Authority in accordance with the NHS C&M Anti-Fraud, Bribery & Corruption Policy⁵ and the NHS C&M Standing Financial Instructions, with a view to an appropriate investigation being conducted and potential prosecution being sought.

9. Related Documents

Legislation and statutory requirements

- Fraud Act 2006

- Bribery Act 2010
- Data Protection Act 2018/ General Data Protection Regulations (GDPR) 2018

Other related policy documents

- NHS C&M Conflicts of Interest Policy
- NHS C&M Working with the Pharmaceutical Industry (PI), Dispensing Appliance Contractors (DACs) and Prescribing Associated Product Suppliers Policy
- NHS C&M Anti-Fraud, Bribery & Corruption Policy
- NHS C&M Freedom to Speak Up (Raising Concerns) Policy

Best practice recommendations

- NHS Code of Conduct and Code of Accountability (2004)
- Records Management: NHS Code of Practice 2016

10. Monitoring and Reporting

- 10.1 Compliance with this policy will be reviewed by the Audit Committee. The Audit committee shall escalate any areas of concern to the ICB Board, as required

11. Training and Awareness

- 11.1 All staff must complete mandatory training relevant to standards of business conduct, including conflicts of interest and counter fraud awareness, as required by NHS England guidance. Compliance with training requirements will be monitored and reported through the ICB's governance framework.
- 11.2 The ICB will take a proactive approach to promoting understanding and compliance with this policy. This will include, but is not limited to:
- inclusion of the Standards of Business Conduct Policy within corporate induction arrangements for all new starters;
 - targeted training, briefings or updates where changes to the policy are made, or where learning from incidents, audits or reviews indicates a need to reinforce expectations; and
 - ongoing awareness activity, including regular communications and reminders through established staff channels.
- 11.3 Managers are responsible for ensuring that staff understand how the policy applies to their role and are supported to comply with its requirements. The ICB recognises that effective training and awareness are essential to maintaining high standards of integrity, transparency and accountability.

12. Dissemination and Implementation

- 12.1 This policy will be available to all NHS C&M staff, via the staff intranet Hub and ICB Website.

- 12.2 All managers are responsible for ensuring that relevant staff within the organisation have read and understood this document and are competent to carry out their duties in accordance with the procedures described.
- 12.3 The chief executive has overall responsibility for ensuring this policy and the supporting systems and processes are in place.
- 12.4 This policy should be read in conjunction with the policies listed at Section 9.

13. Review

- 13.1 This policy will be reviewed at least every three years on an annual basis or earlier if there are changes in legislation, relevant case law decisions, significant incidents and/or changes to the organisational infrastructure of the ICB.

Appendix One: The Seven Principles of Public Life (Nolan Principles)

- **Selflessness** – Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends
- **Integrity** – Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties
- **Objectivity** – In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit
- **Accountability** – Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office
- **Openness** – Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands
- **Honesty** – Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest
- **Leadership** – Holders of public office should promote and support these principles by leadership and example.

Appendix Two: The Chartered Institute of Procurement and Supply (CIPS) Code of Ethics

Organisations adopting the Code will need to commit to the following:

Understanding and commitment

- ensure consistent understanding of business ethics across the organisation at all levels
- continually enhance knowledge of all relevant laws and regulations in the countries in which the organisation operates, either directly or indirectly
- commit to eradicating unethical business practices including bribery, fraud, corruption and human rights abuses, such as modern slavery and child labour

Ethical practice

- conduct all business relationships with respect, honesty and integrity, and avoid causing harm to others as a result of business decisions
- treat all stakeholders fairly and impartially, without discrimination or favour
- actively support and promote corporate social responsibility (CSR)
- avoid any business practices which might bring the procurement profession into disrepute.

Professionalism

- use procurement strategies to drive unethical practices from the supply chain
- ensure procurement decisions minimise any negative impact on human rights and the environment whilst endeavouring to maximise value and service levels
- put ethical policies and procedures in place, regularly monitored and updated, and ensure compliance
- mandate the education and training of all staff involved in sourcing, supplier selection and supplier management to professional standards
- practise due diligence in all business undertakings.

Accountability

- accept accountability and take ownership of business ethics
- foster a culture of leadership by example
- take steps to prevent, report and remedy unethical practices
- provide a safe environment for the reporting of unethical practices.

References

| | |
|---|---|
| 1 | https://www.gov.uk/government/publications/the-nhs-constitution-for-england (last checked 01.04.26) |
| 2 | https://www.nhsbsa.nhs.uk/sites/default/files/2017-02/Sect_1_-_D_-_Codes_of_Conduct_Acc.pdf#:~:text=Accountability%20%E2%80%93%20everything%20done%20by%20those%20who,and%20its%20staff%2C%20patients%20and%20the%20public. (last checked 01.04.26) |
| 3 | https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/constitution/ (last checked 01.04.26) |
| 4 | https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/managing-conflicts-of-interest/ (last checked 01.04.26) |
| 5 | https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/anti-fraud-bribery-and-corruption/ (last checked 01.04.26) |

Meeting of the Board of NHS Cheshire and Merseyside

28 May 2026

Highlight report of the Chair of the ICB Remuneration Committee

Agenda Item No: ICB/05/26/22

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) | 27 January 2026, 28 January 2026 and 01 April 2026 |

| |
|---|
| Key escalation and discussion points from the Committee meeting |
| Alert |
| n/a |
| Advise |
| <p>The Committee met on 27 January 2026 and:</p> <ul style="list-style-type: none"> received a report on and approved recommendations regarding the recognition of continuous service for an ICB Executive position. The Committee was advised that this decision was consistent with organisational precedent and mitigated potential equality and discrimination risks. <p>The Committee met on 28 January 2026 and:</p> <ul style="list-style-type: none"> considered the outcome of Phase 1 of the Cheshire & Merseyside ICB Voluntary Redundancy (VR) Scheme which had been open to all staff within the ICB. <p>On 01 April 2026 the Committee met and:</p> <ul style="list-style-type: none"> considered a report on the outcome of Phase 2 of the Cheshire & Merseyside ICB VR Scheme, a targeted round focused on Very Senior Managers (excluding Executive Directors) and staff down to Band 8C. The Committee received a full update on process, decision-making rationale, and equality considerations. <p>At both the 28 January 2026 and 01 April 2026 meetings the Committee was assured that the process around the VR Scheme Phase 1 and Phase 2 was conducted through a robust, fair and transparent process, including consultation with Trade Unions, HR oversight, equality impact assessment, and regional (NHS England) representation and challenge. Financial impacts and risks were explicitly considered as part of the VR decision-making process, supporting ongoing affordability and alignment with the organisation’s agreed transformation trajectory.</p> <p>The Committee at both meetings supported the recommendations within the reports regarding the approval of the VR applications received and approved the submission of the outcomes of the Phase 1 and Phase 2 VR Scheme to NHS England for regional approval following each of the Committee meetings</p> <p>The Committee meeting on 01 April 2026 also:</p> <ul style="list-style-type: none"> received a report on and noted the Executive Team Pay Framework update, confirming alignment with the national NHS VSM (Very Senior Manager) framework. |

- Reviewed and agreed updates to the ICBs Fit and Proper Persons Test Policy, brought forward ahead of the review cycle to reflect legislative changes, including the new corporate offence of failure to prevent fraud, and to update role titles and references. The Committee agreed a function-based approach to scope, rather than applying the test solely by pay grade, focusing on roles exercising significant authority, statutory functions, or delegated decision-making responsibilities. The Committee noted the need for simplified and clearer policy wording to ensure alignment with regulatory intent and consistent application in practice. The Committee approved the proposed amendments to the Policy.

Assure

n/a

The next meeting of the Committee is scheduled for **02 June 2026**



Compassionate



Inclusive



Working Together



Accountable

Meeting of the Board of NHS Cheshire and Merseyside

28 May 2026

Highlight report of the Chair of the ICB System Primary Care Committee

Agenda Item No: ICB/05/26/23



Compassionate



Inclusive



Working Together



Accountable

Highlight report of the Chair of the ICB Remuneration Committee

| | |
|---------------------------|---|
| Committee Chair | Erica Morriss |
| Terms of Reference | https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/ |
| Date of meeting(s) | 16 April 2026 |

Key escalation and discussion points from the Committee meeting

Alert

Workforce Risk: The Board is alerted to the operational risk posed by the loss of specialised expertise within the Primary Care function following the Voluntary Redundancy (VR) scheme.

Primary Care Resourcing: A short-term risk has been formally raised regarding the future primary care resourcing model. Current staffing levels may impact the ICB’s ability to effectively monitor performance, quality, and the delivery of the Primary Care Action Plan, specifically regarding patient access and experience.

Advise

Estates Governance: Following the New Build/UMF best practice report, a review of approval procedures and delegations for Strategic Primary Care Estates is underway. This will ensure that future estate decisions are fully aligned with the Strategic Estates Plan, with a completion target of June 2026.

Assure

UMF Process Review (25/26): The Committee has received a formal lessons-learnt report. Governance is being strengthened through improved pipeline management and closer collaborative working between ICB teams and GP practices to ensure best practice in funding utilization.

Financial Oversight: While year-end completion is pending, the Committee is maintaining close oversight of pressures within the prescribing budget (specifically Tirzepatide) and delegated budget strains (locum and lease costs). A "Deep Dive" report for Prescribing is scheduled for the Finance and Investment Committee (FIC) and full report to SPCC in June 26 to address these specific variances.

Commissioning & GP Contracts: Assurance was provided on commissioning requirements across all four contractor groups. The committee is overseeing the development of a unified Primary Care Action Plan (due May 2026) to meet 26/27 GP contract requirements and NHS England mandates, focusing on a single set of performance and quality metrics.

Strategic Delivery: Dental Access Current Performance & Challenges

- **Patient Feedback:** While care quality remains high, Healthwatch reports persistent barriers to routine access. This has led to an increased reliance on urgent care

services. Patients lacking transport and those in deprived areas remain the most impacted.

- Improvement Initiatives:
 - Vulnerable Groups: 68 practices are now active in the local Quality and Access scheme.
 - Urgent Care: As of April 1st, 207 practices across Cheshire and Merseyside are contractually mandated to provide urgent care.
 - Workforce: Under the National Dental Recruitment Incentive Scheme, 3 of 7 identified priority practices have successfully recruited new staff.

Forward Planning & Risk Mitigation

- **Post-Reform Review:** A strategic review of new dental reforms planned for early 26/27.
- **Practice Sustainability Framework:** This framework will be utilised to manage UDA (Unit of Dental Activity) reviews and contract hand-backs.
 - *Governance Milestone:* A formal report on UDA rates and performance monitoring will be presented to the Committee in August.
- **Strategic Objective:** Transition toward a more targeted ICB approach, prioritising additional UDA allocations for the most deprived communities to reduce health inequalities.

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 NHS Dentistry | Update as detailed above on forward planning and risk mitigation. |

Committee risk management

Individual risk report due to the Committee in June 2026, additional Risk raised in April SPCC regarding future Primary Care Resource to managed increased Performance and Quality monitoring across all four Contractor groups.

Date of Next Meeting: 25 June 2026

