NHS
Cheshire and Merseyside

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

24 September 2026

- **Public Board Meeting - 14:15pm**

Village Hotel,
110 Centre Park Square,
Village Hotel Warrington,
Warrington, WA1 1QA

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.

There will be an opportunity for attendees to ask a question at the AGM. Questions received in advance will be prioritised, so please submit your question(s) in writing to Board@cheshireandmerseyside.nhs.uk by Friday 18 September 2026.

Additionally, following the next board meeting, a response will be published on our website which will be available for you to view the week after the meeting. Where a question requires a personalised response, this will be sent to you directly and a summary of the response will also be published on the website.

Further details can be found at:
NHS Cheshire and Merseyside Integrated Care Board September 2026 - NHS Cheshire and Merseyside

Agenda

AGENDA NO & TIME	ITEM	Format	Lead or Presenter	Action / Purpose	Page No
14:15pm	**Preliminary Business**				
ICB/09/24/26/01	Welcome, Apologies and confirmation of quoracy	Verbal	**Sir David Henshaw** *ICB Chair*	For information	-
ICB/09/24/26/02	Declarations of Interest *(Board members are asked to declare if there are any declarations in relation to the agenda items or if there are any changes to those published on the ICB website)*	Verbal		For assurance	-
ICB/09/24/26/03	Minutes of the previous meeting: • 30 July 2026	Paper		For approval	Page 5
ICB/09/24/26/04	Board Action Log	Paper		For approval	Page 19
ICB/09/24/26/05	Key issues – significant items to raise	Verbal		For discussion	-
ICB/09/24/26/06	Chairs announcements	Verbal		For information	-
ICB/09/24/26/07	Experience / achievement story	Film		For information	-
14:25pm	**ICB Business Items**				
ICB/09/24/26/08	Children, Young People Mental Health Review of 2024-26 and CYP Mental Health Transformation Plan 2026-2027	Paper	***Clare Watson*** *Executive Director of Health & Integrated Care Commissioning* ***Claire James*** *Programme Director Mental Health, LD and Neurodiversity Transformation*	For approval	Page 20
ICB/09/24/26/09 14:45pm	Cheshire and Merseyside Winter Plan 2026-27, and UEC Deep Dive	Paper & Presentation	**Jude Adams** *Executive Director of Transformation & Strategy (Interim)*	For approval	Page 29
15:25pm	**Leadership Reports**				
ICB/09/24/26/10	Report of the ICB Chief Executive • Thirlwall Inquiry Report - public inquiry established to examine the events at the Countess of Chester Hospital from 2015 to 2018	Paper	**Liz Bishop** *Chief Executive*	For assurance	Page 102
ICB/09/24/26/11 15:40pm	Cheshire and Merseyside ICB and System Finance Report – Month Five	Paper	**Andrea McGee** *Executive Director of Finance and Contracting*	For assurance	Page 118

AGENDA NO & TIME	ITEM	Format	Lead or Presenter	Action / Purpose	Page No
ICB/09/24/26/12 15:50pm	Highlight report of the Chair of ICB Finance, Investment and Contracting Committee	Paper	**Sue Lorimer** *Non-Executive Member*	For assurance	Page 125
ICB/09/24/26/13 15:55pm	NHS Cheshire and Merseyside Integrated Performance Report	Paper & Presentation	**Jude Adams** *Executive Director of Transformation & Strategy (Interim)*	For assurance	Page 131
ICB/09/24/26/14 16:10pm	Highlight report of the Chair of ICB Quality and Performance Committee	Paper	**Tony Foy** *Non-Executive Member*	For assurance	Page 180
ICB/09/24/26/15 16:15pm	Highlight report of the Chair of the Audit Committee • Audit Committee Annual Report	Paper	**Mike Burrows** *Non-Executive Member*	For assurance	Page 192
ICB/09/24/26/16 16:20pm	Highlight report of the Chair of System Primary Care Committee	Paper	**Erica Morriss** *Non-Executive Member*	For assurance	Page 204
ICB/09/24/26/17 16:25pm	Highlight report of the Chair of Northwest Specialised Commissioning Committee	Paper	***Dr Ruth Hussey*** *Non-Executive Member*	For assurance	Page 207
ICB/09/24/26/18 16:30pm	Highlight report of the Chair of Remuneration Committee	Paper	***Tony Foy*** *Non-Executive Member*	For assurance	Page 211
16:35pm	**Closing Business**				
ICB/09/24/26/19	Closing remarks and review/reflections of the meeting	Verbal	**Sir David Henshaw** *ICB Chair*	For information	-
ICB/09/24/26/20	Any Other Business	Verbal		For information	-
16:40pm CLOSE OF MEETING					

Date and start time of future meetings

26 November 2026. 09:30pm, 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

NHS
Cheshire and Merseyside

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

Thursday 30th July 2026, 1:00pm – 4:30pm

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

Draft 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) (Left at 2:00pm)
Adam Irvine	Partner Member (Primary Care), Cheshire & Merseyside ICB, (voting member)
Dr Fiona Lemmens	Executive Clinical Director, Cheshire & Merseyside ICB (voting member)
Clare Watson	Executive Director of Health and Integrated Care Commissioning, Cheshire & Merseyside ICB (voting member)
Sue Lorrimer	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Dr Naomi Rankin	Partner Member (Primary Care) (voting member)
Trish Bennett	Partner Member (NHS Trust), Cheshire & Merseyside ICB (voting member)
Andrew Lewis	Partner Member, (Local Authority) (Voting Member)
Andrea McGee	Executive Director of Finance and Contracting, Cheshire and Merseyside ICB (voting member)
Ben Vinter	Executive Director of Corporate Services and Governance, Cheshire and Merseyside ICB (voting member)
Delyth Curtis	Partner member (Local Authority) (voting member)
Janelle Holmes	Partner Member (NHS Trust), Cheshire & Merseyside ICB (voting member)
In Attendance	
Jude Adams	Interim Executive Director of Strategy and Transformation, Cheshire and Merseyside ICB
Prof. Ian Ashworth	Director of Population Health, Cheshire & Merseyside ICB (regular participant)
Louise Robson	Chair, Health Innovation North West Coast (regular participant)

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Paul Mavers	Chief Executive, Healthwatch Knowsley
Jennie Williams	Senior Executive Assistant (Note Taker), Cheshire and Merseyside ICB
Sallyanne Hunter	Head of Corporate Business Support, Cheshire and Merseyside ICB
Apologies	
Name	**Role**
Mike Burrows	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Erica Morriss	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Prof. Paul Kingston	Chair of ICB Research and Innovation Committee, (regular participant)

Agenda Item, Discussion, Outcomes and Action Points
Preliminary Business
ICB/07/30/26/01 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/07/30/26/02 Declarations of Interest
None.
ICB/07/30/26/03 Minutes of the previous meeting of 28th May 2026
The minutes of the previous meeting held on 28th May 2026 were accepted and recorded as a true and accurate reflection of the meeting.
ICB/07/30/26/04 Board Action Log
The Board reviewed all actions and closed actions ICB-AC-104, ICB-AC-105, ICB-AC-114.
ICB/07/30/26/05 Key Issues – Significant Issues to Raise
There were no key issues raised by Board members.
ICB/07/30/26/06 Chairs Announcements
The Chair thanked and congratulated Adam Irvine on his re-appointment as member of the Board for a further three-year term. The Board recognised Adam's continued commitment and contribution and expressed its appreciation for his ongoing service.
ICB/07/30/26/07 Questions Received from Members of the Public
The Board discussed questions received from members of the public; full responses will be available on the ICB website from 30th July 2026 - July 2026 ICB Board Questions and Responses .docx
ICB/07/30/26/08 Experience / Achievement Story
Liz Bishop (LB) introduced a patient story from Pat, who shared his experience of receiving care and treatment at Liverpool Heart and Chest Hospital during a period of uncertainty leading up to major heart surgery. The story highlighted not only the high quality of clinical care provided, but also the compassion, professionalism, teamwork and kindness demonstrated by staff throughout

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his treatment journey. **The Board welcomed the video.**
ICB Business Items
ICB/07/30/26/09 Reflecting on Government Commissioned Reviews – Ockenden (Nottingham) and Amos Maternity Reviews
The Board received a report from Kerry Lloyd (KL) summarising the findings and implications of the recently published Ockenden Review and Amos Review into maternity services in England. The significant personal and professional impact of both reviews was acknowledged, recognising the courage and resilience of the families affected and the staff who contributed to the review processes. It was noted that the findings serve as a powerful reminder of the need to accelerate improvements in maternity services and ensure that learning is translated into sustained action. The Board noted that both reviews identified consistent and recurring themes, including failures to listen to women and families, inadequate escalation of safety concerns, inequity, discrimination and racism, workforce capacity pressures, cultural and leadership challenges, weaknesses in governance and oversight, and failures to embed learning from previous investigations and reviews. It was highlighted that, despite numerous recommendations arising from national maternity reviews over recent years, implementation and sustainability of improvement actions have often been insufficient. The Ockenden Review, the largest review of a single NHS trust undertaken to date, examined maternity care provided over a 13-year period and identified a series of immediate and essential actions. These included strengthening engagement with women and families, ensuring safe staffing and workforce planning, enhancing multidisciplinary training, improving dynamic risk assessment throughout pregnancy, increasing family involvement in investigations, strengthening governance and board oversight, and improving psychological safety and bereavement support. The Board further noted that the Amos Review considered maternity services from a national and system-wide perspective and identified similar themes. Additional recommendations included the establishment of a statutory Maternity and Neonatal Commissioner, development of a modern maternity service framework, strengthening leadership and culture, improving investigative processes, addressing racism affecting both patients and staff, enhancing digital infrastructure and estates, and ensuring that women's experiences are routinely incorporated into safety measures. Members were advised that many of the areas highlighted in the reviews are already subject to established assurance arrangements across Cheshire and Merseyside. These include monthly reporting to the Quality and Performance Committee, development of a system-wide maternity safety dashboard, weekly provider staffing and operational pressure reporting, and regular maternity Gold Command meetings to coordinate oversight, risk management and mutual aid arrangements. Progress was also noted in standardising maternity triage arrangements across providers and maintaining robust escalation processes from ward to board level. The Board noted correspondence from NHS England, including a ten-point action plan and expectations for system partners, alongside details of further national investment in workforce and estates. It was reported that providers are undertaking gap analyses against the emerging requirements while awaiting further national guidance. The Board discussed – • The findings of the Ockenden and Amos Reviews, recognising the significant distress and

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harm experienced by the women, babies, families and staff affected. Members acknowledged that, whilst extensive assurance processes and performance reporting are already in place, the reviews highlighted the importance of cultural and qualitative improvements in addition to monitoring quantitative performance metrics. • The need for assurance that meaningful cultural change is being embedded across provider organisations. Members emphasised that improvements in patient outcomes and safety would be underpinned by stronger organisational cultures, effective multidisciplinary working, and an environment in which concerns are heard and acted upon. • The importance of ensuring that the voices of women and families are consistently heard, recognising that traditional feedback and complaints mechanisms may not always be accessible or culturally appropriate. Members highlighted the need to explore more inclusive and innovative approaches to gathering patient experience and feedback, particularly from underrepresented communities and those who may share their experiences sometime after receiving care. • Workforce sustainability was identified as a further area of importance. Members noted national concerns regarding student midwife attrition and discussed the potential implications for the future maternity workforce. It was suggested that further consideration be given to local attrition rates, engagement with higher education institutions, and the long-term impact on workforce capacity and service resilience. In response, the Chief Nursing Officer acknowledged the challenges facing the profession and the importance of balancing the public narrative around maternity services with recognition of the high-quality care delivered by maternity staff every day. The Board was advised that existing partnerships with higher education providers could support further work in this area. • Drawing on experience within provider organisations, members reflected on the significant improvements that can be achieved through sustained leadership development, cultural transformation and multidisciplinary teamworking. It was noted that the recommendations emerging from both reviews aligned closely with approaches that have previously supported successful service improvement. • Assurance regarding ongoing system-wide improvement activity, including the delivery of the Maternity and Neonatal Safety Improvement Programme across Cheshire and Merseyside. This programme includes initiatives focused on patient safety, quality improvement, workforce development, clinical practice improvement, frontline engagement and the rollout of Martha's Rule. • The wider relevance of the review findings beyond maternity services, recognising the importance of embedding patient voice and experience across all aspects of healthcare. The Board agreed that listening to women and patients must remain a fundamental component of service improvement, governance and quality assurance processes. **The Board -** **Noted the content of the report.** **Requested future system response/s to the report findings.**
ICB/07/30/26/10 Cheshire and Merseyside Provider Collaborative (CMPC) Annual Work Plan for 2026
The Board received an update on the work of the Cheshire and Merseyside Provider Collaborative from Janelle Holmes (JH) marking the first occasion that its activities had been presented formally to the Board.

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Members were reminded that, following the establishment of separate Acute and Specialist Trust and Community and Mental Health Provider Collaboratives in 2021, these arrangements were brought together in May 2025 to form a single collaborative structure encompassing all 15 NHS provider organisations across Cheshire and Merseyside. The collaborative brings together acute, specialist, community and mental health providers to address challenges that cannot be resolved effectively by individual organisations acting alone and to support delivery of the priorities of the Integrated Care Board.

The Board noted that the Provider Collaborative focuses on addressing clinical fragility, workforce pressures, unwarranted variation and long-term financial sustainability, with the overarching aim of improving patient outcomes and protecting local access to services.

Members were advised of a number of significant achievements during 2025/26, including securing £50 million of diagnostic funding, which contributed to Cheshire and Merseyside maintaining its position amongst the top-performing integrated care systems nationally for diagnostic waiting time performance. The collaborative also supported delivery of more than £40 million in efficiency savings, reductions in 52-week waits, increased utilisation of virtual wards, and the implementation of dermatology artificial intelligence pathways, which avoided over 4,500 unnecessary face-to-face appointments.

The Board noted the development of the Cheshire and Merseyside Provider Blueprint, which had been developed collaboratively across all 15 provider organisations and approved by each Trust Board. The Blueprint provides a framework for delivering the benefits of working at scale, including strengthening fragile clinical services, supporting neighbourhood-based models of care, reducing duplication and developing sustainable provider models for the future.

It was further reported that robust governance arrangements are in place to support collective decision-making and delivery of agreed priorities. The collaborative work programme for 2026/27 will focus on continuing efficiency initiatives at scale, elective and diagnostic recovery and transformation, and the further development of community and clinical pathway programmes.

The Board Discussed –

- The strength and maturity of the Cheshire and Merseyside Provider Collaborative. It was noted that, from experience of working across other systems, the collaborative approach within Cheshire and Merseyside is particularly well established and provides a strong foundation for system-wide working.
- The Provider Collaborative plays a critical role in supporting delivery of operational priorities and performance standards across the system, enabling providers and the ICB to work collectively in addressing shared challenges and delivering improvements for patients. Members recognised that many of the achievements highlighted within the report had been enabled through the collaborative framework and the strong relationships developed between partner organisations.
- The collaborative model provides a valuable blueprint for the development of other system-wide partnerships, including ambitions for greater collaboration within primary care, and represents an important component of the system's long-term success.

The Chair thanked all organisations and individuals involved in the Provider Collaborative for their contribution and commitment. The Board recognised the significant progress made to date and

acknowledged the positive impact of collaborative working in improving services and outcomes across Cheshire and Merseyside.

The Board endorsed the work and future direction of the Cheshire and Merseyside Provider Collaborative and noted the update.

ICB/07/30/26/11 Board Assurance Framework (BAF)

The Board received an update on the Board Assurance Framework (BAF) from Ben Vinter (BV), noting its role in supporting the Board's oversight of delivery against the organisation's strategic objectives and associated risks.

Members were advised that the report provided both a high-level summary and a detailed review of the current risk profile. Following previous discussions at the March 2026 Board meeting, a comprehensive review of the BAF had been undertaken to ensure that the risks, controls, mitigations and actions accurately reflected the current operating environment. The Board noted that significant revisions had been made, with key amendments highlighted within the report. Particular attention was drawn to BAF Risk 15, relating to the sustainability of the health and care system. Members heard that this risk had been revised from its previous focus on provider sustainability alone to better reflect the broader system-wide challenges and responsibilities facing the organisation.

The Board also noted refinements to the risk relating to neighbourhood health and community-based care, ensuring alignment with recent national policy developments and guidance. In addition, a proposed reduction in the finance risk rating was presented, reflecting the ICB's evolving role as a strategic commissioner and the consequent change in responsibilities from a broader system management function to one focused on statutory commissioning duties. Subject to the proposed amendments to the finance and system sustainability risks, the overall risk profile remained largely unchanged.

The Board further noted a recommendation from digital colleagues to develop a separate Board Assurance Framework risk relating to digital infrastructure and resilience, in addition to the existing cyber security risk. Subject to Board agreement, this proposal would be considered further through the Audit Committee in September.

The Board Discussed –

- The progress made in refreshing the Board Assurance Framework and risk register, noting that the revised approach provided a clearer reflection of the organisation's current operating environment.
- The implications of emerging models of care and commissioning, including the increasing devolution of commissioning responsibilities, neighbourhood health arrangements and Integrated Health Organisation (IHO) developments. Members highlighted the importance of considering the Board's future risk appetite, particularly in relation to financial governance and oversight, to ensure that it remains aligned with the changing landscape. It was suggested that a broader discussion on risk appetite would be a valuable next step in the Board's governance development.
- The Board was advised that consideration of risk appetite is already incorporated within the Board Development Programme, with further discussion planned later in the year.
- In considering BAF Risk 16, relating to neighbourhood health and the shift of services into community settings, members emphasised the importance of primary care as a critical enabler

of this transformation. The Board noted the need to maintain oversight of workforce capacity, capability and resilience across primary care and wider contractor services, particularly given existing workforce pressures and the central role these services will play in delivering care closer to home.

- Assurance was sought that workforce challenges within general practice and other primary care services would continue to be recognised and reflected within ongoing risk management and strategic planning arrangements.
- Workforce sustainability within primary care remains a key factor in the successful delivery of neighbourhood health objectives and wider system transformation.

The Board -

- **Noted the current risk profile, progress with mitigating actions, assurances provided and priority actions for the next quarter and consider any further action required by the Board to improve the level of assurance provided or any new risks which may require inclusion on the BAF.**
- **Noted the proposed change in risk description for BAF risk P15 (Sustainability) and increase in risk score.**
- **Considered any further action required by the Board to improve the level of assurance provided, or any 'new' risks which may require inclusion on the BAF.**

ICB/07/30/26/12 Primary Care Business Cases

The Board received an update from Clare Watson (CW) on arrangements to support the relocation of Billinge Medical Practice following notice being served by the practice's landlord in March 2026. Members were advised that the ICB Estates Team and the Primary Care Team had been working closely with the practice to identify and assess potential relocation options. A range of options had been considered against agreed criteria, including patient access, continuity of care, clinical safety, quality of services and long-term sustainability.

Following detailed appraisal, a business case was approved by the Executive Team to relocate the practice from its current premises on Recreation Drive to Garswood Health Centre, located less than two miles away. The proposed relocation was identified as the safest, most deliverable and sustainable option, providing patients and staff with access to a high-quality healthcare facility and supporting the continued delivery of safe and effective services.

The Board noted that the practice had been fully engaged throughout the process and was supportive of the proposed relocation. Work is underway to implement a comprehensive mobilisation plan to ensure a smooth transition of services, staff and patients ahead of the expiry of the current lease, with a particular focus on maintaining continuity of care.

Members also noted the strong views expressed locally regarding the move. It was reported that, despite the support of the practice for the relocation, the ICB would continue to engage with patients and local stakeholders to understand and consider their views. Whilst the relocation to Garswood Health Centre represents the long-term solution, the ICB acknowledged the importance of ongoing dialogue with the local community and will continue to assess any future opportunities for alternative premises as part of wider primary care estate planning across Cheshire and Merseyside.

The Board Discussed -

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- The significant level of local interest and concern regarding the proposed relocation of Billinge Medical Practice.
- The situation had arisen following the deterioration of the existing premises, which were no longer considered suitable for the sustainable delivery of general practice services. Members recognised that, while there is a strong attachment to the current location within the local community, the overriding consideration throughout the decision-making process has been the provision of safe, high-quality and sustainable patient care.
- The practice had been actively involved in the process and was supportive of the proposed relocation to Garswood Health Centre. The Board received assurance that the ICB would continue to engage with and listen to the views of patients, residents and other local stakeholders as implementation progresses.
- That any future consideration of alternative premises would need to be assessed within the context of broader primary care estate priorities and the resources available across Cheshire and Merseyside.

The Board emphasised its commitment to maintaining an open dialogue with the local community and ensuring that patient needs remain at the centre of decision-making.

The Board noted the update.

Leadership Reports

ICB/30/05/26/13 Report of the ICB Chief Executive

The Board received the Chief Executive's report and noted progress across a number of organisational priorities.

Members were advised that the third phase of the Management of Change programme for staff at Band 8b and below commenced on 25 June 2026 and is scheduled to conclude, subject to agreement with Trade Union colleagues, on 9 August 2026. The Board noted that an extensive programme of staff engagement and consultation has been undertaken, including face-to-face team meetings, team briefings and formal consultation processes. More than 600 items of feedback have been received and will be considered as part of the final review process prior to approval of the proposed organisational structure, which remains on track to be finalised in August 2026.

The Board also noted the recent visit by national NHS leaders to Cheshire and Merseyside to review progress in neighbourhood health development. The visit, led by Dr Claire Fuller, NHS England's National Medical Director for Primary Care, was hosted at Alder Hey Children's Hospital and attended by approximately 60 representatives from across the system. Members heard that Sefton and St Helens, as neighbourhood health pioneer areas, presented progress updates, including examples of work focused on frailty and services for children and young people. Feedback from the national team was highly positive, with particular recognition given to the examples of integrated working presented during the visit.

The Board further noted that national colleagues had commended the strong culture of constructive support and challenge demonstrated by partners across local government, the voluntary sector, primary care and provider organisations.

The Board Discussed -

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• The national recognition received for the Stroke and Neuro-Rehabilitation Online Innovation Programme, which was awarded a national excellence award in partnership with Lancashire and South Cumbria. Members heard that the programme represents a successful example of the adoption and spread of innovation across integrated care systems. The initiative was originally developed and piloted within Lancashire and South Cumbria, supported by dedicated funding secured to establish and evaluate the model. Following successful implementation and evaluation, Cheshire and Merseyside adopted the programme as a fast follower, enabling the benefits of the innovation to be extended across a wider population. **The Board -** • **Considered the updates to Board and sought further clarification and detail.** • **Will disseminate and cascade key messages and information as appropriate.**
ICB/07/30/26/14 Cheshire and Merseyside ICB and System Finance Report – Month 3
The Board received the Month 3 Finance Report from Andrea McGee (AMcG), noting that, as at 30 June 2026, the ICB was reporting a balanced break-even position. Members were advised that performance against plan had been supported by a favourable variance in acute activity expenditure. This reflected a combination of the impact of industrial action during April 2026 and effective management of activity levels, including activity commissioned through the independent sector. The Board noted that a number of financial risks continued to require close management, particularly within community services, mental health packages of care and all-age continuing healthcare (CHC). These areas are currently reporting expenditure above plan and represent significant areas of spend for the ICB. It was reported that investment is being made to strengthen capacity within relevant teams to support timely reviews of care packages and improve management oversight. Members also noted emerging risks associated with independent sector mental health provision. Arrangements are being implemented to strengthen activity planning and monitoring to ensure expenditure remains aligned with agreed plans as new market providers enter the sector. The position at Month 3 was further supported by a number of timing-related underspends carried forward from the previous financial year. It was noted that this was not considered a significant concern, given that delivery of Cost Reduction and Efficiency Savings (CRES) schemes is expected to increase later in the year. The Board heard that the ICB has established a CRES programme of £144 million and is currently forecasting delivery of £154 million, providing a degree of assurance against the savings requirement. Whilst the overall position is positive, a risk assessment undertaken at Quarter 1 identified a potential £12 million adverse variance against budget. Members were advised that early indications from Month 4 suggest an improving position, although the scale of the savings programme means continued oversight and management remain essential. The Board also noted the significant progress made in strengthening contract management arrangements across the organisation. Particular attention is being given to contracts relating to all-age continuing healthcare to support improved financial control and performance monitoring. In considering the wider system position, members were advised that the Cheshire and Merseyside system was reporting a £7 million variance from plan at Month 3, predominantly

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attributable to two provider organisations. The ICB will continue to work collaboratively with providers to support delivery of financial sustainability plans across the system.

A further area highlighted for ongoing monitoring was prescribing expenditure, which remains volatile. Overspends in excess of £1 million were reported in both Month 1 and Month 2. The Board noted that prescribing forms a key component of the savings programme and is therefore subject to enhanced oversight through the Finance Committee.

The Board also received an update on several additional initiatives underway to strengthen financial management and long-term sustainability.

These include-

- A comprehensive zero-based budgeting review of the ICB's annual expenditure of approximately £8.5 billion, aimed at improving understanding and scrutiny of spending across all areas.
- Participation in a national review of mental health and community services expenditure within NHS provider organisations, with completion planned by September 2026.
- The commencement of earlier year-end forecasting arrangements to improve visibility of the anticipated financial position, strengthen risk management, and support timely implementation of mitigating actions where required.

The Board noted the Month 3 financial position of both the ICB and the wider Cheshire and Merseyside system and acknowledged the key financial risks and mitigating actions outlined within the report.

ICB/07/30/26/15 Highlight report of the Chair of the ICB Finance, Investment and Contracting Committee

The Board received the Chair's report from the Finance, Investment and Contracting Committee covering meetings held in May and June 2026, together with an update from the most recent Committee meeting.

The Committee reported significant progress in contracting arrangements for 2026/27, with all NHS provider and independent sector contracts agreed. Members noted the successful resolution, through mediation, of the contractual dispute with Mersey and West Lancashire Teaching Hospitals NHS Trust and the establishment of a joint programme of work to support service sustainability and address related issues. It was noted that the formal contract remains subject to completion.

The Committee reviewed a deep dive into third sector contracting and noted that the ICB holds over 200 contracts with voluntary, community and social enterprise organisations, representing approximately 1.9% of total expenditure. Further work is planned to improve understanding of commissioning activity and inform future contracting strategies.

Members also received an update on the national programme to deconstruct mental health and community service contracts, recognising the scale and complexity of the work required to improve transparency of services and associated expenditure within challenging national timescales.

Assurance was provided regarding progress in all-age continuing healthcare services, with

additional resources approved to strengthen capacity and support delivery of improvement plans. The Committee was also assured that implementation of recommendations arising from the financial governance review remains on track.

The Board noted the report and the assurances provided by the Finance, Investment and Contracting Committee.

ICB/07/30/26/16 NHS Cheshire and Merseyside Integrated Performance Report

The Board received the latest Integrated Performance Report (IPR), developed to provide enhanced strategic oversight through a focused set of key performance indicators aligned to the Cheshire and Merseyside Five-Year Strategy and life-course framework. Members noted that the report will continue to evolve, with indicators escalated to Board level where additional scrutiny is required.

The Board welcomed strong performance in planned care, diagnostics and cancer services, whilst noting that urgent and emergency care remains a significant challenge. Particular concern was expressed regarding delayed discharge and the number of patients with No Criteria to Reside (NCTR) in acute settings, recognising the impact on hospital capacity, patient flow and emergency care performance.

Members discussed delayed discharge as a whole-system issue requiring collective action across health, social care, housing and community partners. The Board recognised the potential harms associated with prolonged hospital stays, including patient deconditioning and increased care needs following discharge, and supported further work to better understand patient pathways and opportunities to improve flow and outcomes.

The Board noted ongoing work with provider collaboratives and system partners to address discharge delays, improve patient flow and share best practice across Cheshire and Merseyside. Members also emphasised the importance of strengthening neighbourhood-level intelligence, understanding inequalities in access and outcomes, and incorporating patient and public experience within future performance reporting.

The inclusion of screening and vaccination metrics was welcomed, with continued monitoring of prevention indicators supported. Members agreed that the report represents a significant improvement in strategic performance reporting and provides an effective framework for Board oversight.

Action - JA to bring further analysis and discussion on patient flow, delayed discharge and urgent care pressures to a future Board meeting.

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

ICB/07/30/26/17 Highlight Report of the Chair of ICB Quality and Performance Committee

The Board received the Chair's report from the Quality and Performance Committee and noted a number of quality, safety and performance matters requiring ongoing oversight.

Members were advised that enhanced system oversight arrangements have been re-established in relation to East Cheshire NHS Trust, reflecting continuing concerns regarding service quality, sustainability and performance, including the Trust's CQC rating and mortality indicators. The

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Board recognised the significant improvement efforts being made by the Trust and its clinical teams but supported the continuation of enhanced oversight and ongoing scrutiny of mortality performance and maternity services. The Board also noted that North Cheshire Hospitals NHS Trust has been placed under regional enhanced surveillance following concerns regarding the pace of improvement, with a particular focus on strengthening governance, accountability and maternity service oversight. In contrast, members welcomed the substantial progress achieved by Countess of Chester Hospital NHS Foundation Trust, which has successfully exited enhanced oversight arrangements following evidence of sustained improvement. Particular recognition was given to the significant progress made within maternity services. The Board supported the continuation of enhanced oversight arrangements where required and acknowledged the progress made by organisations demonstrating sustained improvement. **The Board noted the contents of the report**
ICB/07/30/26/18 Highlight report of the Chair of the Audit Committee
The Board received the Audit Committee Chair's report and noted that the Committee had reviewed the draft Annual Report and Accounts. Members were advised that amendments recommended by the Committee had been incorporated, including enhancements relating to corridor care, Board oversight and specialised commissioning, and assurance was provided that these areas are being addressed through established governance arrangements. The Committee approved the Annual Report and Accounts for submission to the Board and received an update on the year-end external audit. Members noted that the audit was substantially complete, progressing to plan, and expected to result in an unqualified audit opinion and a clean regulatory opinion. The external auditors commended the Finance Team for the quality of support provided throughout the audit process. The Committee also reviewed the External Audit Findings Report and Letter of Representation. Whilst a number of challenges relating to financial sustainability and governance were identified, no significant weaknesses requiring qualification were reported. Assurance was provided that work is underway to strengthen financial management, forecasting, organisational effectiveness and governance arrangements. The Board noted the continued oversight of NHS England enforcement undertakings and the progress being made in strengthening financial governance, planning and performance management across the organisation. **The Board noted the contents of the report.**
ICB/07/30/26/19 Highlight report of the Chair of the System Primary Care Committee
The Board received the Chair's report from the System Primary Care Committee and noted key developments across primary care services. Members noted the approval of a three-stage escalation process to manage GP practices operating without valid lease arrangements, recognising the associated financial, estate and

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operational risks and the importance of strengthened oversight. The Committee received an update on delivery of the Primary Care Action Plan and noted positive progress. Members welcomed the 10.3% funding uplift for community pharmacies but acknowledged ongoing financial pressures across the sector and the continuing reduction in pharmacy numbers across Cheshire and Merseyside. The Board recognised the important role of community pharmacies in supporting neighbourhood health services and agreed that the sustainability of the sector should continue to be closely monitored. The Board also welcomed the introduction of the Meningitis B vaccination programme through community pharmacies for young people preparing to attend university and noted the importance of promoting uptake amongst eligible groups. In reviewing the primary care financial position, members noted a Month 2 surplus and emphasised the importance of ensuring that any dental commissioning underspends are reinvested to improve access to NHS dental services and support delivery of local priorities. **The Board noted the contents of the report.**
ICB/07/30/26/20 Highlight report of the Chair of the Northwest Specialised Commissioning Committee
The Board received an update from the chair of the North West Specialised Commissioning Committee and noted that the Neonatal Services Review remains in progress across the North West region. Members were advised that the programme is currently in the engagement phase, with staff, patients and service users being consulted to inform the review and future service arrangements. The Board noted the importance of continued engagement and will receive further updates as the programme develops. The Board also received an update regarding the development of the new OPIC arrangements. Members acknowledged the significant work undertaken by ICB staff in designing and supporting the transition to the new model and expressed appreciation for their continued commitment and contribution to the programme. It was noted that a subsequent meeting of the Specialised Services Committee had taken place in July 2026, following publication of the Board papers. A further report and update from that meeting will therefore be presented to the Board in September. The Board noted the update on the Neonatal Services Review, acknowledged the progress being made in developing the new OPIC model, and recorded its thanks to staff involved in this work. **The Board noted the contents of the report.**
Closing Business
ICB/07/30/26/21 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.
ICB/07/30/26/22 Any Other Business
None.

DRAFT

Date and start time of future meetings
24 September 2026, 13.00pm – The Village Hotel, 110 Centre Park Square, Warrington, WA1 1QA

DRAFT

Cheshire and Merseyside ICB Public Board Meeting Action Log

Updated: **31.07.26**

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-115	30th July 2026	ICB/07/30/26/16 NHS Cheshire and Merseyside Integrated Performance Report	Action - JA to bring further analysis and discussion on patient flow, delayed discharge and urgent care pressures to a future Board meeting.	Jude Adams	Sep-26		Closed	Proposed closed as on the agenda under item **Cheshire and Merseyside Winter Plan 2026 – 27, and UEC Deep Dive**

Meeting of the Board of NHS Cheshire and Merseyside

Date: 24 September 2026

Children and Young People's Mental Health Transformation in Cheshire and Merseyside

Review of the 2024–2026 CYP Mental Health Transformation Plan and Approval of the 2026–2027 CYP Mental Health Transformation Plan

Agenda Item No: **ICB/09/24/26/08**

Responsible Director: **Clare Watson, Executive Director of Health & Integrated Care Commissioning**

Review of the 2024–2026 CYP Mental Health Transformation Plan and Approval of the 2026–2027 CYP Mental Health Transformation Plan

1. Purpose of the Report

The purpose of this report is to:

- Provide assurance to the Board regarding delivery of the Cheshire and Merseyside Children and Young People's Mental Health Plan 2024–2026.
- Summarise the impact and achievements delivered across the Integrated Care System.
- Describe the engagement and co-production undertaken to inform the refreshed Children and Young People's Mental Health Transformation Plan 2026–2027.
- Seek Board approval of the one-year Children and Young People's Mental Health Transformation Plan 2026–2027 following ICB Executive endorsement.

2. Executive Summary

2.1 The Cheshire and Merseyside Children and Young People's Mental Health Plan 2024–2026 was developed to provide a shared strategic framework for improving emotional wellbeing and mental health support for infants, children and young people across Cheshire and Merseyside.

2.2 The plan was developed collaboratively with children and young people, families, local authorities, NHS providers, education settings and the voluntary, community, faith and social enterprise (VCFSE) sector. It focused on eight priority areas including participation, access, crisis care, young adults, eating disorders and support for children with the most complex needs.

2.3 Over the two-year period, significant progress has been achieved. Access to NHS-funded mental health support for children and young people aged 0–17 increased by 32%, with 38,260 children and young people receiving support during the 12 months to March 2026. Access for young adults aged 18–25 increased by 38.4%, Mental Health Support Team coverage expanded to approximately 60% of schools and colleges, 24/7 crisis support became available across all Places, and three Mental Health Response Vehicles were mobilised across Cheshire and Merseyside taking the total number of vehicles to four. The plan also delivered the redesign of community eating disorder pathways, support for young adults and appropriate places of care for children and young people with complex needs. These programmes have developed co-produced models, best practice guidance and implementation proposals, providing a strong evidence base for future commissioning and service transformation.

2.4 The Board is asked to note the progress made through delivery of the 2024–2026 Plan and approve the refreshed Children and Young People's Mental Health Transformation Plan 2026–2027. The new one-year plan builds on the progress achieved to date whilst responding to national policy, financial pressures and feedback from children, young people, families and partners

3. Review of the 2024–2026 Plan

3.1 Overall Progress

The 2024–2026 plan has enabled partners across Cheshire and Merseyside to work towards a shared vision for improving children and young people's mental health.

3.2 Key achievements include:

Achievement	Progress
CYP access (0–17 years)	38,260 children and young people supported over 12 month rolling period (+32%)
Young adult access (18–25 years)	12,800 young adults supported (+38.4%)
Mental Health Support Teams (Schools & Colleges) coverage	Approx 60% of schools and colleges (up to and including Wave 11)
Mental Health Crisis support	24/7 support available in every Place
Mental Health Response Vehicles	3 new vehicles operational (total 4)
Workforce	All-age Mental Health Workforce Strategy developed
Participation	Children, young people and families embedded throughout programme delivery

These achievements demonstrate substantial progress towards improving access, strengthening early intervention and developing more responsive crisis support across Cheshire and Merseyside.

Further details regarding delivery and examples of impact across the eight priority areas can be found within the accompanying infographic (Appendix 1) and the "Making a Difference" impact summary (Appendix 2).

3.3 Key Areas of Impact

Prevention and Early Intervention
Progress has been made in expanding community-based support and improving access to help before needs escalate. This includes the continued rollout of Mental Health Support Teams, development of digital access routes, strengthened partnerships with VCFSE organisations and increased focus on reducing inequalities.

Young Adults (16–25)
The Transforming Care Programme has led the development of a co-produced Transition Policy for CYP with Learning Disabilities, Autism and Mental Health needs. Extensive engagement to identify improvements required for young adults has informed a set of best practice recommendations focused on improving continuity of care, service accessibility and young adult experiences.

Crisis and Urgent Care
Significant progress has been made in strengthening crisis and urgent mental health support. This includes the mobilisation of 24/7 community crisis services, implementation of NHS 111 Option Mental Health, expansion of Mental Health Response Vehicles, development of place-based Gateway arrangements and strengthened support for children and young people with learning disabilities, autism and complex needs. Together, these developments have improved the system's ability to provide timely, coordinated support and reduce reliance on emergency departments and inpatient care where appropriate.

The Mental Health programme has also developed a co-produced Alternative to Crisis best practice model, seeking to reduce variation in community crisis alternatives and inform future strategic commissioning and service development.

Complex and Specialist Care
Significant progress has been made in developing Appropriate Places of Care to provide a response to the growing number of CYP with complex, multi-agency needs who are not suitable for Tier 4 inpatient mental health services and cannot be safely supported at home. Inpatient pathways have been strengthened through the Inpatient Quality Transformation Programme, and improvements made in eating disorder services and enhanced support for children and young people with learning disabilities, autism and complex needs.

4 Engagement and Co-Production Informing the 2026–2027 Plan

4.1 The refreshed one-year plan has been developed through extensive engagement with children and young people, families, carers, NHS providers, local authorities, schools and colleges, VCFSE partners and wider system stakeholders.

4.2 The plan has also been informed by:

- Delivery learning from the 2024–2026 plan.
- Population health and mental health data and intelligence.
- Access, waiting time analysis.
- Children and young people's feedback through participation networks.
- Parent and carer engagement.
- Clinical, operational and commissioning intelligence.

4.3 Feedback consistently highlighted the importance of:

1. Earlier access to support.
2. Reduced waiting times.
3. Better support during transitions.
4. Increased community-based support.
5. Improved community crisis alternatives.
6. Consistent support across Cheshire and Merseyside.
7. Better information and navigation for families.
8. Greater focus on inequalities and underserved groups.

These priorities are reflected throughout the refreshed 2026–2027 plan.

5 Children and Young People's Mental Health Transformation Plan 2026–2027

5.1 The refreshed plan is a system-wide plan, developed in partnership across Cheshire and Merseyside. It reflects the collective priorities and contributions of NHS commissioners and providers, Local Authorities and Directors of Children's Services, alongside VCSE partners, children and young people, families and wider system stakeholders. The plan is intentionally focused on a one-year period. This reflects:

- significant national NHS and wider system reform;
- evolving commissioning, organisational and delivery arrangements;
- continued financial pressures across health and care;
- the need to maintain momentum against agreed priorities and commitments; and
- the importance of retaining sufficient flexibility to respond to emerging national, regional and local priorities.

5.2 The one-year approach therefore provides a clear framework for collective action during 2026–2027, whilst recognising the changing strategic and organisational context within which partners are operating.

5.3 The plan focuses on a small number of high-impact system priorities where partners believe the greatest improvements can be achieved over the next 12 months.

5.4 The four strategic priorities are:

1. **Prevention and Earlier Help**
   Improving access, reducing waiting times and strengthening community-based support.

2. **Smooth Transitions and Support for Young Adults (16–25)**
   Improving continuity of care and implementing recommendations from the co-produced young adult review.

3. **Mental Health Crisis and Urgent Support**
   Strengthening crisis pathways, crisis alternatives and community-based responses.

4. **Appropriate Care Pathways for Complex and Specialist Needs**
   Improving support for children and young people with complex needs, eating disorders and those requiring specialist care.

5.5 A detailed implementation plan underpins the four strategic priorities, identifying lead responsibility for each deliverable, baseline measures and quarterly monitoring of performance and delivery. It also sets out clear commissioning intentions and the ICB's role in enabling and supporting system delivery, including the continued shift towards earlier intervention, prevention and community-based support.

5.6 The language and presentation of the Transformation Plan have been co-produced with system stakeholders, children, young people and families, with the aim of making it clear and accessible across our health and care system. A supporting animation has also been co-produced and voiced by young people. The Plan presented for approval is intended to be the public-facing version, published on the ICB website, with the more detailed implementation plan providing the supporting delivery, accountability and performance framework.

5.7 Delivery against the priorities within the Plan is already underway across the system. The supporting implementation plan provides ongoing oversight and assurance, with progress against agreed deliverables and measures monitored and reported quarterly.

The full draft plan is included in Appendix 3 and is presented to the Board for approval.

6 Risks and Considerations

6.1 The principal risks to delivery include:

- Financial pressures within the ICB and across partner organisations.
- Workforce capacity and recruitment challenges.
- Variable digital maturity and data quality across sectors.
- Continued increases in demand and complexity of need.
- Risk of unwarranted variation across Places.
- Maintaining progress during wider NHS organisational change.

6.2 These risks will be managed through programme governance arrangements, quarterly reporting and delivery oversight through the Children and Young People's Emotional Wellbeing and Mental Health Programme Partnership.

7 Financial Implications

7.1 Delivery of the Children and Young People's Mental Health Transformation Plan 2026–2027 will primarily be supported through existing commissioned services, aligned partner resources and nationally allocated programme funding.

7.2 National NHS Service Development Funding (SDF) remains ring-fenced to support the continued rollout of Mental Health Support Teams (MHSTs) in schools and colleges across Cheshire and Merseyside, in line with the national ambition to achieve full coverage by December 2029.

7.3 During 2025/26, a decision was taken not to recurrently fund four new MHSTs from ICB resources in line with national expectations/operational planning. A recovery plan was subsequently approved which addresses this shortfall by December 2029 on a phased basis. Indicative national SDF allocations have been published to support further expansion; however, there is a risk of confirmed allocations being approved at a lower value. The risk associated with the recovery of developing these four teams will therefore continue to be monitored through MH programme governance arrangements.

8. Ask of the Board and Recommendations

8.1 **The ICB Board is asked to:**

1) Note the progress and achievements delivered through the Children and Young People's Mental Health Plan 2024–2026.
2) Note the ongoing risks and challenges outlined within this report.
3) Approve the Children and Young People's Mental Health Transformation Plan 2026–2027.
4) Support publication of both the 2024–2026 achievements summary and the 2026–2027 plan on the NHS Cheshire and Merseyside website.

9. Next Steps

9.1 Following approval of this report by the ICB Board, the Children and Young People's Mental Health Transformation Plan 2026–2027, supporting appendices and a young person-led animation explaining the plan and its priorities will be published on the NHS Cheshire and Merseyside website. Feedback will be shared with children, young people, families and partners in line with the Lundy principles of participation and engagement.

9.2 Implementation of the refreshed plan has commenced (April 2026), supported by a system-wide implementation plan and delivery arrangements across partners and local authority footprints. Progress against the plan will be monitored through quarterly reporting to the Cheshire and Merseyside Children and Young People's Emotional Wellbeing and Mental Health Programme Partnership, providing oversight of delivery, risks and impact.

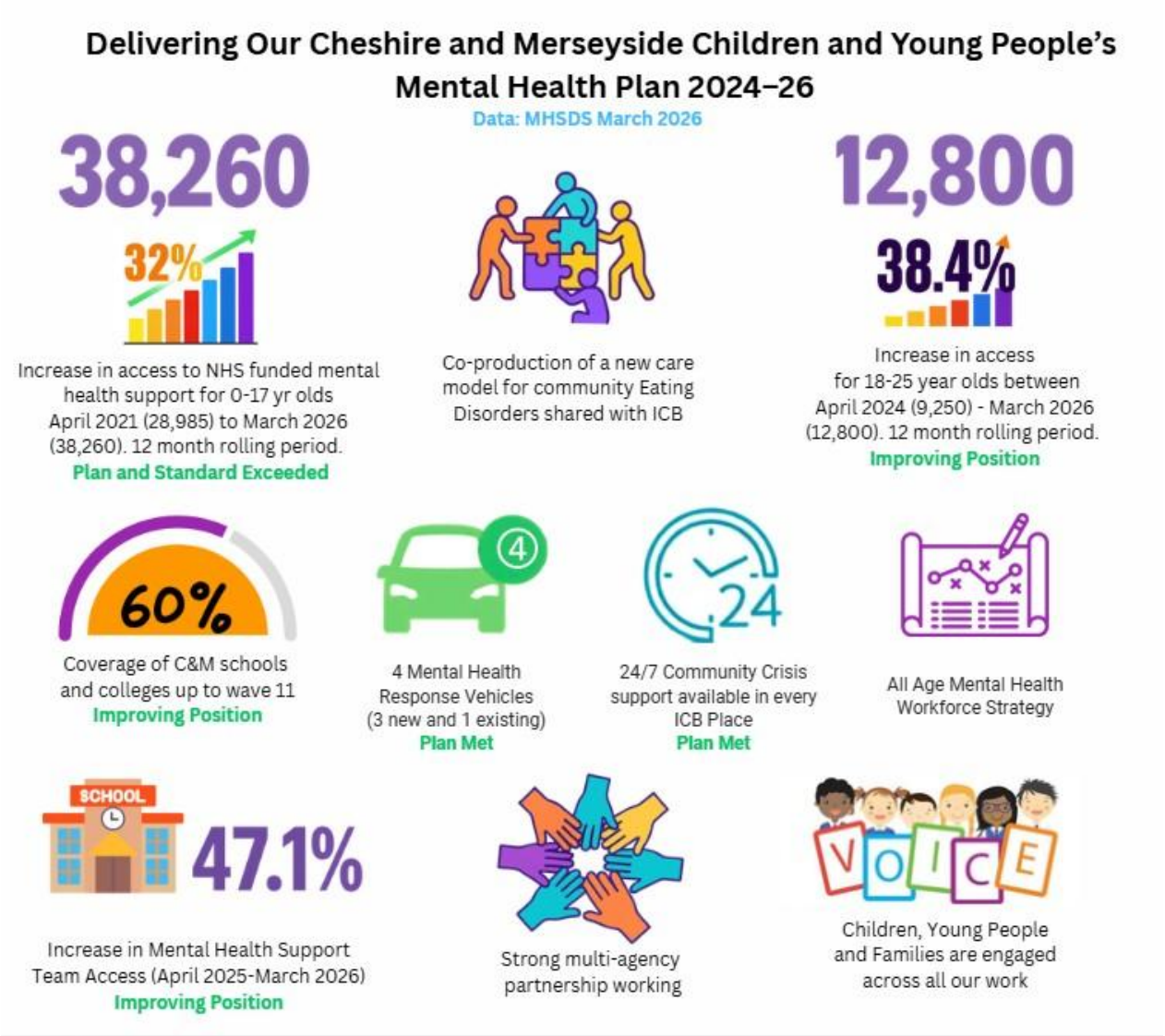
9.3 Any significant risks, issues or delivery challenges will be escalated through the appropriate programme, commissioning and ICB governance arrangements to ensure timely decision-making, mitigation and assurance regarding delivery of the plan's priorities and outcomes.

10 Officer contact details for more information

- Rachel Smethurst, Programme Manager, C&M Mental Health Programme
- Claire James, Director Mental Health, Learning Disability and Neurodiversity Services

Appendices

Appendix One: CYP Mental Health Transformation 2024-2025 Infographic



Appendix Two: Making a Difference: Children and Young People's Mental Health in Cheshire and Merseyside (2024-2026) Summary

PDF

Making a Difference Summary 24_26 FINA

Appendix Three: For approval – Cheshire and Merseyside Children and Young People's Mental Health Transformation Plan 2026-2027.

PDF

Children and Young People's Mental Healt

Meeting of the Board of NHS Cheshire and Merseyside

24th September 2026

Urgent and Emergency Care Deep Dive and Winter 2026/27 Readiness

Agenda Item No: **ICB/09/24/26/09**

Responsible Director:
Jude Adams: Interim Executive Director of Strategy and Transformation (Turnaround)

Urgent and Emergency Care Deep Dive and Winter 2026/27 Readiness

1. Purpose of the Report

1.1 This paper provides the Board of Directors with:

- a strategic deep dive into urgent and emergency care across Cheshire and Merseyside;
- an overview of the current performance and delivery position;
- the principal risks requiring oversight and opportunities for improvement;
- an assessment of preparedness for winter 2026/27;
- the C&M six-point winter plan and accompanying Board Assurance Statement.

2. Executive Summary

2.1 Urgent and Emergency Care (UEC) remains one of the most significant operational, quality and patient safety challenges facing Cheshire and Merseyside. Whilst there are encouraging signs of improvement in some areas, the system continues to experience sustained pressure associated with prolonged emergency department waits, delayed discharge, ongoing flow constraints, mental health delays and increasing demand amongst older people. These pressures increase the risk of patient harm, reduce patient experience and impact workforce wellbeing.

2.2 This needs to be recognised as a system challenge, one that cannot be resolved by any individual health or care provider alone. It requires collaboration, consensus on solutions and trusted partnerships. Solutions must focus on health prevention, demand management (keeping people in their own homes wherever possible), improving hospital flow and reducing delays to discharge.

2.3 The fundamental premise underpinning the Cheshire and Merseyside approach is that winter performance will be improved not through a series of short-term seasonal initiatives, but through accelerated implementation of our five-year UEC strategy. Winter therefore represents a practical test of whether the strategic changes, operational system response and trusted partnerships are sufficiently mature to manage predictable seasonal surge demand.

2.4 The system has already invested in key components of the future UEC model, including Unscheduled Care Coordination, Urgent Community Response (UCR), Same Day Emergency Care (SDEC), Hospital at Home, Virtual Wards, frailty pathways, discharge improvement and strengthened system escalation arrangements. The strategic challenge is increasingly one of implementation, utilisation and consistency rather than identifying new solutions.

2.5 The focus must be prevention and demand management of urgent need through our strengthened neighbourhood health and ‘Home First’ approach, alongside clear leadership and delivery of acute hospital standards such as the Getting It Right First Time (GIRFT) Clinical Operational Standards, Model Emergency Department (ED) and Model Discharge Pathway.

2.6 Winter 2026/27 will focus on six predictable areas of seasonal pressure:

- Staff Capacity
- Trauma Flow
- Respiratory Syncytial Virus (RSV) Surge
- Adult Respiratory Disease
- Frailty
- Mental Health Response

2.5 These six priorities are not separate winter projects, they are areas of focus representing the system's ability to prevent deterioration, navigate patients effectively, provide alternatives to hospital and protect acute capacity.

2.6 The accompanying UEC Deep Dive presentation provides detailed performance analysis and delivery plans. This paper summarises the strategic position, principal risks, winter response and current Board Assurance Statement (BAS) position.

3. Ask of the Board / Recommendations

3.1 The Board of Directors is asked to:

1) Receive the current urgent and emergency care performance position.
2) Endorse the principle that winter preparedness will be delivered through accelerated implementation of the Cheshire and Merseyside UEC strategy rather than through standalone winter initiatives.
3) Support the six-pillar winter focus approach.
4) Receive NHS England feedback on the initial Winter Plan Board Assurance Statement (BAS) submission and the actions taken in response.
5) Note the current Board Assurance Statement (BAS) position and remaining areas requiring further assurance before final submission, and delegate authority to the Chair & Chief Executive to sign off the final BAS for submission by 30 September 2026.
6) Support the governance arrangements through strengthened Locality UEC Boards, the Cheshire and Merseyside System UEC Board and the System Coordination Centre.
7) Maintain executive oversight of identified patient safety and operational risks through the winter period.

4. Current UEC Performance Position

4.1 Detailed performance analysis is provided within the accompanying UEC Deep Dive presentation and in the Integrated Performance report. In summary, the system presents a mixed picture entering winter:

Areas of Improvement

- Ambulance handover performance has improved.
- Overall non-elective admissions are reducing.
- Use of Urgent Treatment Centres and Walk-in Centres is increasing.
- Corridor care indicators have improved from previous levels.
- Paediatric emergency performance continues to show improvement.

Areas of Continuing Concern

- Type 1 four-hour performance remains significantly below ambition.

- Twelve-hour waits remain at unacceptable levels.
- Mental health patients continue to experience prolonged waits.
- Demand amongst older people continues to increase.
- Length of stay remains stubbornly high.
- Delayed discharge continues to constrain flow.
- More than one fifth of beds continue to be occupied by patients with no medical reason to remain in hospital. This means that on any given day hundreds of people across Cheshire and Merseyside remain in hospital despite no longer requiring acute care, spending additional days away from their own homes, families and communities whilst simultaneously reducing capacity for patients waiting for admission from emergency departments.

4.2 Taken together, the evidence suggests that whilst individual components of the pathway are improving, those improvements are not yet consistently translating into whole-system flow. This leaves the system vulnerable to predictable winter demand surges.

5. Key Risks Entering Winter

5.1 The principal risks entering winter are both operational and clinical:

- **Patient Flow and Discharge:** Delayed discharge remains the single largest constraint on hospital flow and bed availability. Improvements at the front door will have limited impact unless matched by improvements in inpatient flow, discharge and recovery pathways. Delays to discharge are not only an operational issue, prolonged hospital stays increase the risk of deconditioning, loss of independence, hospital-acquired infection and poorer outcomes, particularly for older people living with frailty.

- **Prolonged Emergency Department Waits:** Extended waits continue to create risks to patient safety, patient experience and staff wellbeing, particularly during periods of increased demand.

- **Older Adults and Frailty:** Increasing attendances and admissions amongst older people suggest current prevention, anticipatory care and community alternatives are not yet achieving sufficient scale or consistency. Frailty presents one of the greatest opportunities to improve both patient outcomes and system flow. Many of the patients experiencing prolonged hospital stays, delayed discharge, deconditioning and repeat admission are older people living with frailty. Earlier identification, anticipatory care planning and rapid community response therefore represent both a patient safety priority and a winter resilience priority.

- **Seasonal Respiratory Demand:** The system faces predictable risks relating to flu, RSV and wider respiratory illness, creating pressure across community, acute and social care services.

- **Workforce Resilience:** Winter performance remains heavily dependent upon workforce availability, sickness absence management and vaccination uptake. Our people are our capacity, keeping them safe, fit and healthy in work across the health and care sector is a key success measure.

- **Variation:** There remains unwarranted variation between organisations and localities in pathway utilisation, admission avoidance, discharge and flow.

6. Winter Planning Through Delivery of the UEC Strategy

6.1 Unlike previous years, NHS England has not requested submission of a traditional winter plan. Instead, Acute Trusts are required to demonstrate winter readiness through Board Assurance Statements and evidence-based assurance processes.

6.2 The Cheshire and Merseyside response has therefore been to align winter preparedness directly with delivery of the five-year UEC strategy. The strategic ambition for all partners remains to:

- anticipate need earlier;
- prevent avoidable deterioration;
- improve care navigation;
- maximise community alternatives;
- reserve emergency departments for those who genuinely require them;
- improve flow through hospital pathways; and
- support timely discharge and recovery.

6.3 The key message for the Board is that the initiatives expected to improve winter performance are largely the same initiatives required to deliver sustainable long-term UEC improvement. Winter planning is not a separate programme, rather winter is a stress test of strategy delivery and operational grip.

6.4 To support our urgent care locality boards in focusing on local priorities and opportunities to reduce reliance on our hospitals we have used data. A ‘left shift’ tool has been developed nationally. The tool identifies 34 types of potentially-mitigatable activity and considers care delivered in inpatient wards, outpatient clinics and accident and emergency departments and categorises activity that can be mitigated through four mechanisms: prevention, de-adoption, redirection/substitution, hospital efficiency. A summary pack of the key areas of opportunity/variation is being prepared for each of the 6 UEC locality boards, to complement the six pillars of the UEC plan and gives UEC Board further data in which to inform their additional local plans.

7. Strategic Approach

7.1 The detailed delivery plans are included within the accompanying presentations. The principal strategic responses currently being implemented include:

7.2 Improving Navigation and Access:

- Unscheduled Care Coordination from October 2026.
- NHS111 integration.
- Ambulance alternatives to conveyance.
- Improved digital connectivity between services.

7.3 Strengthening Community Alternatives:

- Urgent Community Response.
- Hospital at Home.
- Step-up community beds
- Community respiratory and frailty pathways.

- Falls response.
- Care home support.

7.4 Improving Hospital Flow:

- Model ED and Clinical Operational Standards.
- Same Day Emergency Care.
- Model discharge pathways.
- Reducing delayed discharges

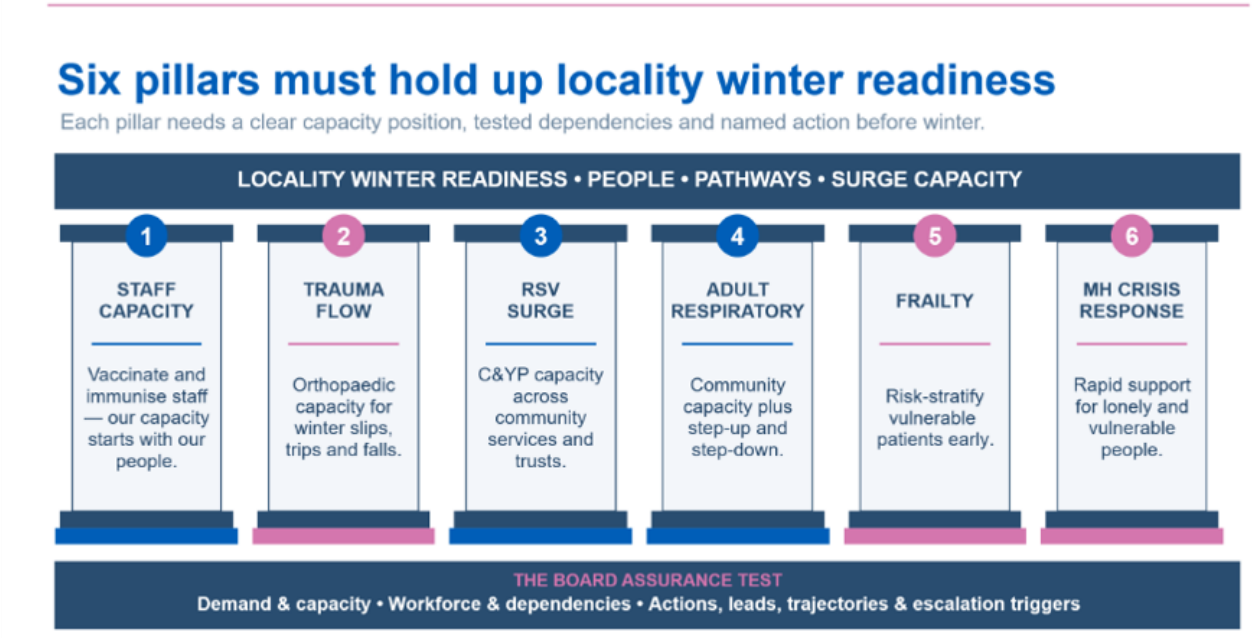
7.5 Prevention and Population Health:

- Vaccination programmes.
- Population Health Management including risk stratification.
- COPD biologics.
- Frailty identification.
- Targeted preventative interventions.

8. Winter 2026/27 Six-Pillar Plan and Quality Rationale

8.1 Our ambition for winter 2026/27 is to support more people to receive care at home where appropriate, reduce the number of people waiting unnecessarily for emergency or inpatient care, and reduce avoidable harm associated with winter.

Figure 1:



8.2 The six pillars provide the operational focus for winter readiness and are aligned directly to the strategic priorities within the UEC strategy. They have been selected because they represent predictable areas of seasonal demand and the greatest opportunities to proactively manage capacity and demand whilst reduce avoidable patient harm.

8.3 Collectively, the six pillars seek to reduce deterioration whilst waiting for care, ensure care can be delivered as close to peoples own homes as possible, and reduce avoidable attendance and admission. Each pillar provides a focus for locality UEC Boards to collectively align partner demand and capacity planning, clinical leadership, operational trajectories, escalation arrangements, quality oversight and locality accountability.

8.4 Detailed delivery plans, trajectories and supporting actions are provided within the accompanying UEC Deep Dive and Winter Planning presentations. The following table sets out the strategic intent and quality and safety rationale for each pillar.

Table 1:

Winter Priority	Strategic Intent	Quality and Patient Safety Rationale
Staff Capacity	Prevent workforce disruption and reduce vaccine-preventable illness.	Maintaining workforce resilience reduces delays in assessment and treatment, supports service continuity and reduces harm associated with prolonged waits for care.
Trauma Flow	Reduce avoidable conveyance and maintain trauma and orthopaedic capacity.	Timely access to falls and trauma pathways reduces deterioration, delayed treatment, avoidable admission and unnecessary pressure on emergency departments.
RSV Surge	Manage predictable paediatric respiratory demand proactively.	Early assessment and treatment of children with respiratory illness reduces the risk of deterioration and ensures timely access to specialist care where required.
Adult Respiratory	Prevent deterioration and avoidable respiratory attendance and admissior	Vaccination, early identification and rapid access to respiratory pathways reduce the risk of severe illness, avoidable admission and winter mortality amongst high-risk patients.
Frailty	Identify and support vulnerable patients earlier through proactive intervention.	Early intervention reduces crisis presentations, falls, deconditioning loss of independence and prolonged hospital stays.
Mental Health Crisis Response	Reduce inappropriate ED attendance and prolonged waits for assessment.	Timely crisis support and access to specialist assessment reduce prolonged ED stays, avoidable distress and delays in receiving appropriate care.

9. NHS England Feedback on Draft Plans and Response

9.1 NHS England reviewed the initial August ICB Board Assurance Statement submission during September 2026. Feedback was broadly positive, particularly in relation to vaccination and prevention plans, governance arrangements and the locality-led approach to winter planning.

9.2 NHS England requested further articulation of primary care capacity, demand management and admission avoidance arrangements, together with a stronger clinical quality and patient safety narrative throughout the plan.

9.3 These areas have been strengthened through the updated Board Assurance Statement (BAS), winter planning narrative and supporting assurance documentation.

9.4 This 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 which also links to the Board Assurance Framework.

10. Current Winter Plan Board Assurance Statement Position

10.1 The current BAS self-assessment indicates an overall position of **Substantial Assurance.**

10.2 Further evidence and assurance will be confirmed following the North West Region Winter Planning Exercise scheduled for 18th September, this will inform the final Regional submission due on 30th September.

Domain	Current Position
Governance	Substantial Assurance
Prevention & Vulnerable Cohorts	Full Assurance
Flow, Occupancy & Discharge	Full Assurance
Demand, Capacity & Surge Management	Moderate Assurance
Primary Care, NHS111 & Admission Avoidance	Full Assurance
Community Health Capacity	Full Assurance
Whole System Response	Full Assurance
Leadership & Operational Grip	Full Assurance

10.3 The principal remaining assurance gaps relate to:

- validation of workforce assumptions;
- NHS111 surge resilience;
- completion of Exercise Aegis;
- formal Board and QEIA sign-off processes. An initial QEIA panel is scheduled for 23 September.

10.4 Provider BAS submissions demonstrate a generally strong level of reported organisational readiness, with assurance ratings predominantly Full or Substantial across prevention, flow, IPC and leadership domains.

11. Governance and Accountability

11.1 Winter planning is being delivered through a locality-led governance model. Locality UEC Boards are responsible for developing and assuring locality winter plans, monitoring delivery and escalating unresolved risks and dependencies.

11.2 The Cheshire and Merseyside UEC Board provides system-wide oversight, assurance and strategic direction, while the System Coordination Centre manages day-to-day operational coordination, escalation and situational awareness throughout the winter period.

11.3 The Executive Team and Board retain overall accountability for winter preparedness, system risk management and approval of the final Board Assurance Statement. The report has been completed with input from ICB programme leads, place partners, workforce and finance leads and is made public through presentation to the Board.

12. Conclusion

12.1 The strategic direction for UEC across Cheshire and Merseyside is established. The infrastructure required to deliver that strategy is increasingly in place.

12.2 The key challenge for winter 2026/27 is not identifying new initiatives, but ensuring that existing interventions are implemented consistently, utilised effectively and translated into measurable improvements in patient outcomes, safety and flow.

12.3 Winter therefore represents an important test of whether the Cheshire and Merseyside UEC strategy is mature enough to withstand predictable seasonal pressures. Success should ultimately be judged not only by operational metrics, but by whether fewer people experience avoidable deterioration, unnecessary hospital stays, prolonged waits in emergency departments or delays in accessing appropriate care.

12.4 The BAS process, provider assurance, locality assurance, system modelling and regional stress testing provide a comprehensive framework for assessing readiness and supporting continued improvement through the winter period.

13. Next Steps and Responsible Person to take forward

13.1 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.

13.2 The final BAS will be prepared by Jude Adams for sign off by Chair & CEO.

14. Officer contact details for more information

- Claire Sanders – Director of Urgent & Emergency Care Operations and Improvement
- Michelle Harris – Interim Director of Urgent & Emergency Care Operations and Improvement

15. Appendices

Appendix One: UEC Deep Dive & Winter Planning Presentation
Appendix Two: Board Assurance Statement

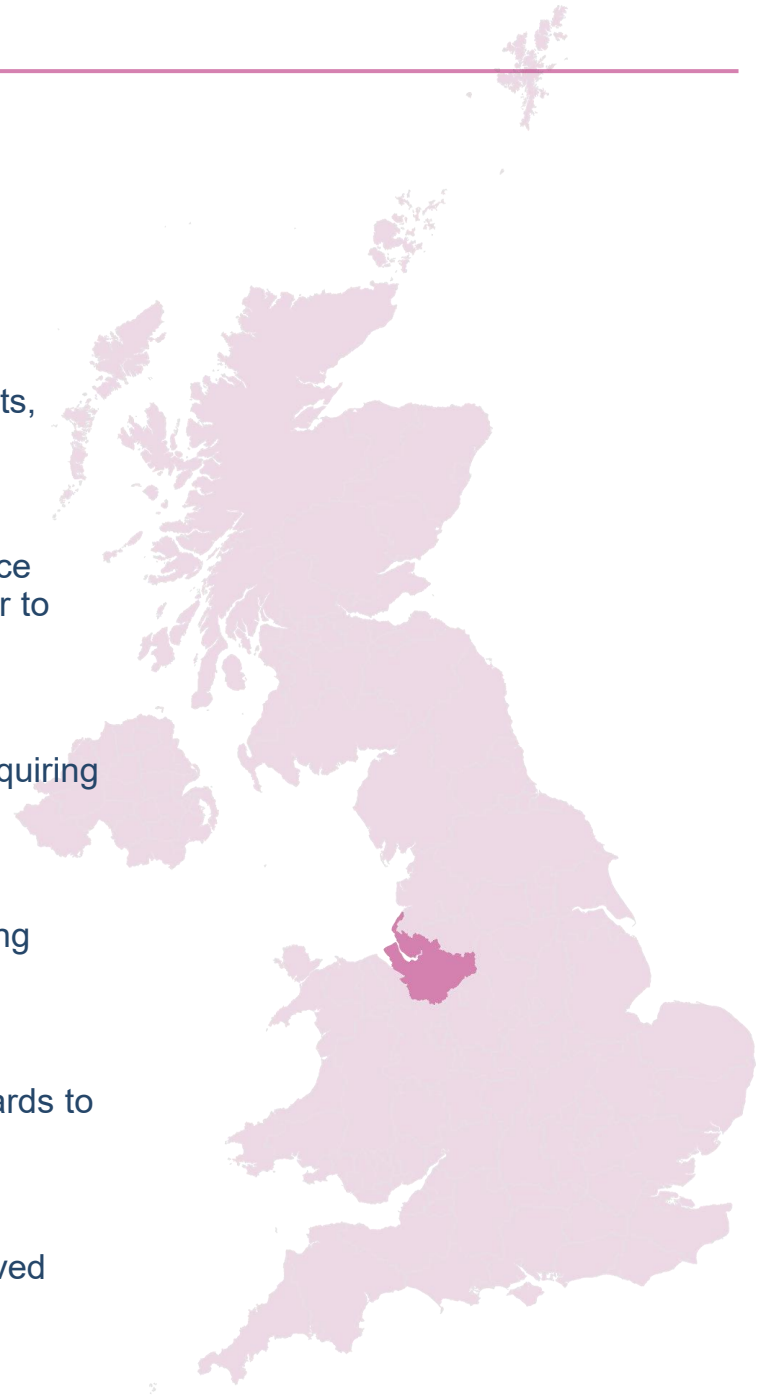
NHS
Cheshire and Merseyside

UEC Deep Dive and Winter Planning

24th September

Cheshire & Merseyside: Our UEC story

- Demand across urgent and emergency care remains high, with significant pressure from 12-hour waits, delayed discharge and patients remaining in hospital despite being medically ready to leave.
- We are seeing early signs of improvement through reduced non-elective admissions, better ambulance handovers, expanded Urgent Community Response and 430 virtual ward beds supporting care closer to home.
- The biggest opportunity lies in improving whole-system flow, with four out of five ED attendees not requiring admission and over one in five acute beds occupied by patients with no criteria to reside.
- Our strategy is to shift from a hospital-centred model to a neighbourhood-centred model, strengthening prevention, community services, frailty support, care coordination and discharge pathways.
- Winter planning is a test of our five-year UEC strategy, bringing partners together through locality boards to deliver a single, coordinated system response
- Success will be measured by fewer avoidable admissions, fewer days spent away from home, improved patient flow and more people supported safely in their own communities.



Introduction

Nearly 1 in 5 people who attend Emergency Departments will wait 12 hours or more before being admitted, transferred or discharged.

Almost 4 out of 5 people attending ED (79.7%) are not admitted to hospital, suggesting many people could potentially be cared for through alternative urgent care services. [

Around 1,000 people every day are occupying a hospital bed despite no longer meeting the criteria to stay in hospital.

Those delayed discharges account for 25,000 bed days every month, costing around **£9 million each month**.

More than 1 in 5 hospital beds (22.1%) are occupied by someone who is medically ready to leave hospital.

People who are ready to leave hospital wait an average of 8.7 more days before they are discharged.

Nearly 1 in 5 emergency patients (19.4%) spend more than 12 hours in ED, while for people presenting with mental health needs the figure is even higher at **22.2%**.

Only 52.9% of Type 1 ED patients are seen, treated, admitted or discharged within four hours, meaning almost half wait longer than the national standard.

1,457 people a day are already using Urgent Treatment Centres and Walk-in Centres, demonstrating growing demand for alternatives to ED.

407 people are admitted to hospital as an emergency every day across Cheshire and Merseyside.

People stay in hospital for an average of 11.1 days once admitted.]

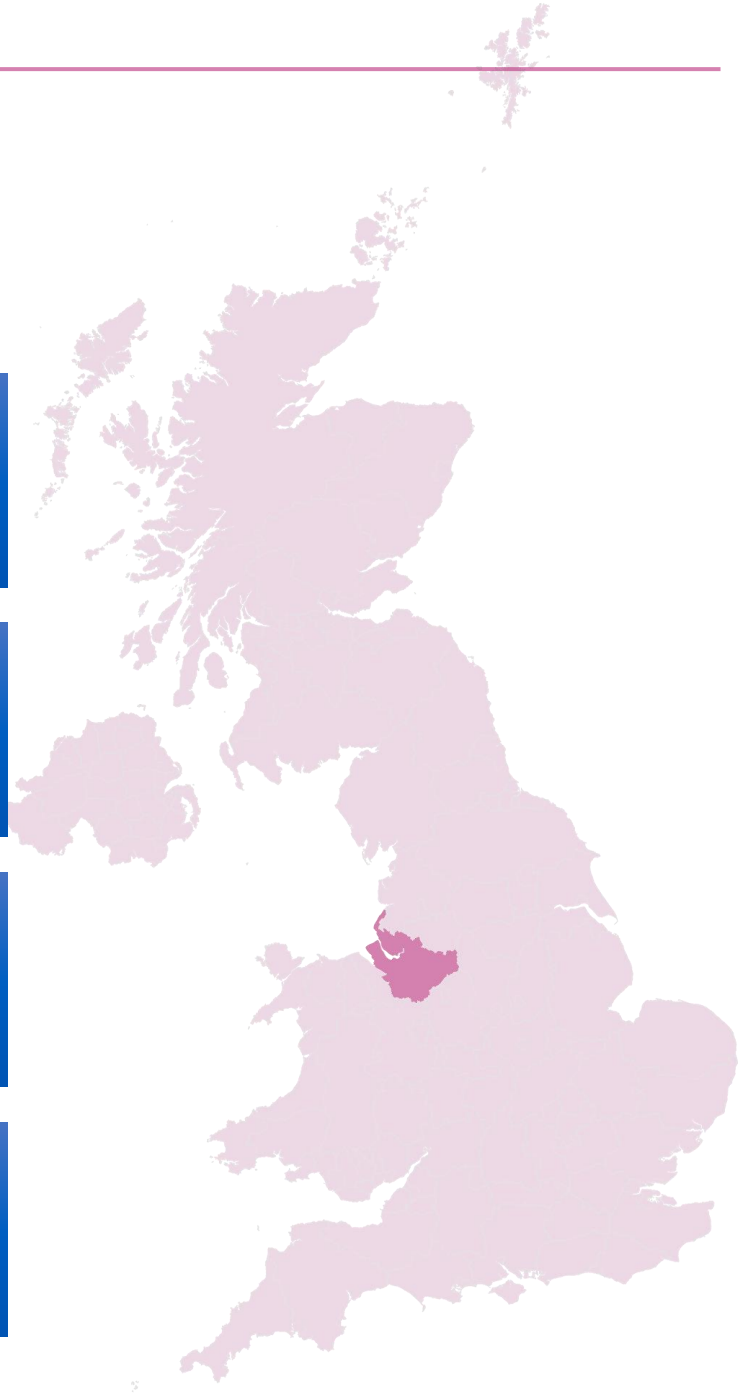
94.7% of people discharged from hospital return home with no or only limited ongoing support.

37,200 people living with frailty have a greater than 50% chance of an emergency hospital admission in the next year.

18,386 people with asthma or COPD are at high risk of an emergency admission in the next 12 months.

There are over 800,000 people identified as potentially living with frailty across Cheshire and Merseyside.

Virtual wards now provide the equivalent of 430 beds, helping people receive care at home rather than in hospital.



Our 5 year Urgent & Emergency Care strategic plan

OUR VISION FOR 2031

Urgent care starts with a partnership working in neighbourhoods and communities to respond to urgent needs, enabling hospitals to focus on true emergencies

This vision will be executively supported, clinically led and digitally & operationally enabled

STRATEGIC PRIORITIES

1. **Coordinated care and alternatives to ED :** e.g. 111, OOH's, UCR & SPOA Urgent need met through clinical advice, navigation before ED attendance; including out of hours response and capacity
2. **Neighbourhood urgent response as default:** Integrated neighbourhood teams provide rapid response to deterioration at home, including for people living with mental health, frailty or dementia via community services, General Practice and Urgent dental care
3. **Frailty and dementia embedded in UEC pathways:** Early identification and anticipatory care planning. Crisis response outside hospital where safe and enablement after illness to prevent dependency. Support for care homes with a consistent, system-wide clinical support offer to keep patient in their place of residence, urgent response, and discharge support to prevent avoidable admissions and enable timely return from hospital
4. **CYP and all age mental health alternatives to ED:** Urgent pathways designed around children and young people and families, avoiding ED as the entry point
5. **Hospitals and ambulance services focussed on true emergencies:** Acute providers optimise flow, SDEC and strengths based discharge. Ambulance pathways reduce conveyance

Winter Insights	
Key System Insights	• Flow is the principal determinant of winter resilience. • Cheshire and Merseyside is reported to have one of the highest NCTR rates nationally relative to population. • Corridor care appears concentrated in the most flow-constrained systems and should be viewed as a symptom of wider system pressures. • High bed occupancy contributes to poor performance but does not fully explain variation.
Provider Learning Opportunities	• WUTH: sustained reduction in NCTR compared to peers. • COCH and MCHT: comparatively strong ambulance handover performance. • NCM and ECT: stronger paediatric four-hour performance. • MCHT and MWL: higher levels of weekend discharge activity.
Winter Planning Implications	• Prioritise discharge improvement and NCTR reduction. • Explore replication of successful practices from positive outliers. • Reduce long length of stay patients to release capacity and improve flow. • Treat corridor care and handovers as indicators of underlying flow problems.

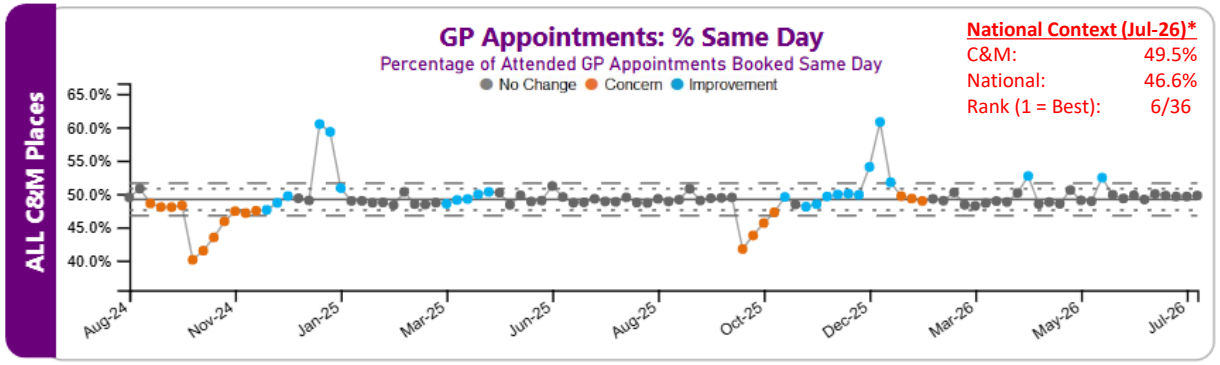
UEC Cheshire and Merseyside

Current position

Demand Management

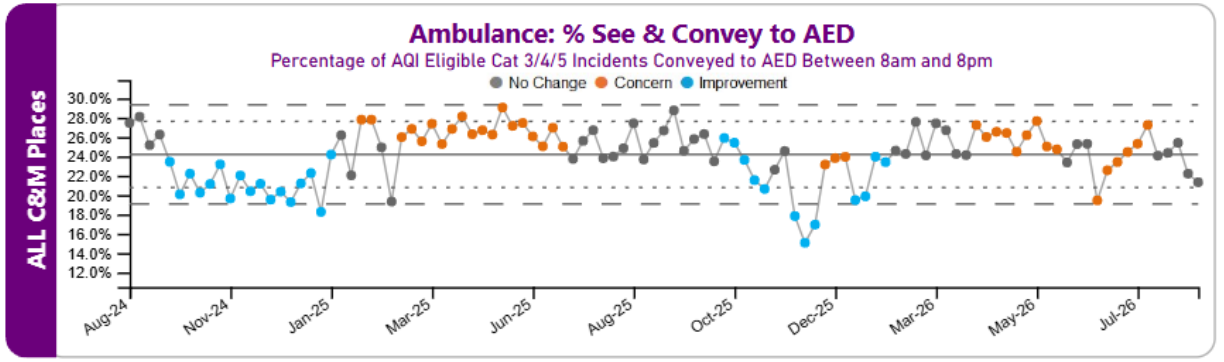
NHS
Cheshire and Merseyside

Demand management performance is mixed. UCR referrals show sustained improvement, reaching **7.3 per day per 100,000 population**, indicating greater use of rapid community alternatives to admission. Ambulance conveyance to AED is **21.3%**, although performance remains subject to common-cause variation. Same-day GP access is stable at **49.7%**, while virtual ward referrals have plateaued at **41.9 per day**, suggesting further opportunity to strengthen access and utilisation.

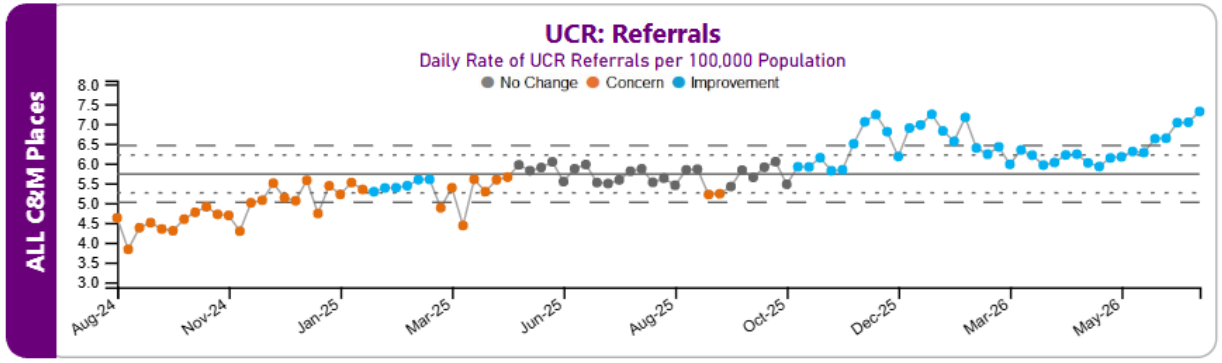


*https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice

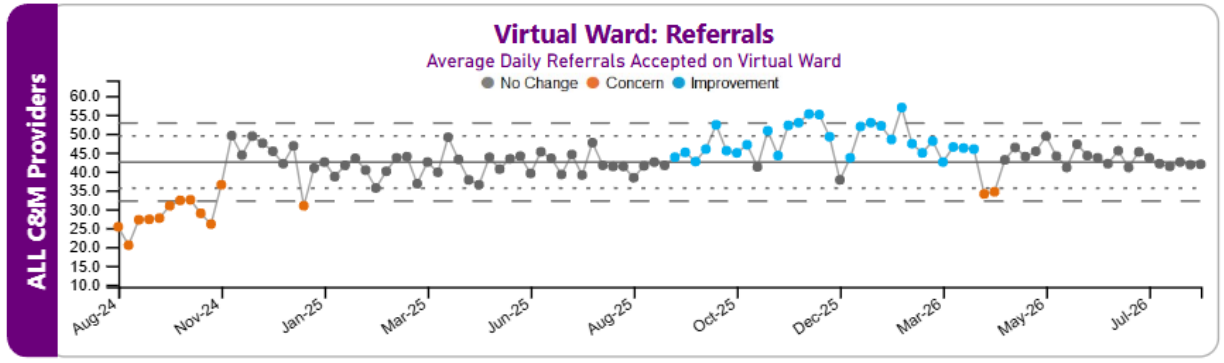
Common cause variation. Latest: 49.7%.



Common cause variation. Latest: 21.3%.



Special cause – higher/improving. Latest: 7.3 referrals per day per 100,000 population.

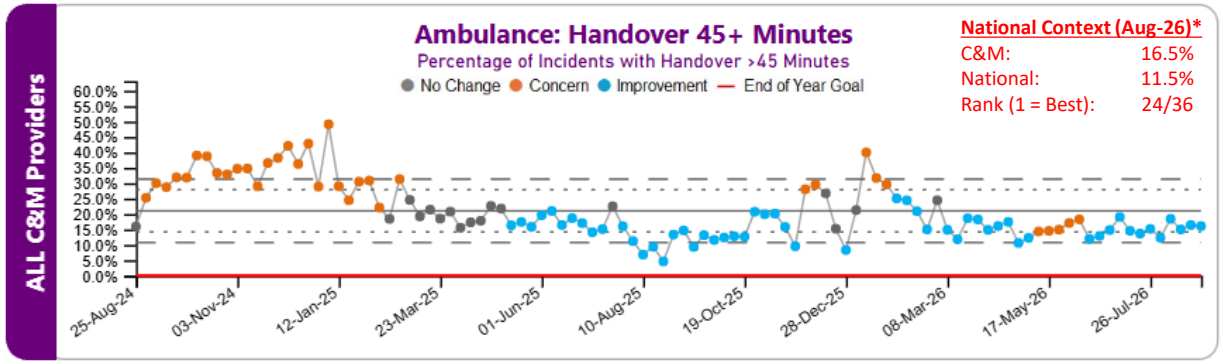


Common cause variation. Latest: 41.9 referrals per day.

Front Door

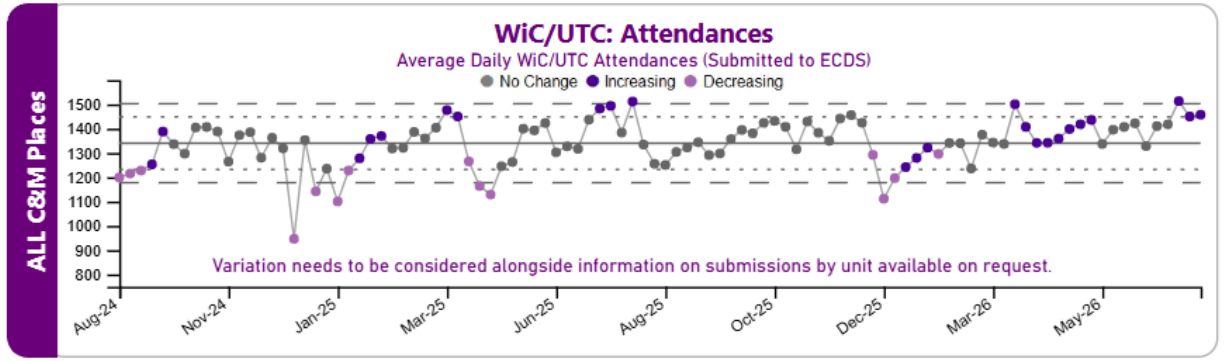
NHS
Cheshire and Merseyside

Front-door performance shows improvement in ambulance handovers, with **16.1% exceeding 45 minutes**, although this remains above the zero-delay ambition. WiC/UTC activity has increased to **1,457 attendances per day**, demonstrating growing use of alternatives to Type 1 ED. However, **79.7% of Type 1 ED attendances are non-admitted**, a concerning special-cause shift that suggests many patients could potentially be managed through alternative urgent care or same-day pathways.

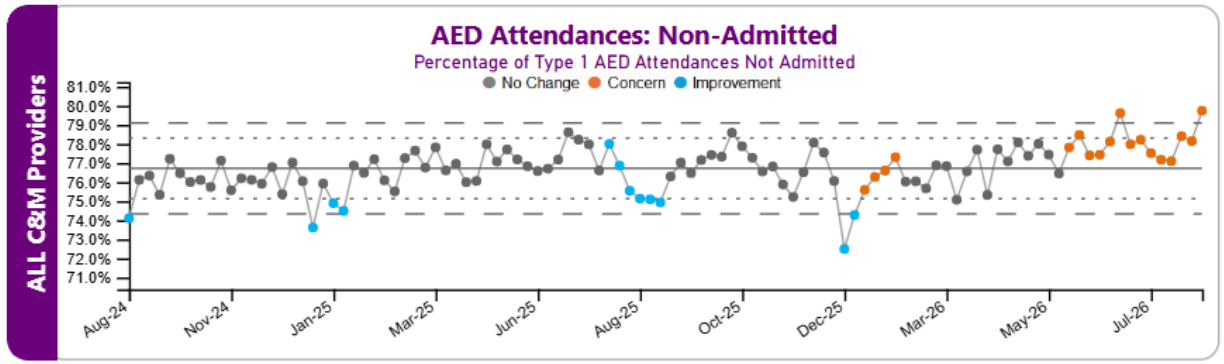


*https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/ambulance-management-information/

Special cause – lower/improving. Latest: 16.1%.



Special cause - neutral improvement direction - higher. Latest: 1,457 daily attendances.

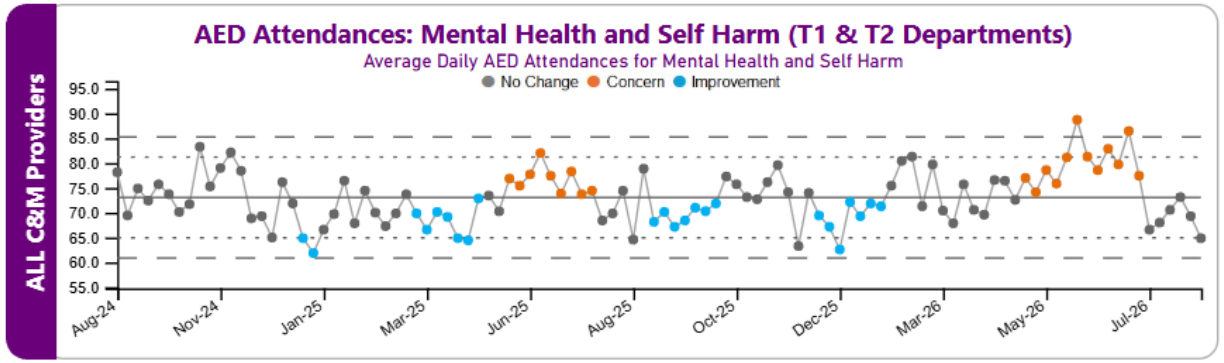


Special cause – higher/concerning. Latest: 79.7%.

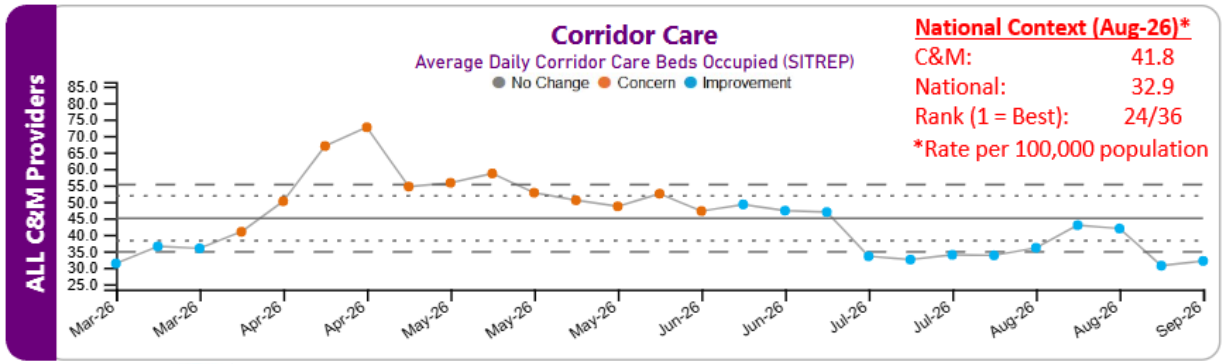
Front Door

NHS
Cheshire and Merseyside

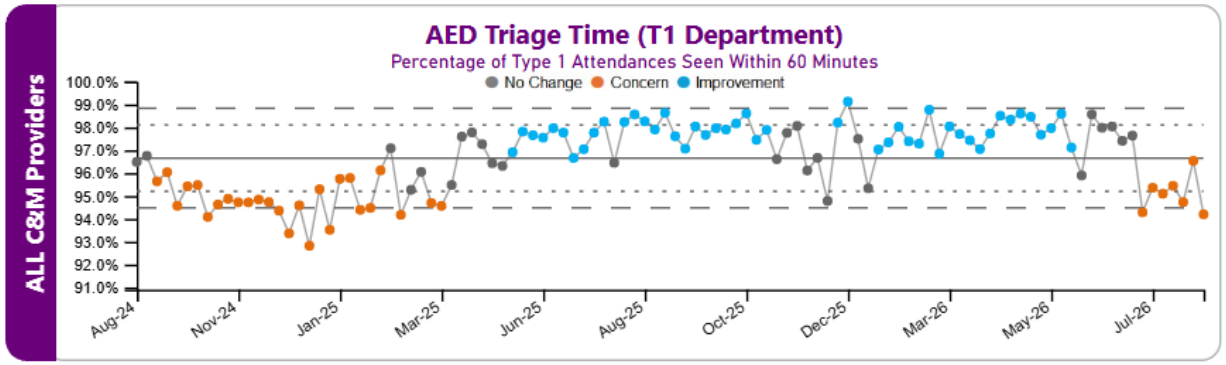
Front-door safety presents a mixed picture. Mental health and self-harm attendances remain broadly stable at **64.9 per day**, but continue to create a distinct demand requiring specialist pathways. Corridor care has improved significantly to **32 occupied beds per day**, although any continued use represents a patient safety and quality concern. Timely triage has deteriorated to **94.2% within 60 minutes**, indicating emerging pressure on initial assessment processes.



Common cause variation. Latest: 64.9 daily attendances.



Special cause – lower/improving. Latest: 32 beds occupied per day.

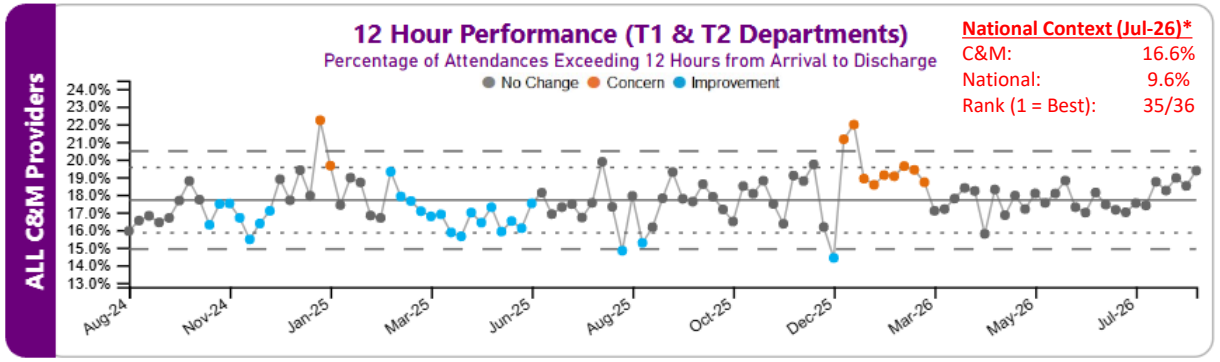


Special cause – lower/concerning. Latest: 94.2%.

In Hospital

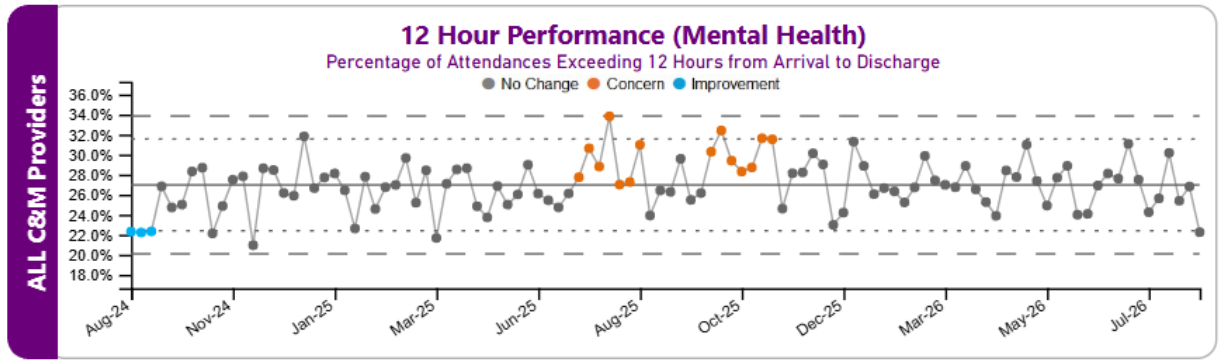
NHS
Cheshire and Merseyside

In-hospital flow remains the principal constraint. **19.4% of T1/T2 patients** and **22.2% of mental health patients** spend more than 12 hours in ED, with common-cause variation indicating persistent system-wide problems rather than isolated deterioration.



*https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/ae-attendances-and-emergency-admissions-2026-27/

Common cause variation. Latest: 19.4%.

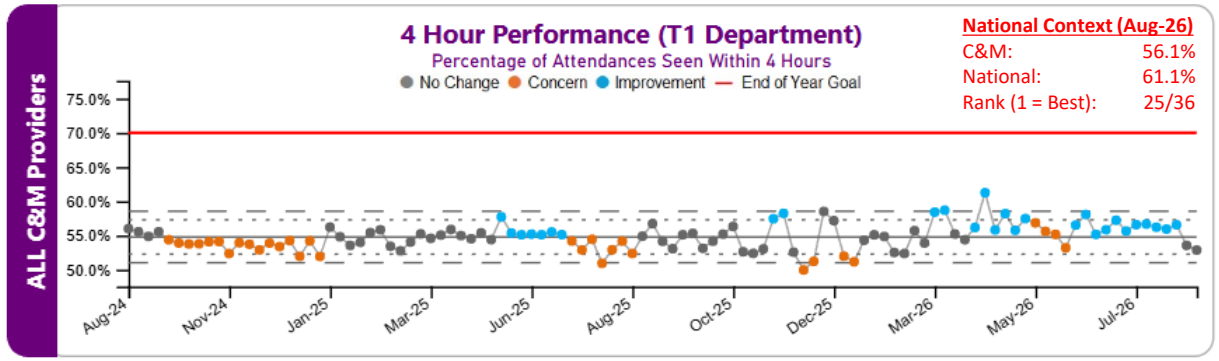


Common cause variation. Latest: 22.2%.

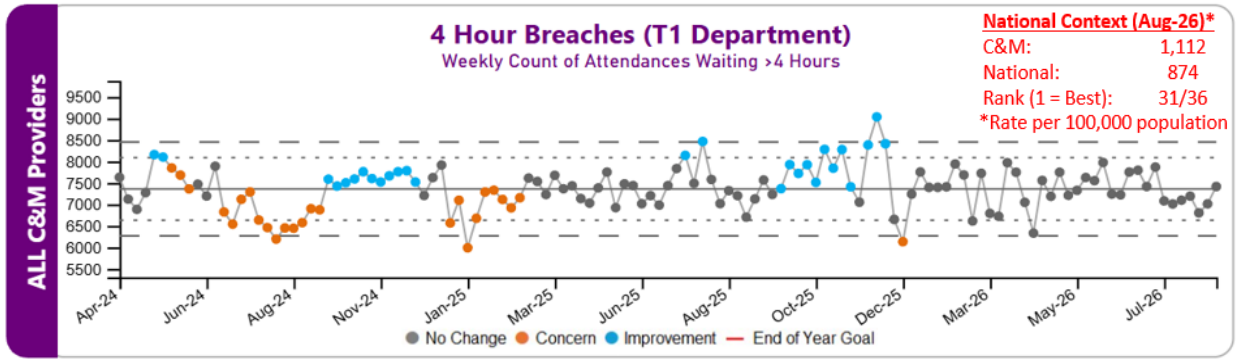
In Hospital

NHS
Cheshire and Merseyside

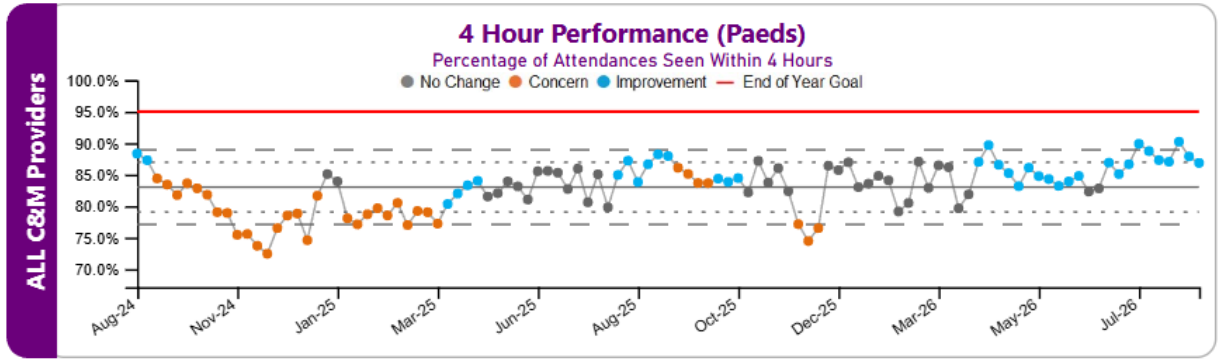
Type 1 four-hour performance remains significantly below ambition at **52.9%**. Paediatric performance is stronger and improving at **86.8%**, although still below the **95% goal**.



Common cause variation. Latest: 52.9%.



Common cause variation. Latest: 7,415.

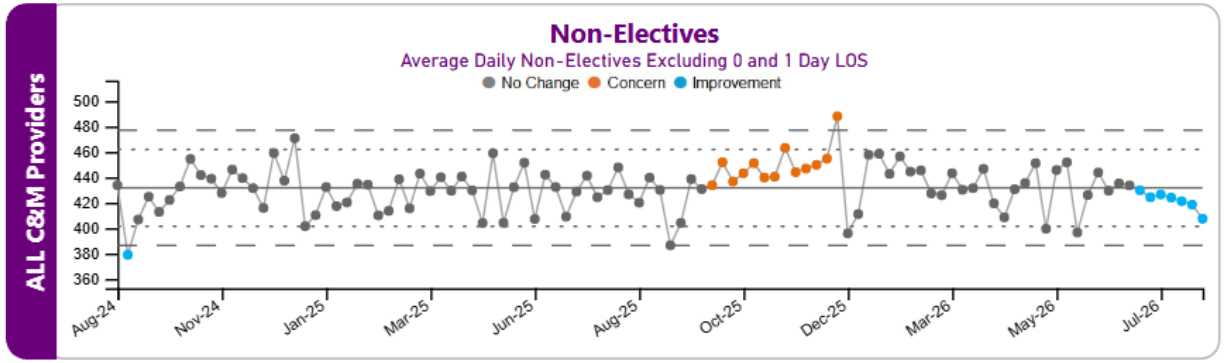


Special cause – higher/improving. Latest: 86.8%.

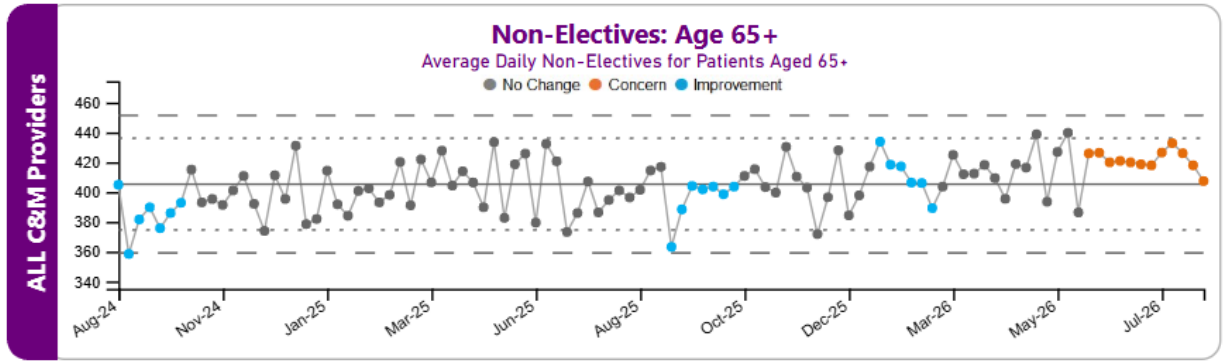
In Hospital

NHS
Cheshire and Merseyside

Overall non-elective admissions are showing a **special-cause improvement**, reducing to **407 per day**. However, admissions among people aged 65 and over show a **higher, concerning shift**, indicating that improvement is not being realised consistently for older people.



Special cause – lower/improving. Latest: 407 daily non-electives.

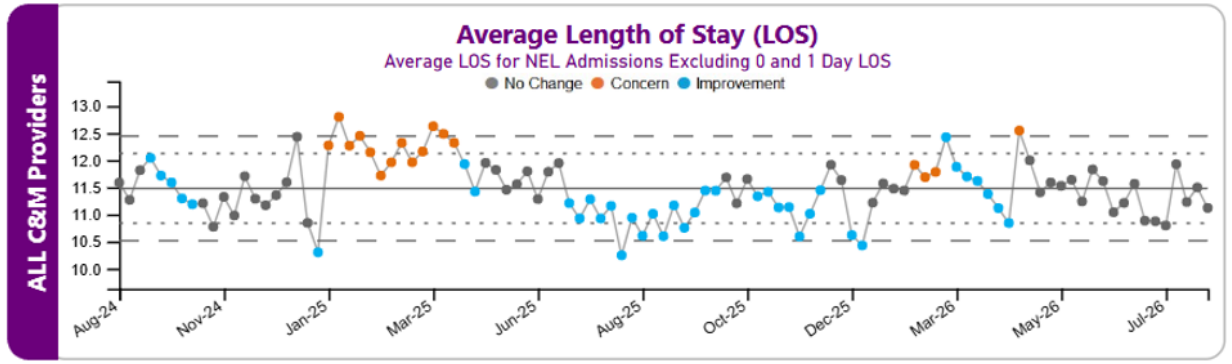


Special cause – higher/concerning. Latest: 407 daily non-electives.

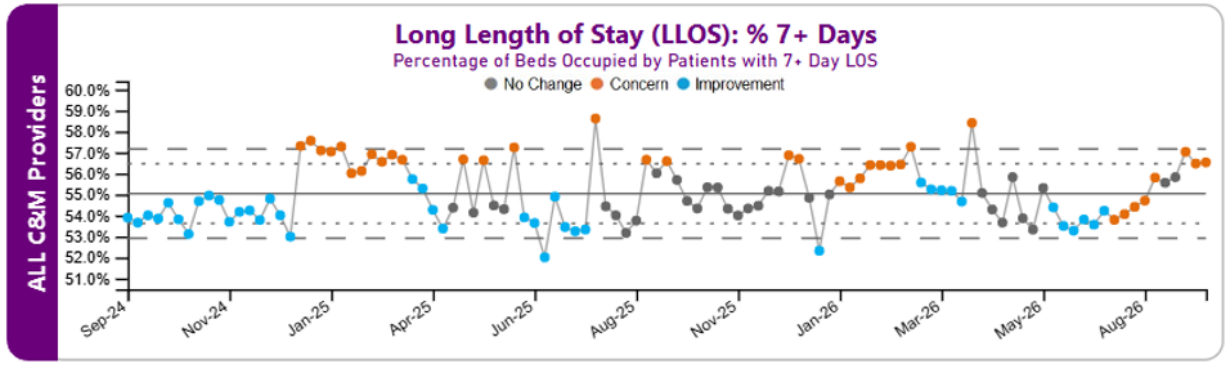
In Hospital

NHS
Cheshire and Merseyside

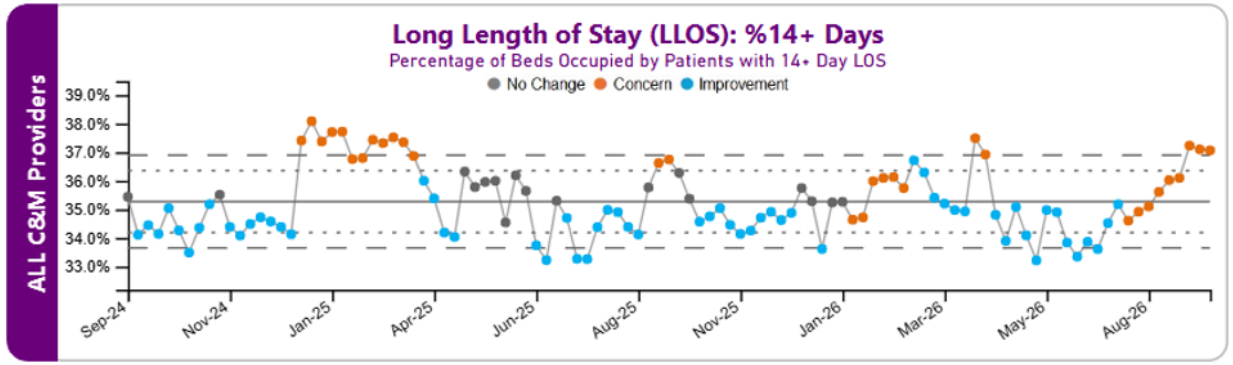
Average length of stay remains stable at **11.1 days**, suggesting that sustained change to inpatient processes and discharge pathways has yet to be achieved. Long lengths of stay are all showing a recent **higher, concerning shift** with 56.5% of patients staying 7+ days, 37.1% staying 14+ days and 26.1% staying 21+ days.



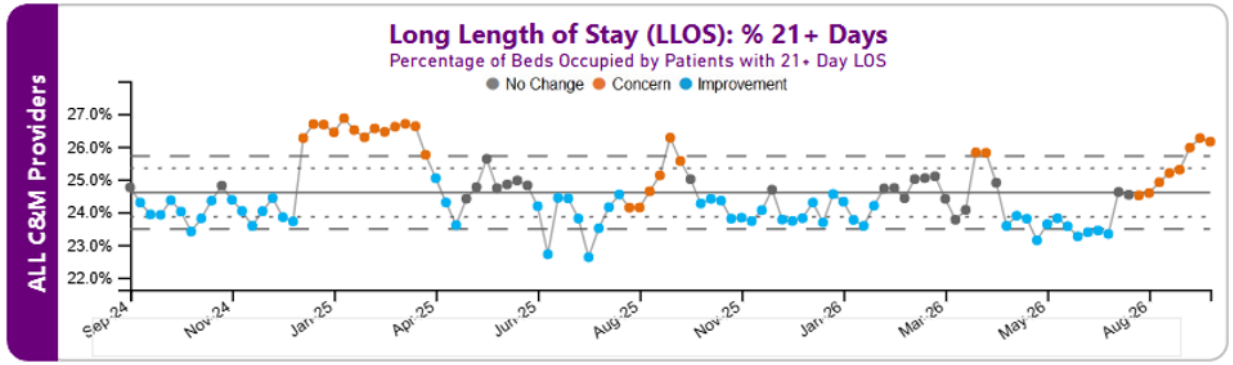
Common cause variation. Latest: 11.1 days.



Special cause – higher/concerning. Latest: 56.5% patients staying 7+ day.



Special cause – higher/concerning. Latest: 37.1% patients staying 14+ day.

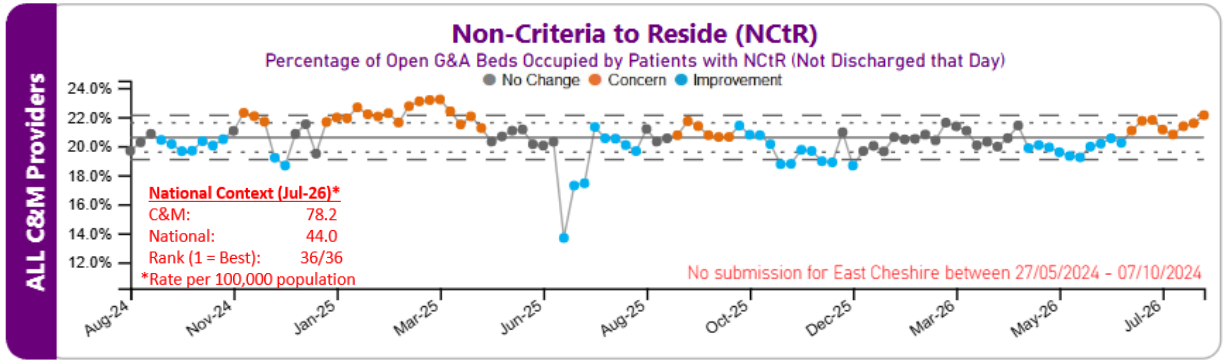


Special cause – higher/concerning. Latest: 26.1% patients staying 21+ day.

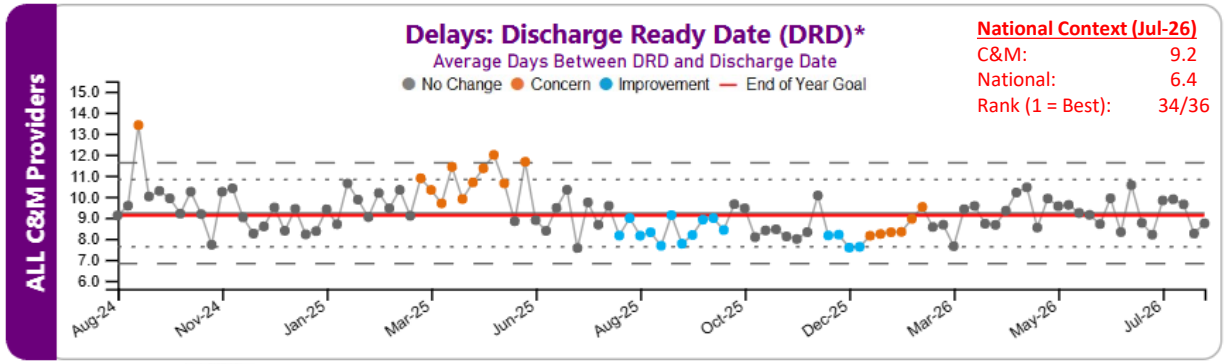
Discharge & Flow

NHS
Cheshire and Merseyside

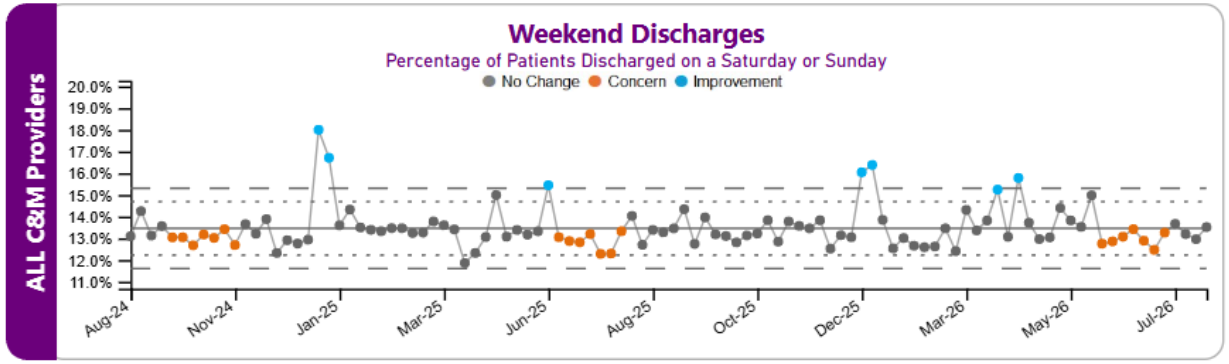
Discharge remains a significant constraint on flow. **22.1% of beds are occupied by patients with no criteria to reside**, with a special-cause deterioration indicating increasing pressure. Patients wait an average of **8.7 days from discharge-ready date to discharge**; although marginally within the nine-day goal, there is no sustained improvement. Weekend discharges remain static at **13.5%**, demonstrating that discharge is not yet operating consistently as a seven-day process.



Special cause – higher/concerning. Latest: 22.1%.



Common cause variation. Latest: 8.7 days.

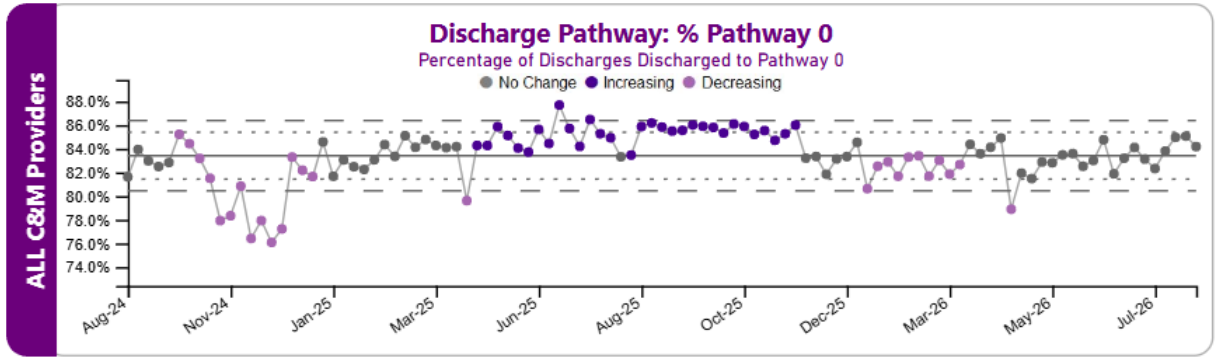


Common cause variation. Latest: 13.5%.

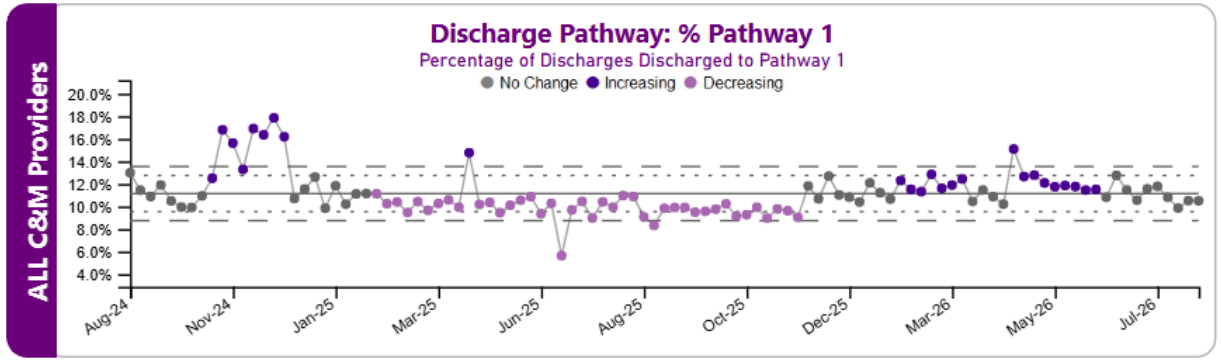
Discharge & Flow

NHS
Cheshire and Merseyside

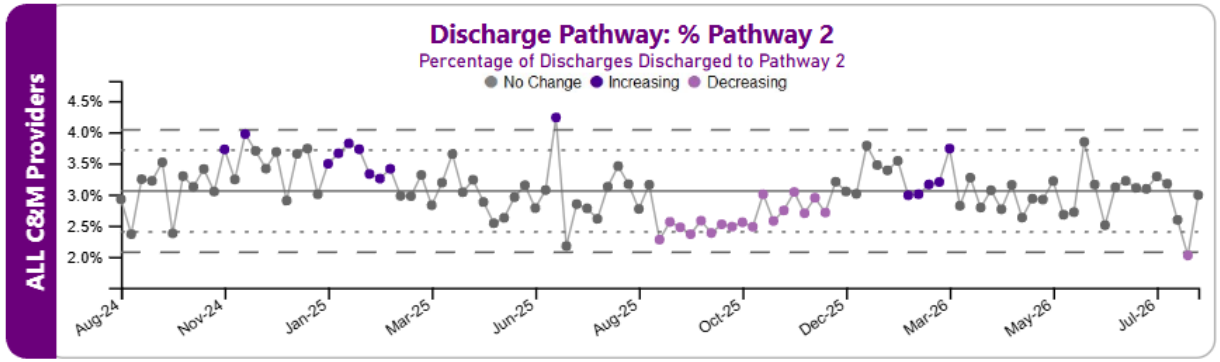
The discharge pathway profile remains stable, with no sustained shift in the model of care. **84.2%** of patients are discharged through Pathway 0 and **10.5%** through Pathway 1, meaning **94.7% return home with no or limited additional support**. A further **3.0%** use Pathway 2 and **2.3%** Pathway 3. The common-cause variation across all pathways suggests that transformational change is not yet evident.



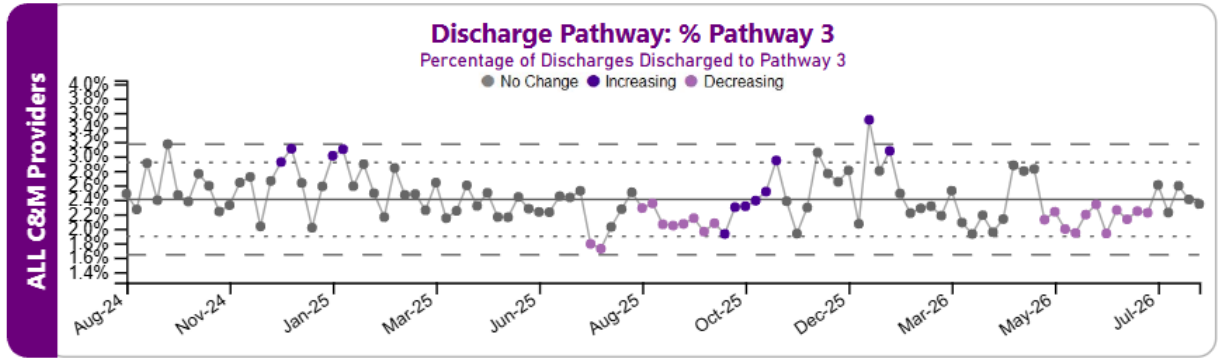
Common cause variation. Latest: 84.2%.



Common cause variation. Latest: 10.5%.



Common cause variation. Latest: 3.0%.



Common cause variation. Latest: 2.3%.

Non-Criteria to Reside

On any given day, around **a thousand people** are **NCtR** in Cheshire & Merseyside

Those people account for **25,000 bed days** per month, which cost the ICB around **£9m** per month

Cheshire and Merseyside has the **highest NCtR** per head of population **in the country** (36/36)

	Daily Delayed *30-Aug-26*	Monthly bed days *Jul-26*	Est. monthly cost *Av NELXBD tariff 26/27*
Countess	117	3,231	£1,189,008
East Cheshire	58	1,170	£430,560
LUHFT	306	4,887	£1,798,416
MWL	229	7,117	£2,619,056
Mid Cheshire	77	2,248	£827,264
NCM	86	2,849	£1,048,432
WUTH	99	3,257	£1,198,576
Total C&M	**972**	**24,759**	**£9,111,312**

250,000 days away from home every month costing £9m

Sources

Daily NCtR: Discharge SitRep (30-Aug-26)

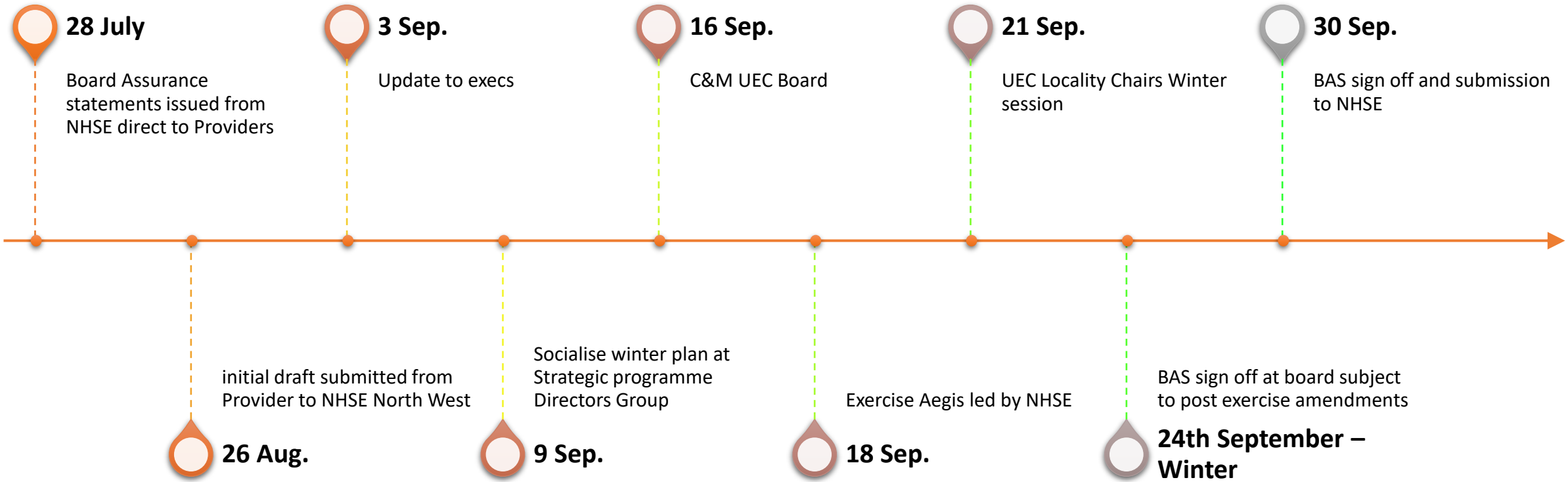
Monthly Bed Days: NHS E reporting (Timeliness of Acute Hospital Discharges completed within the month), based on SUS data

Unit Cost: Internal NELXBD average price in 2026-27 of £368

2026/27 Winter Planning Approach

- Unlike previous years, for 2026/27, NHSE have not issued a winter planning template to be submitted
- Instead, they have issued Board assurance statements for completion
- **Winter planning for 26/27 is a test of our UEC strategic plan**
- Winter planning is coordinated via UEC Locality boards

Winter planning Timeline



Ask of locality boards for winter

- Bring together the winter plans of acute, community, mental health, primary care, local authority, ambulance, and other relevant partners into a shared locality-wide plan.
- Ensure plans reflect anticipated demand, capacity, and flow pressures across the whole urgent and emergency care pathway, recognising that effective winter delivery depends on coordinated action across organisational boundaries.
- Review and constructively challenge key assumptions, including capacity, workforce, discharge, admission avoidance, ambulance handover, escalation, and mutual aid arrangements.
- Identify and test dependencies between organisations, particularly where delivery relies on support, capacity or actions provided by partners elsewhere in the system.
- Develop a common understanding of risks, opportunities, and areas of variation in organisational assurance.
- Work collectively to address gaps and risks wherever possible, ensuring any unresolved issues are clearly documented and escalated where appropriate.
- Be satisfied that there are clear operational actions, named leads, trajectories and measures that enable delivery to be monitored throughout the winter period.
- Consider the resilience of the overall locality response during periods of sustained operational pressure, including escalation arrangements and the ability of partners to respond together; and
- Formally endorse the locality winter plan and provide assurance on overall locality readiness on behalf of the partnership.

Locality UEC Boards	Chair	Commissioner	Quality Lead
North Mersey	Beth Weston	Claire Sanders	Kerrie France
Mid Mersey	Rob Cooper	Leigh Thompson	Lisa Ellis
Wirral	Hayley Kendall	Sharon Dooner	Helen Meredith
East Cheshire	Simon Goff	Rich Burgess	Helen Meredith
Cheshire West	Cathy Chadwick	Judith Nielson	Helen Meredith
North Cheshire & Mersey	Dan Moore	Rich Burgess	Lisa Ellis

Membership:

- Acute providers
- Community providers
- Local Authority
- Primary care
- Mental health providers
- NWAS
- VCSFE

Our ambitions across localities and system

Acute	Community	System
Reduce the number of patients who no longer meet the criteria to reside (NCTR)	Reduce Community bed LOS	Reduce the number of days spent away from home
Reduce 12 hour ED delays	Increase access to and utilisation of step up beds	Improve flow across whole UEC pathway
Lower G&A Occupancy	Increase the number of people supported at home through virtual wards, UCR and intermediate care	Reduce avoidable admissions and ED attendances
Increase the proportion of patients discharged to usual place of residence	Strengthen community response for frailty, respiratory illness and falls	Maximise utilisation of community based alternatives to hospital care
Improve discharge timeliness and reduce discharge-ready delays	Support more people to remain independent in their usual place of residence	Support more people to remain in and return to their usual place of residence
Improve same-day emergency and frailty pathways		Accelerate the shift from hospital centred care to neighbourhood centred care

Six pillars must hold up locality winter readiness

Each pillar needs a clear capacity position, tested dependencies and named action before winter.

LOCALITY WINTER READINESS • PEOPLE • PATHWAYS • SURGE CAPACITY

1 STAFF CAPACITY

Vaccinate and immunise staff — our capacity starts with our people.

2 TRAUMA FLOW

Orthopaedic capacity for winter slips, trips and falls.

3 RSV SURGE

C&YP capacity across community services and trusts.

4 ADULT RESPIRATORY

Community capacity plus step-up and step-down.

5 FRAILTY

Risk-stratify vulnerable patients early.

6 MH CRISIS RESPONSE

Rapid support for lonely and vulnerable people.

THE BOARD ASSURANCE TEST

Demand & capacity • Workforce & dependencies • Actions, leads, trajectories & escalation triggers

How will we know the plan is working?

Pillar	Process	Outcome	Balancing
1.Staff Capacity	Staff vaccination uptake (%)	Staff absence rate	Agency spend
2.Trauma Flow	UCR falls response within 2 hours (%)	Falls admissions per day	7-day reattendance rate
3.RSV Surge	RSV vaccination uptake (%)	RSV admissions	CYP bed occupancy
4.Adult Respiratory	High-risk respiratory reviews completed	Respiratory admissions	Respiratory LOS
5.Frailty	Frailty patients proactively managed	Frailty admissions	% discharged home
6. MH Crisis Response	Crisis assessments within target (%)	MH ED attendances	Repeat crisis presentations

Winter planning Pillar 1 – Staff Capacity

Vaccinate and immunise staff — our capacity starts with our people

1.1 Cheshire & Merseyside Vaccine Task Force

A prevention-led winter approach will help to reduce avoidable infectious disease UEC demand by maximising uptake of flu, COVID-19, RSV and pneumococcal vaccination in eligible and higher-risk cohorts ahead of peak winter pressure.

SEP

Prepare & start

- Flu: pregnancy + children from 1 Sep
- RSV: new at-risk 65–74 cohort; maintain maternal and older-adult offer
- Pneumococcal and shingles – engage practices to register interest to the GSK/CHASE project

OCT

Accelerate access

- Flu: remaining adult cohorts from 1 Oct
- COVID-19: 75+, older-adult care homes and immunosuppressed
- Co-administer; use pharmacy, mobile and home visits
- Continue to support the GSK/CHASE project

NOV–DEC

Close gaps

- Weekly cohort and practice level data reporting
- Mop-up care homes, housebound people and non-responders
- Use every contact for RSV, Pneumococcal and shingles

JAN–MAR

Sustain & learn

- Continue late seasonal offers where eligible
- Maintain year-round RSV and pneumococcal delivery
- Review admissions, outbreaks, equity and learning

BOARD TRAJECTORY CONTROL

1. **Lock denominator** — Cohort + eligibility
2. **Set trajectory** — Weekly cumulative uptake
3. **Watch variance** — Plan + equity gap
4. **Trigger recovery** — Action

Escalate if the Board-agreed tolerance is breached for 2 weeks or an inequality gap widens.

WEEKLY DATA REPORT AND REVIEW

Eligible → invited → booked → vaccinated → DNA; stock and capacity; by place, practice, cohort, deprivation and ethnicity.

MONTHLY BOARD ASSURANCE

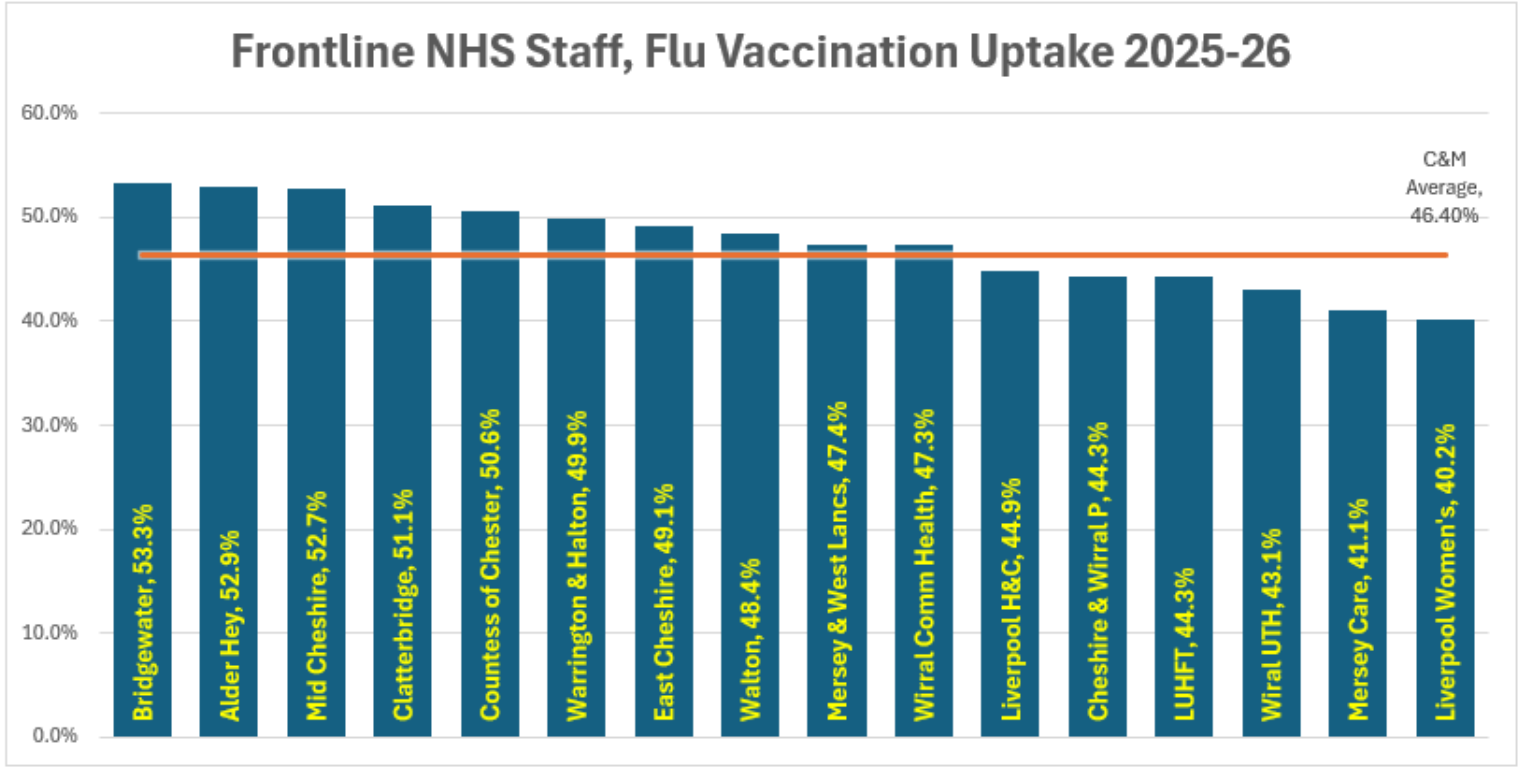
Uptake vs trajectory; respiratory activity; admissions / ICU / outbreaks; staff absence; risks, mitigations and recovery date.

Flu Vaccination uptake 2025 - 26

Flu Trust Uptake 2025-26

Source: NHS England Reporting, Federated Data Platform

	Frontline Staff	Vaccinated	% Uptake
Cheshire & Merseyside	57,170	26,529	46.4%
Bridgewater	993	529	53.3%
Alder Hey	2,915	1,541	52.9%
Mid Cheshire	4,433	2,337	52.7%
Clatterbridge	1,112	568	51.1%
Countess of Chester	3,794	1,918	50.6%
Warrington & Halton	3,320	1,657	49.9%
East Cheshire	1,777	873	49.1%
Walton	1,010	489	48.4%
Mersey & West Lancs	7,200	3,414	47.4%
Wirral Comm Health	1,086	514	47.3%
Liverpool H&C	1,202	540	44.9%
Cheshire & Wirral P	3,271	1,450	44.3%
LUHFT	9,790	4,334	44.3%
Wiral UTH	4,915	2,118	43.1%
Mersey Care	8,943	3,680	41.1%
Liverpool Women's	1,409	567	40.2%



Average uptake of the Flu vaccine last year across frontline staff was 46% across our providers

Frontline Health Care Worker Staff Flu vaccination

SYSTEM PLAN • 100% OFFER • ≥70% UPTAKE • MAJORITY VACCINATED BY 30 NOV • OFFER TO 31 MAR

OUR APPROACH

70% **minimum C&M uptake ambition**
National ambition 60%

100% offer to all FLHCWs

30 Nov majority vaccinated before peak

31 Mar offer throughout flu season

- Walk-in, bookable, OH and mobile/roving provision
- Peer vaccinators plus evening, weekend and night access
- Target low-uptake teams with leaders, champions and myth-busting

MONITORING

WEEKLY VIEW
ESR, RAVS and FDP/local actuals vs trajectory and the prior campaign.

FOCUSED CUTS
Site, division, staff group and ward/team heatmaps identify low-uptake and high-risk areas.

DATA ASSURANCE
Reconcile ESR denominators with RAVS/FDP and capture off-site vaccination.

EXECUTIVE CONTROL
Weekly review of gaps, interventions, owners and recovery dates.

9/16 plans unsigned • 2 Trusts with leads TBC

ACTION & ESCALATION

5 **HIGH-PRIORITY RETURNS need immediate closure**

1 Close plan sign-off and confirm accountable executive and delivery leads.

2 Cost and secure vaccinator, booking, admin, communications and incentive capacity — with a fallback model.

3 If below trajectory, trigger extended hours, roving/mobile clinics and targeted manager/champion outreach.

4 Reconcile NWAS access and reporting inconsistencies; escalate unfunded capacity and unresolved data gaps.

BOARD ASSURANCE ASK • Weekly system view of trajectory, gaps, owners and recovery dates

Source: FLHCW Flu 2026 Assurance Paperwork

Vaccination uptake ambitions AW26

Cohort	AW25 baseline	Proposed AW26 ambition	AW28 ambition
Flu: 2 to 3 year olds	39%	43%	50%
Flu: primary school-aged	51%	56%	65%
Flu: secondary school-aged	39%	44%	55%
Flu: frontline healthcare workers	47%	53%	65%
Flu: clinical at-risk, 18 to under 65	59%	Maintain at least 59%	60%
Flu: aged 65+	73%	74%	75%

Cohort	Current	Proposed AW26 ambition
RSV: Older adult catch-up	70.0%	75%
RSV: Older adult routine	43.9%	50%
RSV: Newly eligible 80+	34.8%	45%
RSV: Maternal RSV	43.7%	50%

Cohort	Previous ambition	Proposed AW26 ambition
Covid: care home residents	66.2%	70%
Covid: 75+	59.9%	65%
Covid: Immunosuppressed	25.0%	35%

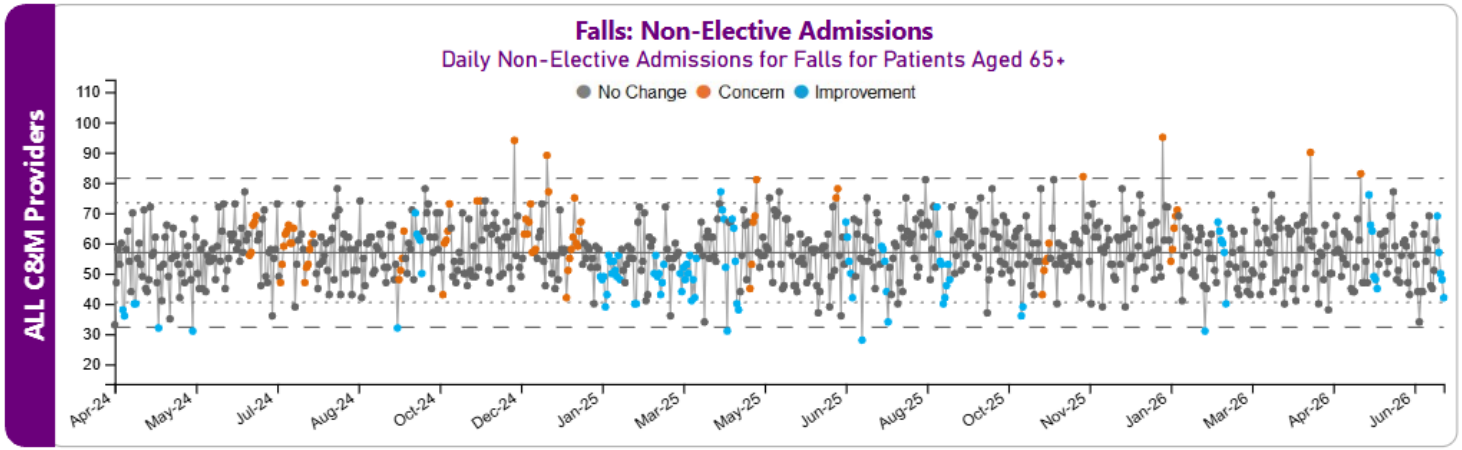
Winter planning Pillar 2 – Trauma Flow

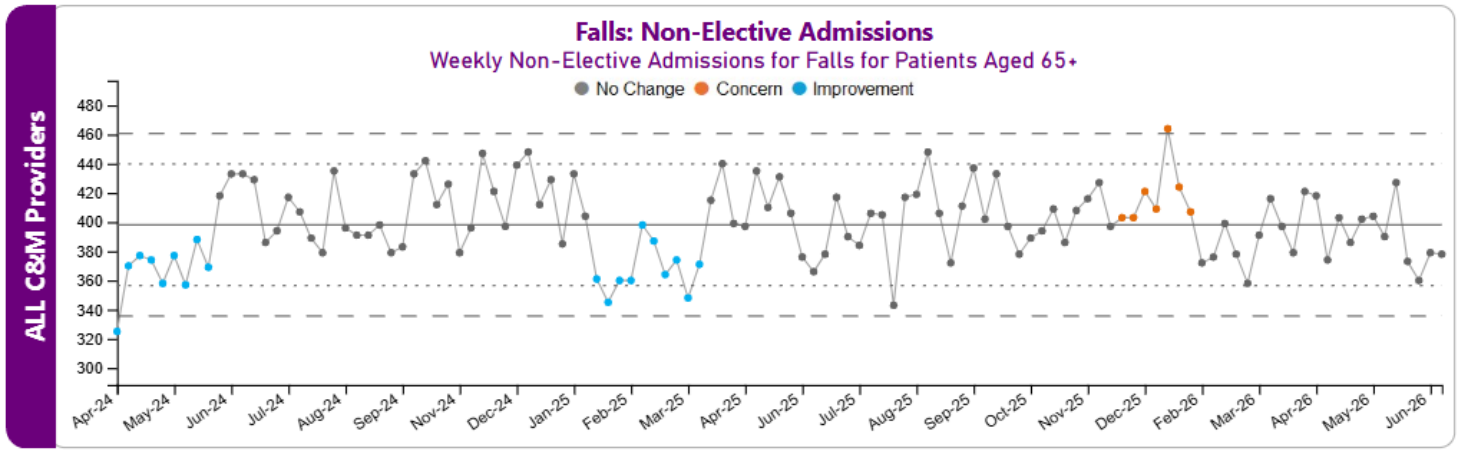
Orthopaedic capacity for winter slips, trips and falls.

Falls

NHS
Cheshire and Merseyside

Falls are a **persistent, year-round source of hospital demand**, with considerably less seasonality than respiratory illness or RSV. Activity remains elevated across all seasons with daily admissions ranging between **50 and 75 patients.** Peak admissions occur year-round with high-volume days regularly exceeding **80 admissions.**





Winter 2026/27

October to November
- Stable but increasing presentations

December to January
- Highest risk period.
- Daily adms likely to remain between 60 and 80
- Potential for surges approaching 90-100 adms

February to March
- Gradual return towards baseline levels

Current AED Indication
Analysis of AED attendances with a chief complaint of T&O for patients aged 65+ shows activity over the most recent four-week period has been slightly lower than previous years.

Unscheduled Care Coordination

Two 'All age' unscheduled Care Coordination hubs will go live across Cheshire & Merseyside from 1st October

Aim of this service is to navigate people to the appropriate service for their urgent care need rather than a default journey to an Emergency Department

Specialist pathways will be embedded into this service including frailty and paediatrics

The 'Hubs' will be able to navigate patients to community services including 2 hour Urgent Care Response (UCR) as well as Urgent Treatment Centres (UTC) and Same day Emergency Care (SDEC)

UCR will provide an integrated falls pick up service for people who have fallen at home with the aim of minimising a conveyance to hospital or an admission

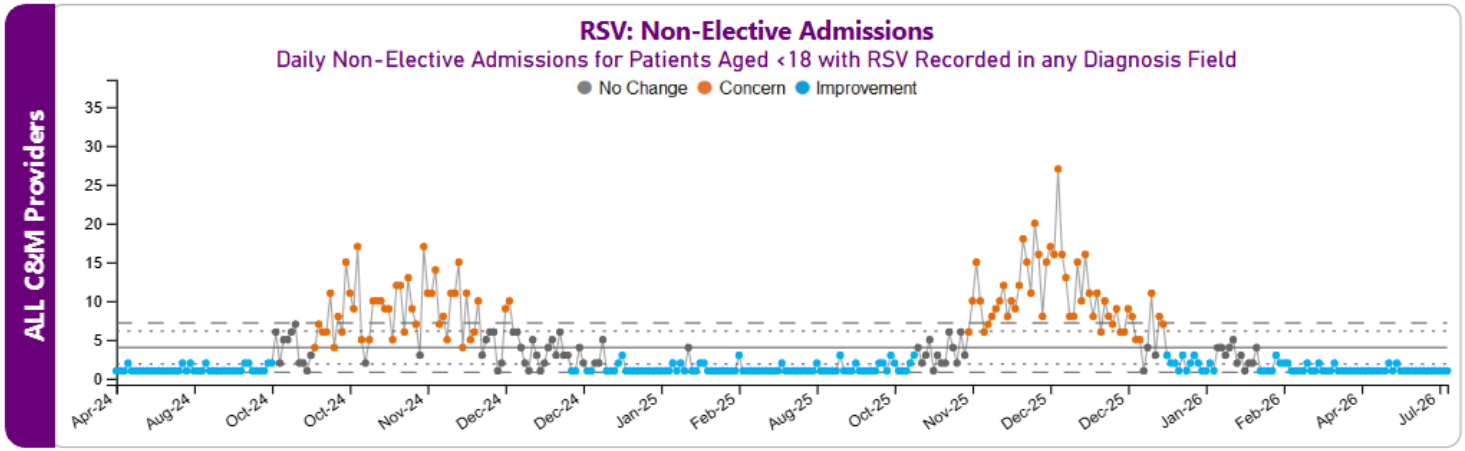
Winter plan Pillar 3 – RSV Surge

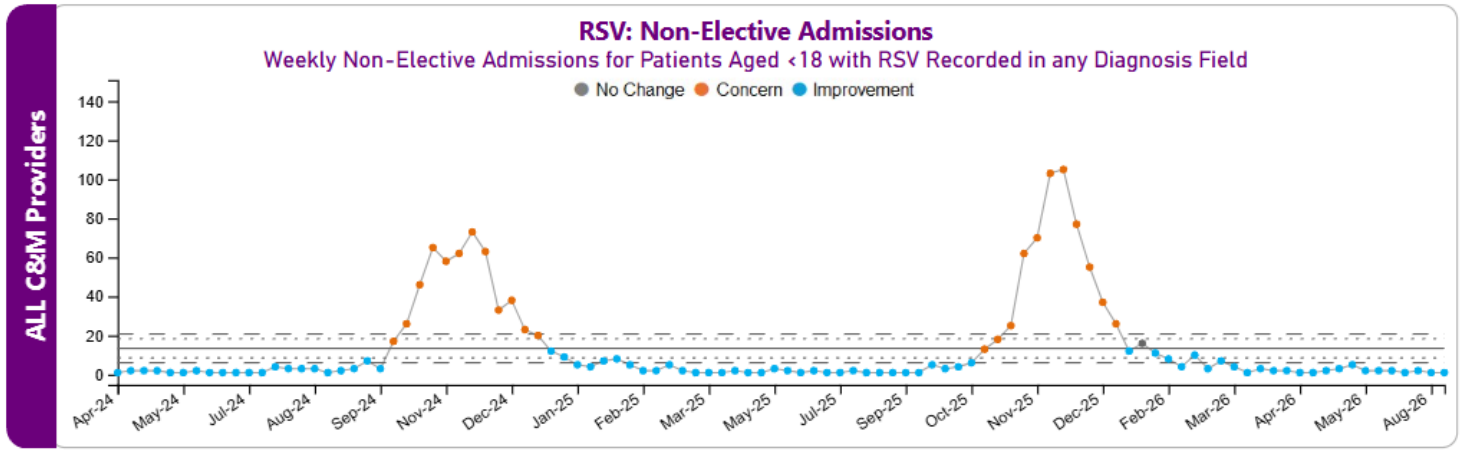
Children & Young Peoples capacity across community services and trusts

Respiratory Syncytial Virus (RSV)

NHS Cheshire and Merseyside

RSV admissions demonstrate a consistent and predictable seasonal pattern, with activity increasing rapidly during October, peaking throughout November and early December, before falling sharply after Christmas.





Winter 202/27

October
- Emerging RSV activity

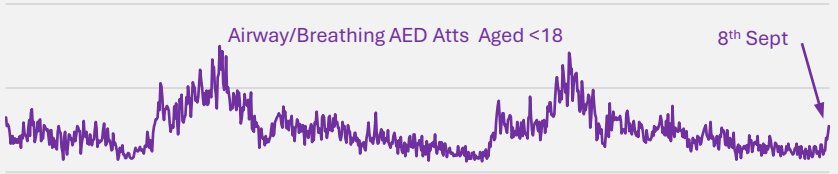
November
- Significant escalation in demand

Late November to Early December
- Highest risk period
- Daily admissions could exceed 25/26 peaks

January
- Rapid reduction in RSV-related demand

Current AED Indication

Recent rise AED activity suggests an increase in adms is imminent



CYP RSV readiness

International Data: No exceptional concerns for RSV or Flu for Winter 2026/27
2025/26 RSV Vaccination Impact: 80-85% protection against infant RSV hospitalisation & further 50% reduction in severe RSV admissions requiring ICU care

1 PREVENTION

Maximise Maternal RSV vaccination uptake

Population vaccination campaigns

2 DEMAND MANAGEMENT

Expanded PCAS integral part of Unscheduled Care Coordination Hubs

Digital front door

Appointment-based urgent care

AI supported triage

3 MAXIMISING ALTERNATIVE CAPACITY

Community nursing

Virtual Ward

Respiratory pathways

Hospital at home

GP & WIC advice line into ED
Expansion of CYP assessment capacity via SDEC, PAU and EEMAC

Enhanced ambulatory pathways

4 HOSPITAL SURGE

PAU and increased assessment capacity

Clear G & A bed escalation via provider surge plans

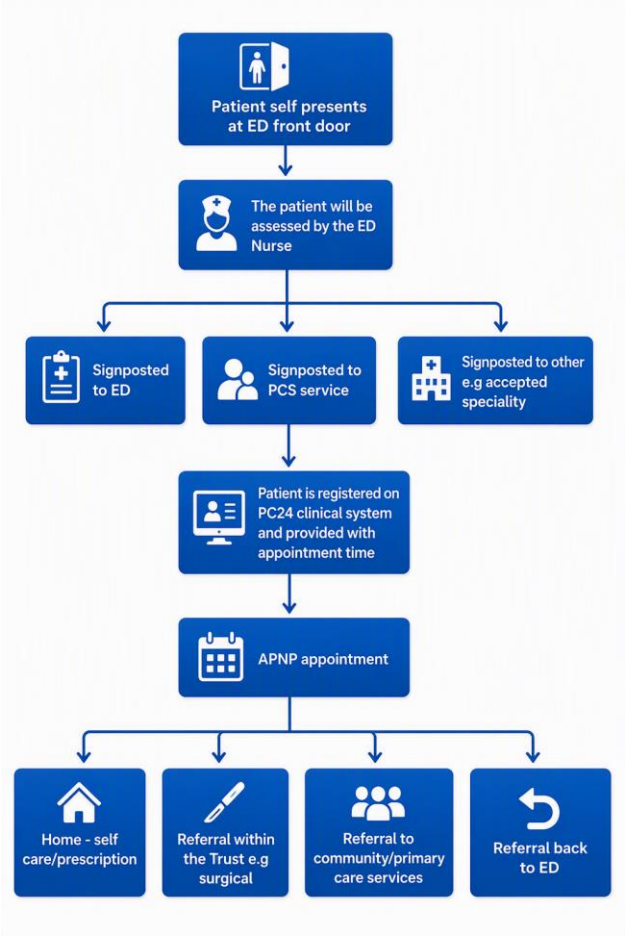
Critical care escalation via strong existing North-West PCC ODN surge model

Development of Neonatal network surge escalation model

SYSTEM OUTCOME **reducing avoidable ED attendance and admission whist retaining safe escalation for deteriorating children.**

ENABLERS Whole System capacity reporting & escalation triggers across for CYP via command and control structure, summary of C & M CYP capacity (general bed base plus surge capacity), connection into UEC CYP clinical delivery group, UEC Board & CYP Alliance.

Paediatric Primary Care Streaming – PC24



PC24's Paediatric Primary Care Streaming model provides a dedicated urgent primary care pathway for children and young people who self-present to the Emergency Department with conditions suitable for primary care management

PC24 currently operates a Paediatric Urgent Treatment Centre at Alder Hey Children's Hospital. Over the past six months, the service has offered more than 8,500 appointments, with utilisation above 80%. This demonstrates sustained paediatric demand, operational experience and the ability to deliver a high-volume, clinically governed paediatric urgent care model within a specialist children's hospital environment.

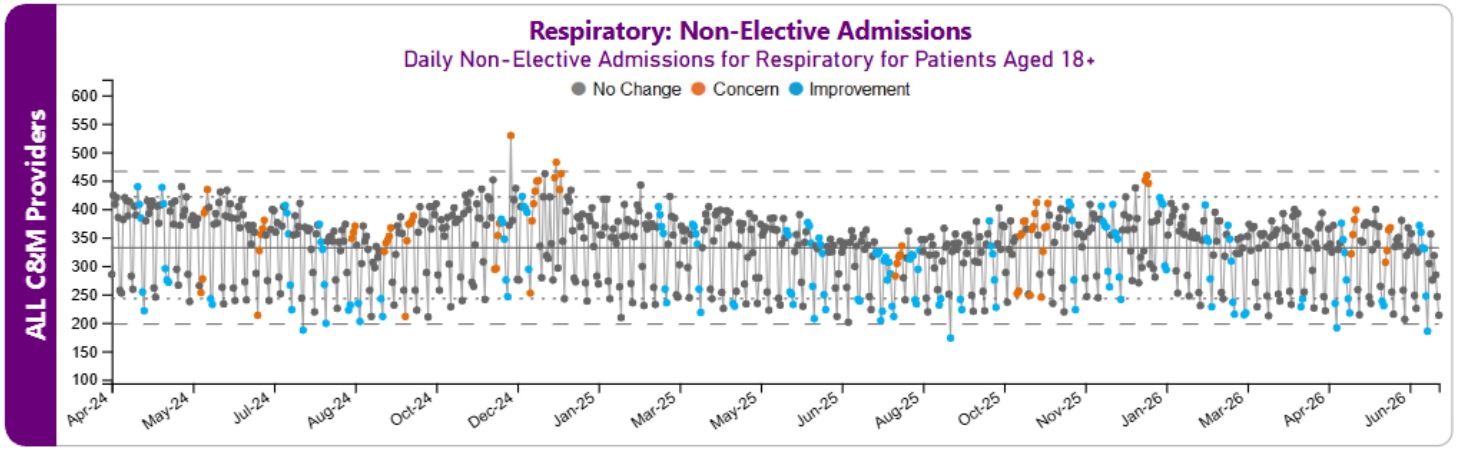
Winter Plan Pillar 4 – Adult Respiratory

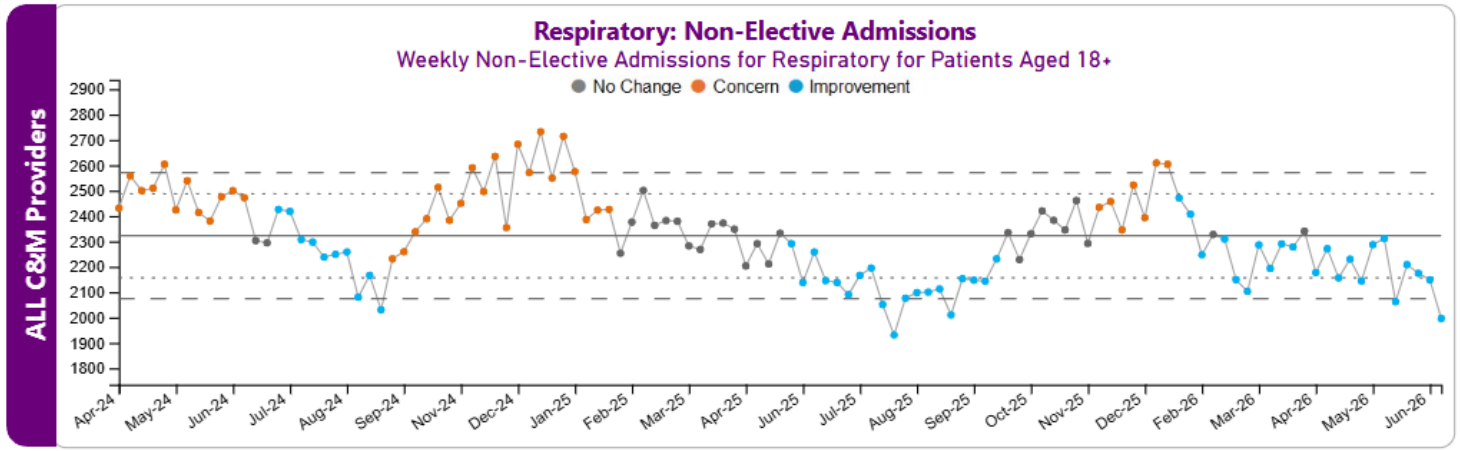
Community capacity plus step-up and step-down

Adult Respiratory

NHS
Cheshire and Merseyside

Winter pressure is not driven by short-term outbreaks but by prolonged periods of elevated respiratory activity occurring simultaneously with other winter-related pressures. Recent winters have consistently produced daily admissions in excess of 400 patients.





Winter 2026/27

October
- Increasing respiratory activity
- Rising impact from seasonal respiratory infections

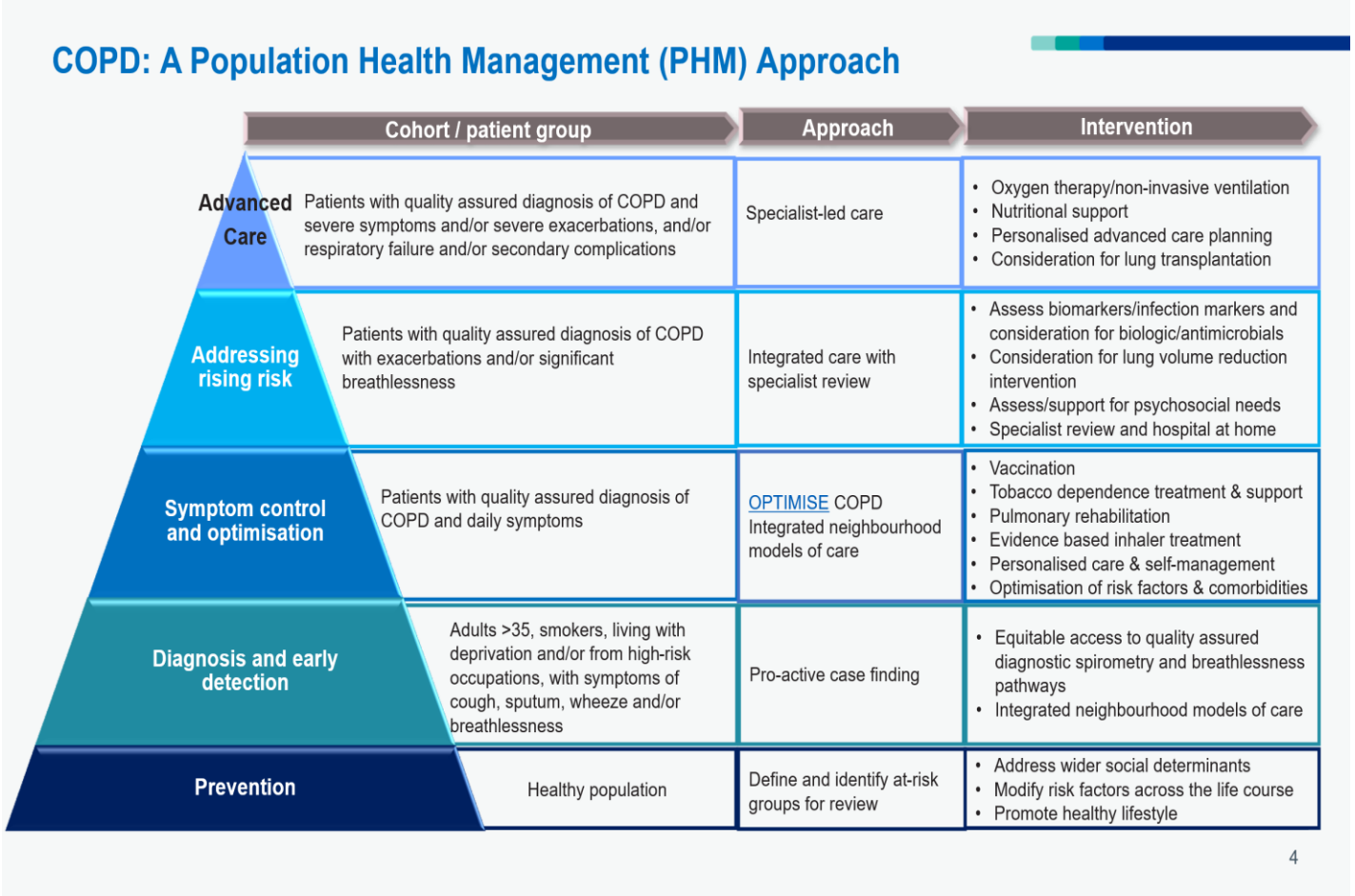
November
- Significant increase in acute respiratory adms

December to January
- Highest risk period
- Daily adms >400, peaks of 450 adms, surges >500 adms

February to March
- Gradual reduction in demand.
- Residual pressure above summer levels

Current AED Indication
Analysis of AED atts with a chief complaint of airway/ breathing for patients aged 18+ shows activity over the most recent four-week period is broadly stable but marginally lower than last year

Prevention: COPD Biologics Programme



COPD Biologics Programme

- Biologics offer a new treatment for chronic obstructive pulmonary disease (COPD) patients with frequent exacerbations, elevated eosinophil counts, and ongoing symptoms despite optimised care.
- A 30% reduction in exacerbation frequency is expected in patients initiated on COPD Biologic therapy, leading to an improved health related quality of life, improved health and a longer life expectancy. COPD biologics will be prescribed:
- for patients who meet NICE eligibility, following MDT approval once patients are optimised in line with ‘Cheshire and Merseyside Fundamentals of COPD Care’
- The programme and roll out is expected to move COPD management from reactive non-elective secondary care admissions to an emphasis upon both proactive and preventative management.

- **Mechanisms to identify suitable patients:**
  - Optimisation and COPD biologic assessment of all patients admitted to hospital, hospital at home or Virtual Ward services
  - Integrated, cross system working to diagnose COPD early and fully optimise patients in their Primary care setting
  - Proactive identification of patients in primary care who are fully optimised and continue to have 2 or more moderate exacerbations of COPD/year

The eligible cohort of patients currently exceeds 4000 patients across the ICB footprint.

Adult Respiratory

Current need

There are 18,386 patients aged 18+ on Asthma and COPD QoF registers in C&M who also have a 50% or more probability of having an emergency admission in the next 12 months.

What does the evidence tell us works

Proactive population health management approaches through identification of patients living with respiratory disease and increased risk of poor health outcomes and increased service utilisation.

Preventative interventions include long term condition reviews that incorporate:

- Vaccination
- Smoking cessation
- Exercise/Pulmonary rehab
- Medication reviews
- Income maximisation – including fuel poverty needs

Approach to winter

1. Risk stratified proactive identification

This winter, all PCNs are encouraged to identify patients through PHM tools as having a 50% or greater probability of emergency admission will be proactively targeted for intervention through Community Respiratory and Integrated Neighbourhood Teams. This enables resources to be directed towards those at greatest risk of deterioration and unplanned hospital utilisation

2. Combining clinical and wider determinants of health

The ICB is encouraging teams to combine respiratory risk stratification with fuel poverty intelligence, enabling them to identify patients whose health is likely to be adversely affected by cold homes and energy insecurity and provide targeted support through referral pathways and partner organisations.

3. Earlier Optimisation and treatment

In addition to long-term condition reviews, the Cheshire and Merseyside COPD Biologics Programme provides a new opportunity to identify and optimise patients with frequent exacerbations who remain symptomatic despite standard therapy. The programme aims to reduce exacerbations, improve quality of life and shift care from reactive emergency admissions towards proactive disease management

4. **System wide case finding across:**

- Primary Care
- Community Respiratory Teams
- Hospital admissions
- Virtual Wards
- Hospital at Home services

Together these measures aim to identify high-risk patients earlier, address both clinical and wider determinants of health, reduce exacerbations and prevent avoidable respiratory admissions during the period of highest seasonal pressure.

Fuel Poverty Interventions

Current need

Using the fuel poverty population health management tool and applying the filter of highest fuel poverty LSOA decile and 50% or more probability of an emergency admission the following number of patients have been identified:

- Respiratory disease – 3,714
- Young children - 146
- CVD – 9,625
- Mental Health conditions – 2,870

What does the evidence tell us works

Identification of patients who are living in fuel poverty through proactive population health management approaches for those patients with relevant risk factors.

Making every contact count (MECC) based approaches to identifying patients in fuel poverty within NHS services who don't have access to Population Management Tools with the following patients being prioritised:

•Respiratory disease
•Young children
•Frail and older people
•Cardiovascular disease
•Mental health conditions

Onward referral of these patients to specialist fuel poverty advice provided through Energy Projects Plus.

Fuel Poverty Service Capacity

The Energy Projects Plus service has advised that they have the capacity to response to an increase in calls from referred patients over the winter period and they can access additional funding if demand increases significantly.

NHS service capacity to identify and refer patients
Primary Care

Staff working in GP Practices should be identifying patients living in fuel poverty during Long Term Condition reviews and during social prescribing service assessments and providing onward referrals to Energy Projects Plus. A winter preparedness briefing has been prepared to reinforce the need to implement this approach.

Community/Integrated Neighbourhood teams

Respiratory teams in St Helens, Knowsley and Sefton are already using the fuel poverty population health management tool to proactively identify respiratory patients living in fuel poverty to ensure these needs are addressed. For all other community based teams they should be identifying patients living in fuel poverty and providing onward referrals to Emergency Projects Plus.

Secondary care services

All secondary care services should be identifying patients living in fuel poverty and providing onward referrals to Emergency Projects Plus.

Key risks

Staff capacity or capability to identify patients living in fuel poverty.

Staff awareness of fuel poverty referral pathways.

Mitigations

Communications will be sent out to NHS Providers outlining the services available to support patients identified as living in fuel poverty.

Virtual Wards - renewed focus on Resp and Frailty

430 Commissioned beds

8 Lead Providers

17.22 beds per 100k population

8 days
C&M average LOS

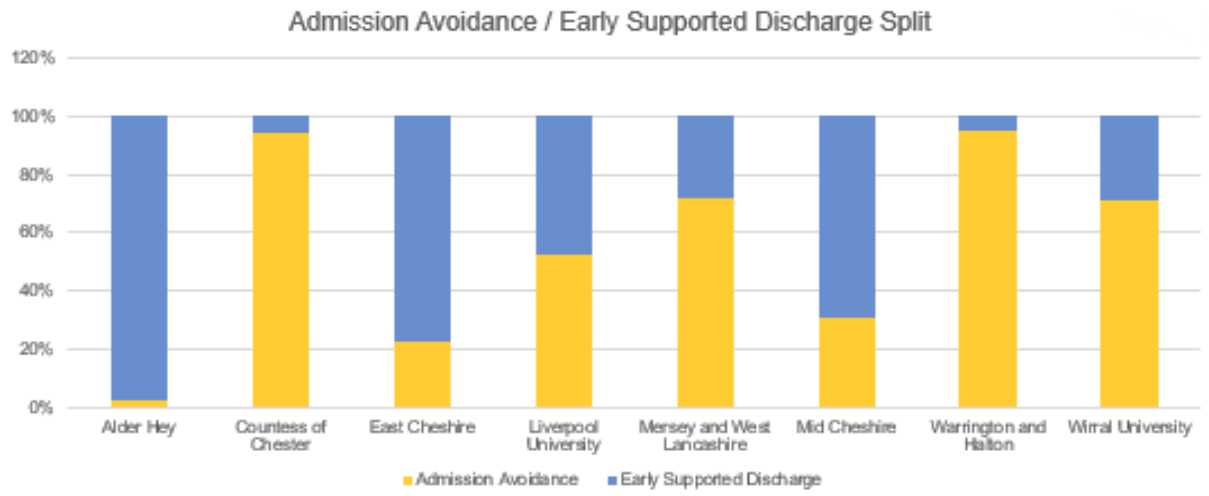
57% Step up referrals

43% Step down referrals

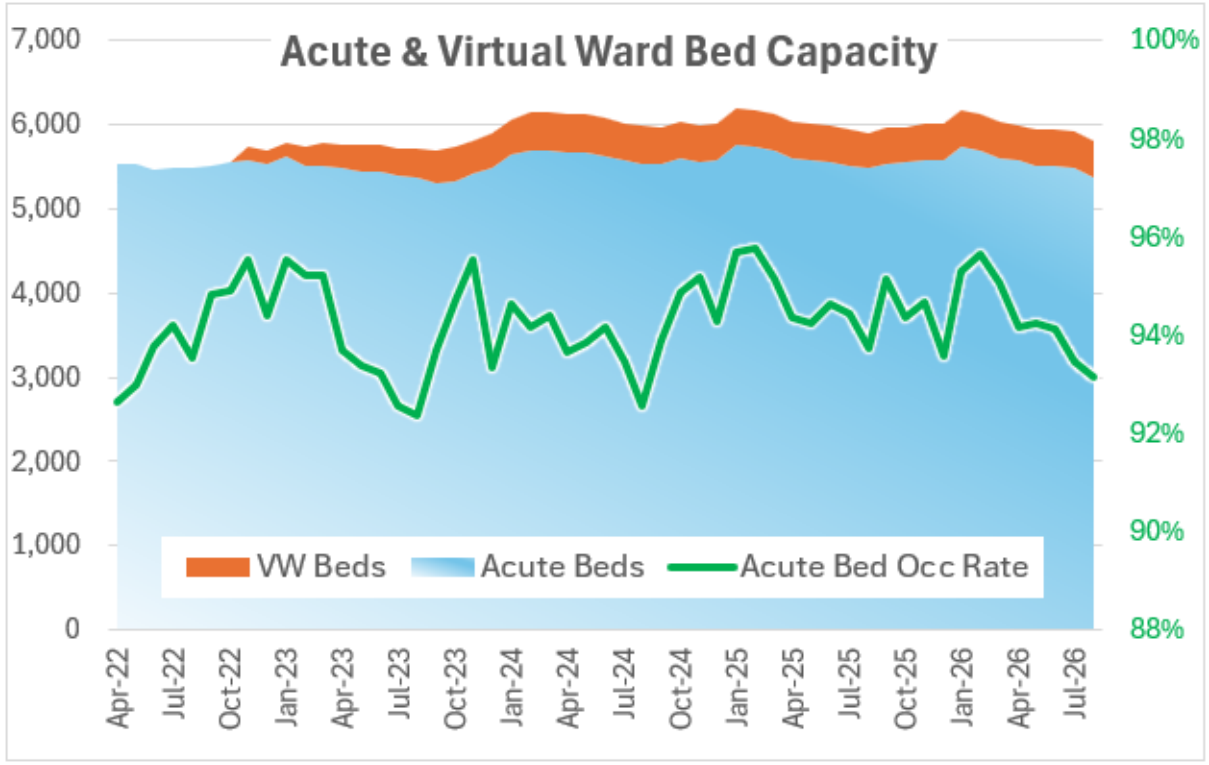
Pathways in place:

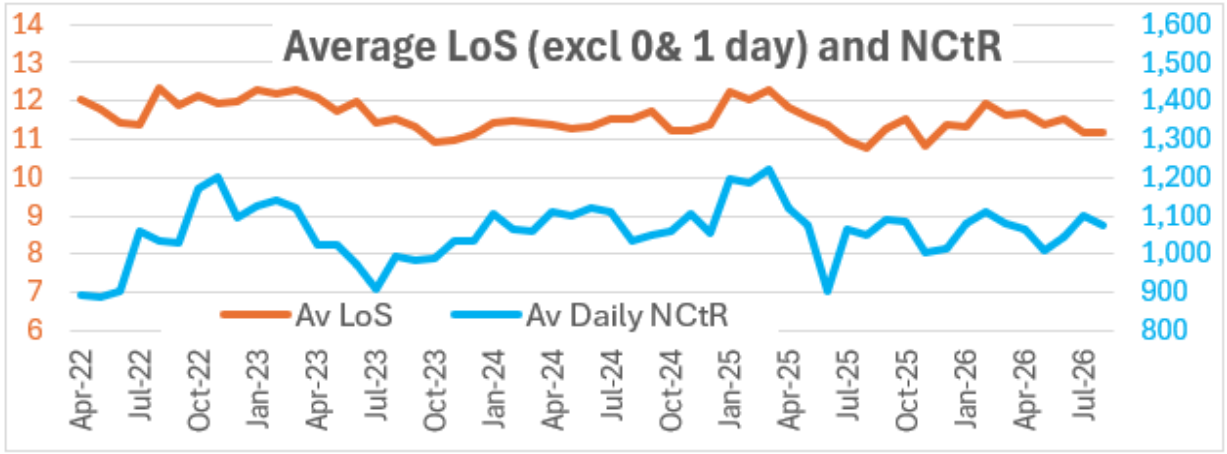
- Paediatric
- Cancer
- Acute Respiratory
- Frailty
- General Medicine
- Heart Failure
- Palliative Care

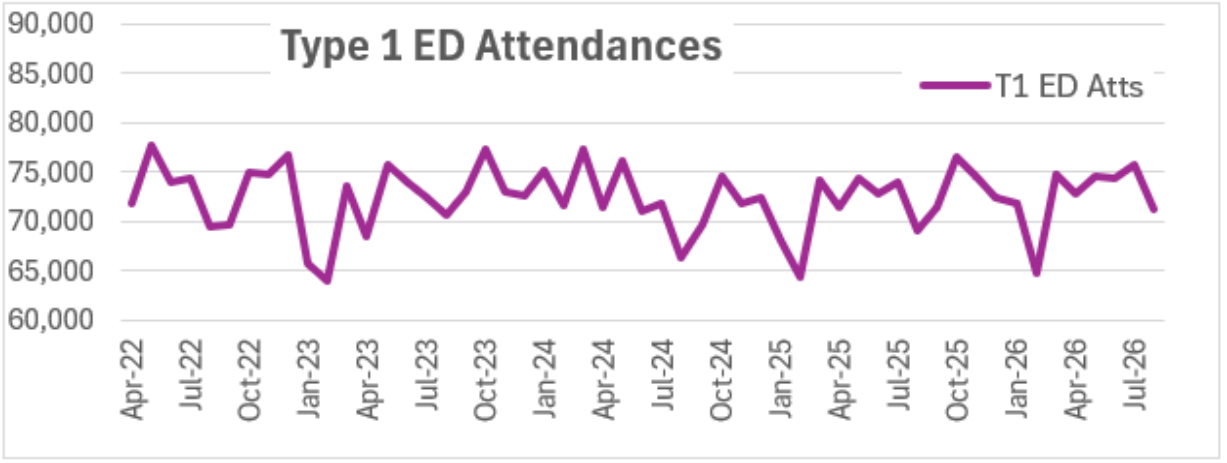
Admissions Avoidance vs Early Supported Discharge



Virtual Wards and Acute Beds







Virtual Wards commenced October 2022.
Other than an immediate reduction in average length of stay, impact on other selected measures has been marginal.
Impact on patient experience and health outcome measures may be more favourable.

Period	Acute Beds	Virtual Ward Beds	Total Beds	Acute Bed Occupancy	Acute Av. LoS	NCtR	T1 ED Atts
Aug-22	5,491	0	5,491	93.5%	12.4	1,036	69,485
Aug-23	5,369	356	5,725	92.3%	11.5	992	70,621
Aug-24	5,545	446	5,991	92.6%	11.5	1,036	66,345
Aug-25	5,479	430	5,909	93.7%	10.8	1,051	69,069
Aug-26	5,383	430	5,813	93.2%	11.2	1,074	71,298
Change from Aug-22 to Aug-26	-108	+430	+322	-0.4%	-1.2	+39	+1,813
	-2.0%	-	+5.9%	-0.4%	-9.3%	+3.7%	+2.6%

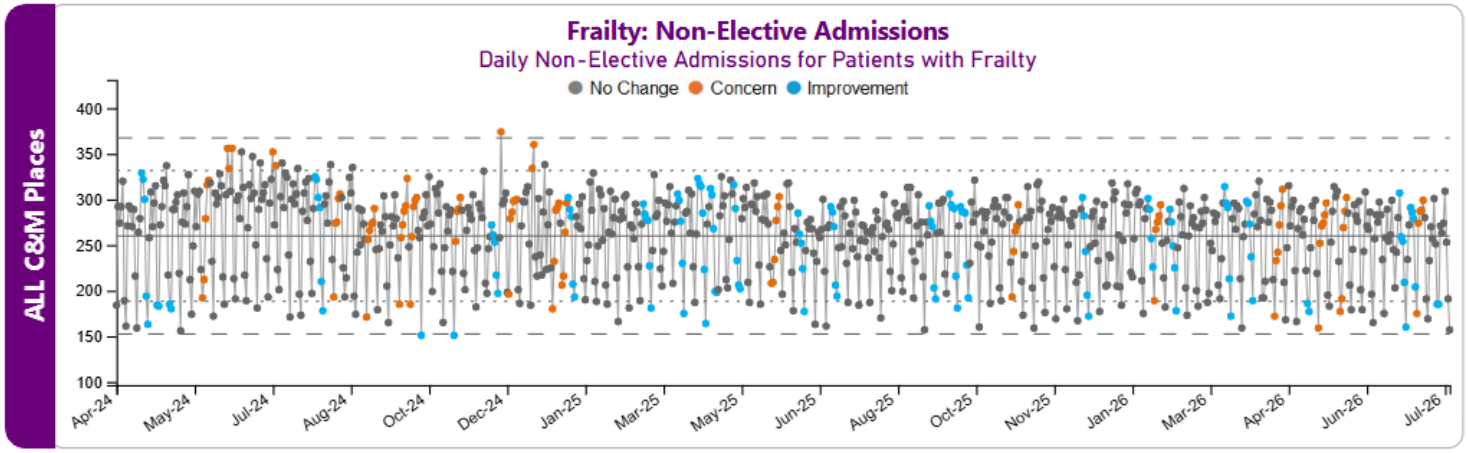
Winter Planning Pillar 5 – Frailty

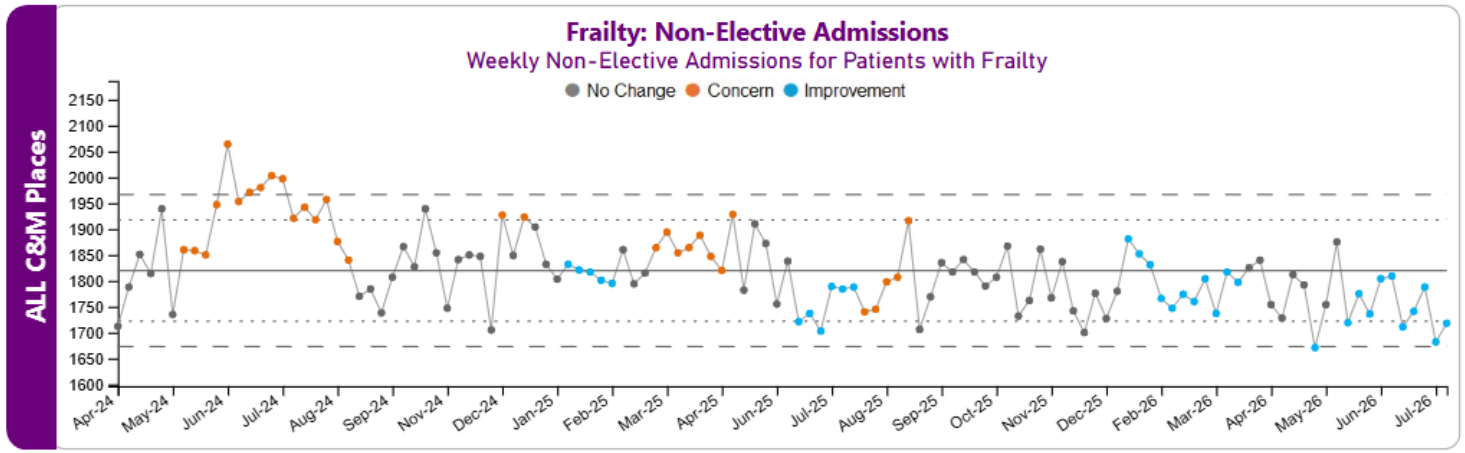
Risk-stratify vulnerable patients early

Frailty

NHS
Cheshire and Merseyside

Frailty admissions represent one of the largest and most significant drivers of non-elective hospital activity. Daily admissions substantially exceed the volumes seen in falls-related admissions or mental health demand. Data show winter can be associated with increased peaks, greater volatility and sustained pressure





Winter 2026/27

October to November

- Remain at a consistently high baseline, approx. 275-300 adms per day

December to January

- Increased daily adms, peaks exceeding 300 adms, and occasional surges above 350 adms

February to March

- Activity expected to remain elevated, with only a gradual reduction from peak winter levels

Current AED Indication

Analysis of AED attendances with a chief complaint of T&O for patients aged 65+ shows activity over the most recent four-week period has been slightly lower than previous years.

Frailty

Frailty is understood as a state of diminished resilience and increased vulnerability resulting from the accumulation of deficits across physical, psychological , cognitive and social domains

The leading cause of emergency admissions among frailty patients is:

•Respiratory disease (Pneumonia or COPD)

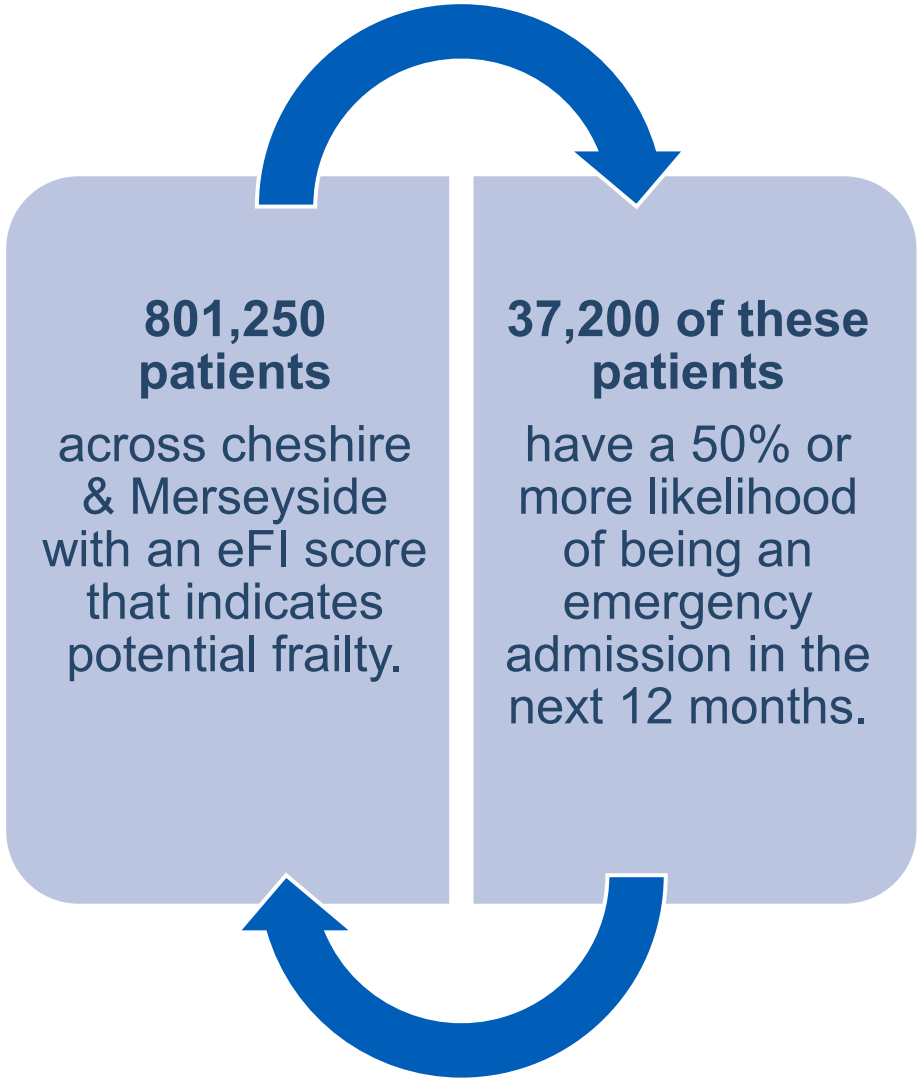
•Falls

What does the evidence tell us works?

Prevention and early intervention across primary and community services

Proactive population health management of patients living with frailty using a risk stratification approach to reviewing frailty patients and where appropriate providing:

- Comprehensive Geriatric Assessments
- Long term condition reviews and optimisation
- Vaccinations – Flu, COVID-19, RSV and Pneumococcal
- Polypharmacy reviews
- Referral to existing support services across smoking, alcohol, weight, physical activity for those with mild frailty
- Comprehensive frailty services for those with moderate to severe frailty focusing on exercise, nutrition, hydration, polypharmacy, falls prevention and social isolation.



C&M Frailty Improvement Driver Diagram

Our Aim

By 2030 C&M will promote independence in people aged 65 and over, by implementing a strengths-based frailty culture.

We will know we have achieved success if we:

- Increase the days people are able to stay in their own home
- Reduce permanent admissions to care homes
- Improve pragmatic prescribing of medication to maintain independence
- Eliminate deconditioning (and measure it as an avoidable harm)

NHS Cheshire and Merseyside

Primary drivers

Consistently identify and risk stratify people with frailty
Identify people needing support early and delay progression

Measures: ↑Early identification; ↑Strength & balance; ↑community support; % population stratified; consistent use CFS/CGA

Ensure care for people with frailty is integrated, proactive and co-ordinated
Ensure services respond effectively

Measures: ↓ Non-elective admissions >65; ↓ED attendances; ↓Conveyances; ↑MDT/CGA utilisation

Help to maintain independence and reduce harm for people with frailty
Focus on outcomes that matter to people

Measures: ↑Days kept at home; ↓Deconditioning episodes; ↓LOS; ↓acute frailty measures; ↓>65s on 5 or more unique meds

Develop a frailty-attuned culture and leadership across C&M

Measures: Delivery of system priorities; evidence of partnership working; staff engagement and culture

Secondary drivers

- Segment population consistently at neighbourhood level (early identification and risk profile incl falls risk)
- Strength and balance available in all neighbourhoods
- System-wide use of CFS for identification and recording of frailty (health, social care & VCSFE)
- Shared Comprehensive Geriatric Assessment
- 24/7 "No wrong" front-door
- Optimise frailty MDT-led care
- Shared pathways and care records aligned to CFS score, stratification, SMR and CGA outcomes
- Incentivise independence - home-first care ethos and expansion of reablement
- Prevent de-conditioning in hospital; recognise and record de-conditioning as avoidable harm
- Integrated system SMR with focus on pragmatic prescribing and reducing anti-cholinergic burden
- Shared vision and strategy
- Collaborative leadership
- Aligned data, commissioning and incentives – hold system to account

Enabling actions

- All >65s have a consistent frailty stratification (CIPHA)
- CFS used and recorded to identify frailty in all settings
- C&M integrated CGA used in all settings
- Integrated falls & fracture prevention and management

- Community demand and capacity modelling
- MDT co-ordination and shared records enabled by asynchronous digital platform

- Step-up & -down reablement
- Incentives and outcomes to keep people at home
- Flexible community workforce
- Acute ward frailty thermometer: mobility focus
- Record deconditioning incidents as harm
- Integrated system SMR

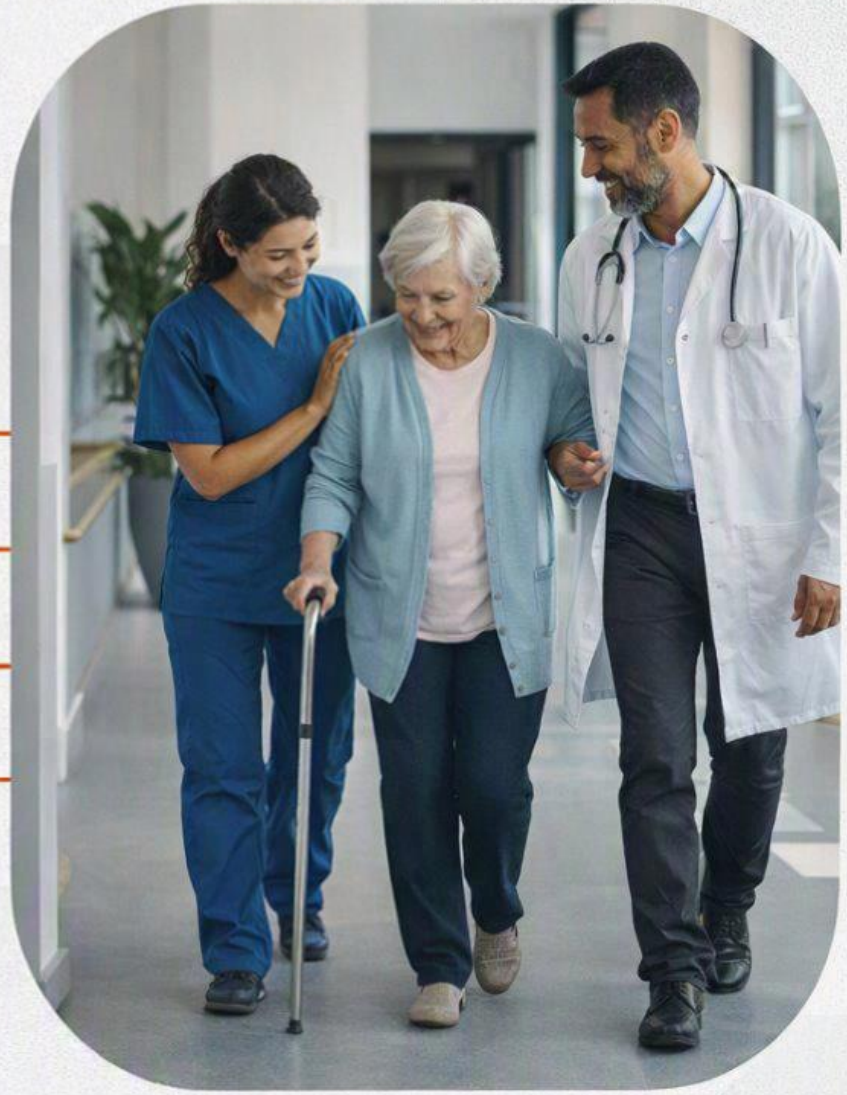
- Shared vision & strategy
- Align data, metrics and commissioning incentives
- System training: frailty-attuned care, delirium recognition and strengths-based care
- Social movement and public awareness

DRIVER DIAGRAM FOCUS

Aiml Maintain independence . Reduce harm

Core Improvement Drivers

- **PREVENT frailty and deterioration**
- **IDENTIFY frailty consistently**
- **RESPOND through proactive, integrated care**
- **SUSTAIN independence for people aged 65+**



Key Enablers

· Neighbourhoods CGA / ACP / CFS / SBA
· MDTs
. SMR & other risk

Measures

- Days at home .Admissions / LoS
- Deconditioning and harm reduction (falls, PU, HAI)

Deconditioning

NHS
Cheshire and Merseyside

A key focus in the management of patients with frailty is to avoid deconditioning during acute admissions. The ICB is working with all NHS Chief Nurses to establish a consistent and high-quality response to preventing deconditioning via a frailty bundle.

Step 1:

The system will gather clarity on existing deconditioning prevention activities in each acute setting and assessing level of assurance around consistent application

Alongside this initial step there will be a standard set for deconditioning recognised harm, with any patient increasing dependency from point of medically optimised to final discharge (with a limited number of exceptions)

Step 2:

There will be an analysis of consistent activities to prevent alongside rates of deconditioning harm. Alongside the wider evidence base this will allow a basis for agreement of standardised prevention activities for all acute providers.

Step 3:

Implement a frailty bundle seeking to reduce deconditioning harm across C&M inpatient settings.

Liverpool City Region Frailty Approach

Population Health Management - Risk Stratification

Population Health Management tools are available to support NHS providers across C&M risk stratify their patients based on prevalence of modifiable risk factors, likelihood of poor winter related health outcomes and/or UEC utilisation and offer proactive preventative care.

1 SEGMENT

Use population health management tools to identify those at higher risk of admission

2 VALIDATE

Patients needs are validated by a member of the PCN team

3 ACT

Prioritise proactive preventative care including vaccination and LTC reviews to reduce poor health outcomes for the patient and increased service utilisation for the NHS

4 LEARN

Weekly refresh; outcomes and equity review; move people up or down a tier

Key Issue

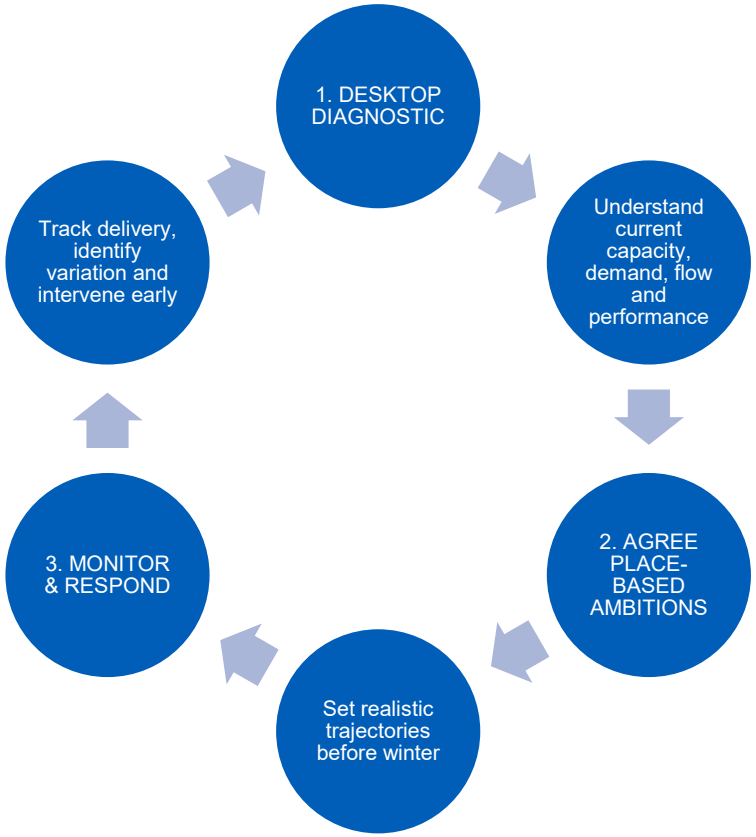
Inconsistent application of the risk stratification approach across Primary and Community/Neighbourhood services and Teams.

Availability of patient level data – currently only PCNs and some Community Respiratory Teams have access to patient level data to proactively identify patients and deliver evidence-based interventions.

Mitigations

Communications will be sent out to NHS Providers outlining the need to use proactive population health management approaches where appropriate.

Bed-Based Intermediate Care: Winter Planning & Readiness



🛏️ Capacity

We will know number of beds commissioned per place

📊 Occupancy

Each Place is developing an improvement trajectory

⏱️ Length of Stay

Know current LOS, including seasonal variation & trends; Each place is agreeing scope to improve

⬆️ Step-Up

Each place will have an agreed number of beds available for step-up from community – utilisation will be tracked across winter

🏠 Discharge Home

Each place is setting their ambition for % discharged to Usual Place of Residency

The objective: Maximise the value of commissioned capacity, promote independence and reduce the number of days people spend away from home.

National Priorities for Discharge

Expectation for the next four months

A new weekly delivery rhythm

The existing nationally led discharge meeting, with regional engagement, will move **from fortnightly to weekly with immediate effect**.

The initial focus will be delivery of the **September Sprint**, followed by the **Discharge Marathon** through to **Home for Christmas** and beyond.

01

SEPTEMBER DISCHARGE SPRINT

- Specific focus on **reducing P0 and hospital-related P1 delays** as a **delivery sprint**.

From 18th September we will identify where the delays are, understand what is preventing people from going home, and intervene rapidly where national, regional or provider action is required.

AIM: eliminate these delays over the course of September.

02

DISCHARGE MARATHON

- Broadening focus across the full range of discharge constraints, but with an additional focus on reduction in people with NCtR in acute, community, UCR, VW and mental health beds and reducing bed occupancy, to give us operational headroom continuing through winter.

From 1st October we will identify the constraints and trajectories, and intervene rapidly where national, regional or provider action is required.

AIM: reduction in proportion of beds occupied by NCtR patients

03

HOME FOR CHRISTMAS SPRINT

- Specific focus on **reducing occupancy** in the lead up to Christmas as a **delivery sprint** with sustainable changes that can be carried through to the New Year and beyond

AIM: Reach 80% occupancy before Christmas and maintain into Quarter 4

The overarching principle will remain the same across the three delivery cycles: **identify the constraint, get the right people around it, and remove it.**

Regions, systems and providers should focus on improving data quality, embedding Model Discharge during September

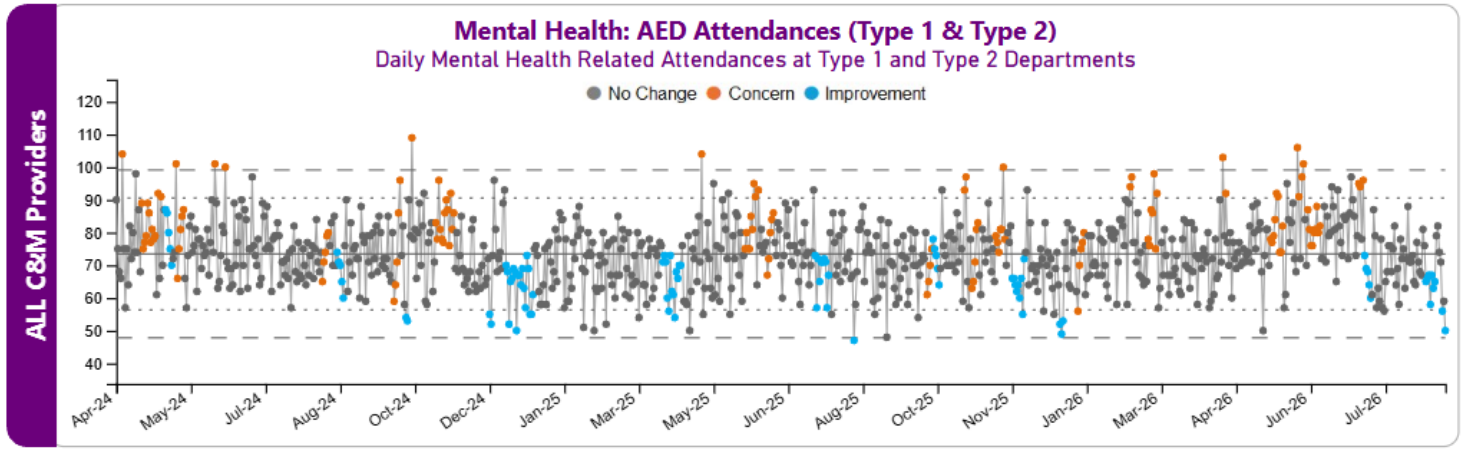
Winter plan Pillar 6 – Mental Health Crisis Response

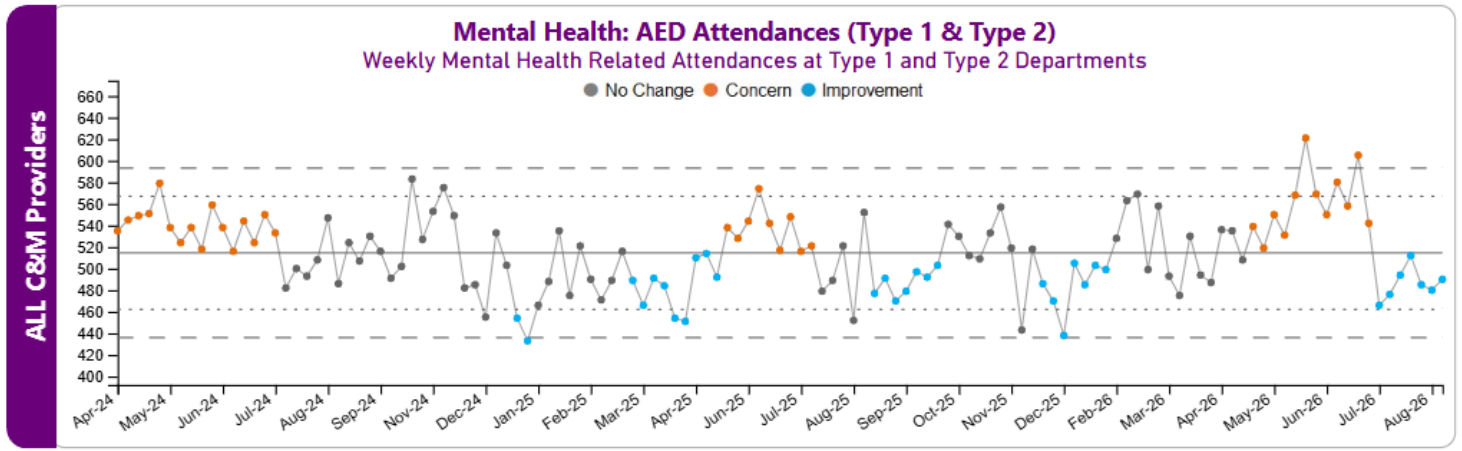
Rapid support for lonely and vulnerable people

Mental Health

NHS
Cheshire and Merseyside

Mental health demand is a **high-volume, sustained and year-round pressure on urgent and emergency care services**, with little evidence of the pronounced seasonality seen in respiratory illness or RSV. Activity appears to have increased over time, with 2026 showing a higher sustained baseline than 2024.





Winter 2026/27

October to November

Attendances remain high and stable.
Increased interaction with wider urgent care pressures.

December to January

- Demand expected to remain comparable with the rest of the year.
- Increased risk of extended waits and delayed assessments.

February to March

- Continued sustained activity
- No significant reduction expected

Current AED Indication

Analysis of AED attendances with a diagnosis related to mental health shows activity over the most recent four-week period is broadly stable but marginally lower than last year.

Mental Health Crisis Care

Our 9 Priorities

1 Preventing Crisis Presentations and Avoidable Attendance to ED

Take earlier action to prevent mental health crises and reduce avoidable attendance at emergency departments.

2 Crisis Assessment & alternative assessment environments

Ensure timely, high-quality assessment with a range of appropriate and accessible environments.

3 Improving Mental Health Flow Through Emergency Departments

Reduce delays and improve the experience and outcomes for people presenting to ED with mental health needs.

4 Section 136 and Places of Safety

Ensure effective, safe and therapeutic use of Section 136 and high-quality places of safety.

5 Mental Health Act Assessment, Conveyance and Crisis Flow

Improve the Mental Health Act assessment process, conveyance arrangements and overall crisis flow.

6 Crisis Workforce and Clinical Model Development

Develop a skilled, resilient workforce and sustainable clinical models to deliver high-quality crisis care.

7 Children and Young People's Crisis Care

Ensure children and young people receive timely, appropriate and compassionate crisis care.

8 Data and Digital

Make better use of data and digital solutions to improve decision-making, drive improvement and support high-quality crisis care.

9 System Learning, Governance and Assurance

Strengthen learning, governance and assurance to continuously improve crisis care across the system.

Mental Health Crisis Care
Winter Readiness 2026/27

Our outcome for winter:
Reduce A&E attendance and reduce long waits

System working | Operational resilience | Better outcomes

Prepared. Together.

Ensuring safe, timely and effective mental health crisis care throughout winter, supporting flow across the UEC system.

Priority	Current capacity position	Key dependencies / risks	Actions to support winter
1 **Preventing crisis presentations and avoidable attendance to ED**	• MHRVs, NHS 111 MH and professional advice lines in place • Targeted prevention initiatives underway	• National NHS 111 MH algorithm • Consistent implementation across system • Community capacity	• Roll out of NHS 111 campaign • Utilisation of MHRV • Promote targeted prevention initiatives (e.g. crisis alternatives)
2 **Crisis assessment & alternative assessment environments**	• Alternative assessment environments being developed • Increased use of community-based options	• Availability of suitable environments • Workforce and estates • Partner alignment	• On-going implementation and utilisation of crisis assessment centres • Review referral pathways
3 **Improving mental health flow through EDs**	• Work underway to reduce delays and variation • System standards being developed	• ED and MH workforce • Consistent operating model • Real-time bed availability	• Implement MH ED flow process • Implement parallel assessment and streaming • Develop MH A&E data dictionary
4 **Section 136 and Places of Safety**	• All acute trusts recognised as a Place of Safety apart from Warrington • POS learning review actioned	• Warrington not operating as a POS • POS capacity • Interface of services e.g. social care, police • Commissioning arrangements	• Implement agreed POS allocation improvement actions • Open MH based place of safety in Chester & additional capacity in MerseyCare • Implement learning and actions in relation to S136 from police custody
5 **Mental Health Act assessment, conveyance and crisis flow**	• Implementation of new S12 doctor solution • Review of assessment and conveyance arrangements	• AMHP capacity • Conveyance and transport • Bed availability and flow	• Implementation of Thalamos solution for S12 doctors • Review social care response times in line with national ambitions • Understand S12 doctor capacity
6 **Crisis workforce and clinical model development**	• MH trusts recruitment and workforce plans • Crisis model review	• Workforce recruitment and retention • Training and supervision • Sustainable funding	• Understand and review workforce capacity and mitigation plans • Review clinical models e.g. for S136 suites
7 **Children and Young People's crisis care**	• CYP crisis response pathways progressing • APOC developments	• CYP service capacity • ED interface • Out of area placements	• Continued implementation of CYP 4 functions • On-going work within APOC
8 **Data and digital**	• Shared data framework developing • Agreement to look to improve visibility of demand and capacity	• Availability and consistency of data • Digital solutions implementation	• Development of MH & A&E data dictionary • On-going digital capital developments • On-going review of S136 demand inc. from police custody
9 **System learning, governance and assurance**	• MH Crisis Oversight Group in place • Reporting aligned to UEC	• Cross-system governance and escalation • Delivery of dependent workstreams	• Implement agreed governance and reporting arrangements e.g. via crisis oversight group • On-going learning review e.g. S136 allocation of place of safety etc

Key interdependencies

Working closely with:

Community transformation
Aligned neighbourhood and community services to prevent crisis and support alternatives to ED

Inpatient quality transformation programme
Safe, timely admissions and discharge, reducing length of stay

Provider collaborative
Shared best practice, consistent pathways and system-wide improvement

How the UEC team can support

Reinforce and mandate consistent engagement from partners
Ensure delivery of agreed actions across all organisations

Mental health as a priority in the UEC space
Parity of esteem and visible Board focus

Capacity visibility and transparency
Shared data, reporting and learning

Escalation route
Help unblock barriers to implementation

Communication and awareness raising
Promote the work being undertaken and clear expectations of all organisations

Primary Care

Primary Care – General Practice Appointments

5% increase in appointments attended

than previous years despite increasing complexity, general practice is managing to field increasing number of appointments each year, albeit this will be expected to stabilise to anew plateau

Annual Growth Trends **Demand**

	Appointments			List Size			Appt per 1000 pop			Sparklines		
	2024-25	2025-26	2026-27	2024-25	2025-26	2026-27	2024-25	2025-26	2026-27	2024-25	2025-26	2026-27
Cheshire & Merseyside												
Cheshire & Merseyside ICB	9.0%	5.9%	5.1%	1.2%	0.7%	-0.3%	7.7%	5.2%	5.5%			
Place Level												
Cheshire East	9.9%	3.8%	4.8%	1.3%	0.8%	0.0%	8.5%	2.9%	4.8%			
Cheshire West	7.4%	2.5%	4.9%	1.1%	0.5%	-0.2%	6.3%	2.0%	5.1%			
Halton	6.1%	7.0%	1.6%	0.4%	0.1%	-0.7%	5.6%	6.9%	2.3%			
Knowsley	15.0%	6.2%	4.8%	1.1%	0.7%	0.0%	13.8%	5.5%	4.8%			
Liverpool	10.7%	3.1%	6.9%	2.0%	1.3%	-0.7%	8.5%	1.8%	7.7%			
Sefton	4.1%	12.6%	7.1%	1.0%	0.7%	-0.2%	3.1%	11.8%	7.3%			
St Helens	11.2%	5.5%	1.6%	0.9%	0.6%	0.2%	10.2%	4.9%	1.4%			
Warrington	10.5%	8.6%	5.0%	1.2%	0.4%	-0.7%	9.2%	8.1%	5.7%			
Wirral	7.5%	9.2%	5.0%	0.8%	0.4%	-0.2%	6.6%	8.7%	5.3%			

Notes
This is a comparison of the July position for each year 2023-2026
Sources: NHSE PDS (Personal Demographics Service), and NHSE Appointments in General Practice Report.

Annual Growth Trends **Workforce**

	GP FTEs			Appts per GP FTE			Appts per Staff FTE			Sparklines		
	2023-24	2024-25	2025-26	2023-24	2024-25	2025-26	2023-24	2024-25	2025-26	GP FTE	Appt/GP	Appt/staff
Cheshire & Merseyside												
Cheshire & Merseyside ICB	3.1%	3.6%	3.2%	5.7%	2.3%	1.9%	6.7%	4.7%	3.8%			
Place Level												
Cheshire East	3.2%	4.0%	4.2%	6.5%	-0.2%	0.7%	6.8%	1.7%	3.7%			
Cheshire West	2.9%	10.0%	-2.9%	4.4%	-6.9%	8.1%	7.3%	0.9%	9.2%			
Halton	1.2%	5.4%	-2.4%	4.8%	1.6%	4.2%	-6.6%	7.3%	8.9%			
Knowsley	8.3%	14.3%	2.3%	6.2%	-7.0%	2.4%	2.6%	-0.6%	-4.8%			
Liverpool	6.4%	-7.8%	11.5%	4.0%	11.8%	-4.1%	10.9%	4.6%	1.4%			
Sefton	-4.6%	15.1%	-4.7%	9.1%	-2.2%	12.4%	7.5%	5.5%	7.6%			
St Helens	0.4%	9.8%	-1.9%	10.8%	-3.9%	3.5%	3.5%	6.8%	0.6%			
Warrington	-5.8%	9.6%	0.5%	17.3%	-0.9%	4.4%	10.7%	9.1%	5.5%			
Wirral	7.1%	0.4%	6.4%	0.4%	8.8%	-1.2%	5.9%	8.9%	2.9%			

Notes
This is a comparison of the July position for each year 2023-2026
'Staff' here is the sum of FTEs of all staff types (GP, Nurse, DPC and Admin)
Sources: NHSE PDS (Personal Demographics Service), NHSE Appointments in General Practice Report, NHSE General & Personal Medical Services Report

3% growth in FTE GPs

The provision of GP appointments is growing at a greater rate than the growth in both list sizes and staffing

Primary Care Winter & Neighbourhood Health Schemes 2026/27

£2.5m invested across PCNs to strengthen winter resilience and accelerate Neighbourhood Health delivery

Proactive frailty and long-term condition management	Additional winter clinical capacity	Prevention and population health	Neighbourhood Health development
• Targeted support for frail people, care home residents and those at highest risk of admission. • Risk stratification, MDTs, anticipatory care planning and neighbourhood-based reviews.	• Additional GP, ANP and nursing capacity. • Same-day appointments, respiratory hubs, acute clinics, home visiting and care home support to reduce winter pressures.	• Vaccination programmes, cardiovascular disease prevention, CKD identification, respiratory management, health checks and community wellbeing initiatives. • Focus on tackling health inequalities and reaching vulnerable groups	• Strengthening integrated neighbourhood teams, MDT working, care coordination and collaboration with community, local authority and VCSE partners. • Building sustainable neighbourhood infrastructure for future delivery

Expected system benefits

- More people supported safely at home.
- Reduced avoidable Emergency Department attendances.
- Reduced non-elective admissions and ambulance conveyances.
- Improved same-day access to primary care.
- Increased personalised care planning and coordinated support.
- Accelerated delivery of the Cheshire & Merseyside Neighbourhood Health model

Primary Care

Unscheduled Dental Care Activity

This is the first year of new dental contract reform requirements for unscheduled care (8.2 per cent of contract value)

Currently the ICB is at 16.2 % of annual target (April-June figures)*

Community Pharmacy

Existing arrangements and pharmacy needs assessments are in place via usual processes.

OOH capacity and commissioned rota services are in process and assured, plus provision of 100 hour pharmacy contracts across the patch – details in action plan.

ICB one of highest delivery rates of DMS nationally , consistently delivering over 3.3K interventions monthly.

Assurance and monitoring in place for Pharmacy First as part of ICB variation plan

Expanded Pharmacy first offer (5 additional conditions)

Winter Communications plan

NHS Cheshire and Merseyside Winter Communications

Coordinated approach to winter and UEC comms, involving all system partners.

Communications activity will be aligned to system, regional and national priorities – including prevention, early intervention, self-care and appropriate access.

Key Priorities

- **Prevention:** Seasonal vaccinations, winter health and early intervention to keep people well and reduce avoidable admissions
- **Self-care:** Improve health literacy and encourage use of NHS app, pharmacies and self-care for minor illnesses and winter conditions
- **Right Service, Right Time:** Highlighting appropriate use of emergency services and the wide variety of alternatives to hospital care
- **Reassurance:** Build public confidence that NHS services are prepared and available for those who need them most
- **Hospital Avoidance:** Highlight admission avoidance initiatives and demonstrate how care is being delivered closer to home

Delivery Model

- System-wide coordination
- Shared assets and toolkits – maximise reach with consistent messaging
- Alignment with national and regional campaign priorities
- Respond to system pressures - linked to OPEL escalation plan and SCC

What's different?

NHS Cheshire and Merseyside will have an increased focus on prevention, particularly winter vaccinations, with an aim to increase uptake amongst eligible cohorts, including health and social care workers.

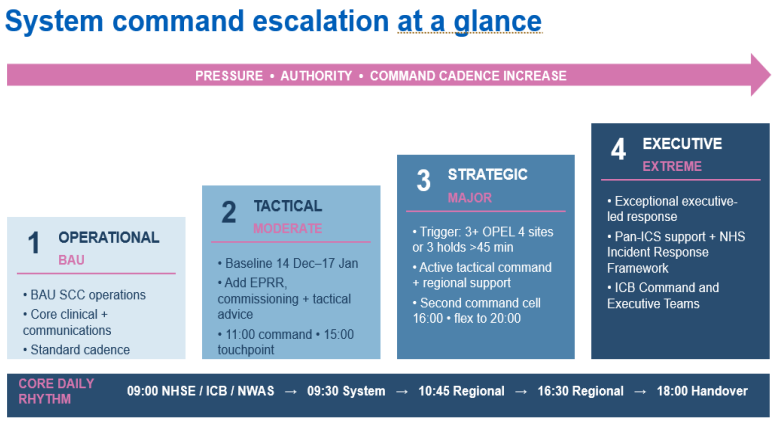
How will we measure the impact?

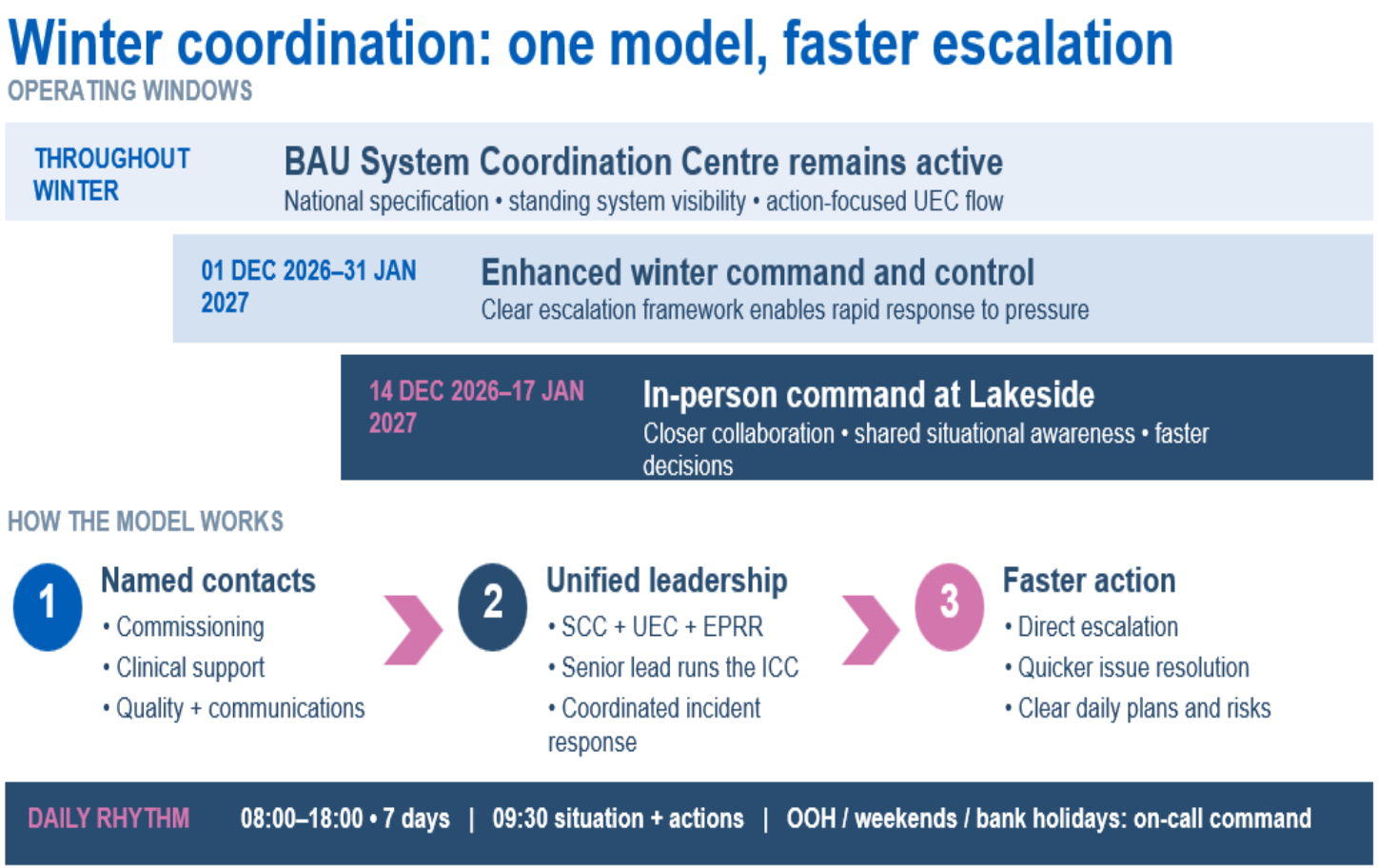
The impact of winter communications will be measured through campaign reach and engagement metrics, including media coverage, partner amplification, website and social media performance, alongside outcomes such as vaccination uptake and indicators of appropriate service use.

System Coordination

Daily Operations and System Coordination

- NHS Cheshire and Merseyside will run a BAU system coordination centre as per national specifications continually throughout the winter period. The 0930-system call will remain as a standing call to ensure system visibility
- Enhanced tracking will be in place to ensure continuity of community services via SHREWD real time reporting and via community provider reps on the system call.
- Implementation of an *enhanced Winter Command and Control model from 01 December 2026 through to 31 January 2027*, based on a clear escalation framework that will allow us to respond rapidly and effectively to emerging system pressures.
- This will bring teams together across SCC, EPRR and Clinical to ensure closer collaboration





Infection Prevention and Control

NHS
Cheshire and Merseyside

The impact of infectious outbreaks can both impact the patients directly involved but also wider patient flow due to temporary closure of inpatient beds during decontamination.

The ICB is targeting providers with increased rates of infection and seeking assurance of timely action to address areas for improvement.

Further negotiation in relation to community infection prevention and control direction will take place in order to increase awareness of the underlying factors leading to community onset community acquired infections and explore opportunities for improvement of preventative measures in patients own homes.

In addition to the broader healthcare associated infection rates, an increased focus on localised outbreaks will commence to understand the patient flow impacts caused by delayed decontamination and reopening of in-patient beds.

This work will seek to understand variation in ability to manage, resolve and reset following localised outbreaks. Targeted work will take place with outlier organisations to identify and resolve areas for improvement allowing efficiency in this process.

Meeting of the Board of NHS Cheshire and Merseyside

24 September 2026

Report of the Chief Executive

Agenda Item No: **ICB/09/24/10**

REPORT SUMMARY SNAPSHOT

Required Information	Details				
Responsible Executive Director	Liz Bishop, Chief Executive				
Report approval	**By**	Liz Bishop, Chief Executive			
	Date	24 September 2026			
Presented by	Liz Bishop, Chief Executive				
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				

Report of the Chief Executive (September 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

3.1 Close of Management of Change for bands 8b and below

The staff consultation on the proposed Band 8b and below structure closed on 9 August 2026, following extensive staff engagement through one-to-one meetings, team sessions, drop-ins and written submissions. More than 1,900 emails and Microsoft Teams submissions were received across the management of change and voluntary redundancy processes. Staff broadly recognised the financial pressures facing the organisation and supported the need to simplify structures and reduce costs, while raising important issues around capacity, local working, fairness, job descriptions, equality and service resilience.

Feedback has informed amendments across Health and Integrated Care Commissioning, Finance and Contracting, Clinical, Corporate Services, Governance, and Strategy and Transformation. Changes include revised job titles and reporting arrangements, targeted adjustments to roles and whole-time-equivalent capacity, strengthened provision in areas such as children and young people's commissioning, mental health and neurodiversity, Transforming Care, urgent and emergency care, and primary care contracting. The final structure seeks to balance financial sustainability with the capacity and capability needed to maintain effective services and statutory functions.

Individual outcomes were confirmed in writing on 7 September 2026, with staff either slotted into suitable roles, ringfenced for competitive selection, or placed at risk of redundancy where applicable. There is now a robust process taking place to ensure staff are supported into roles and through recruitment processes.

The voluntary redundancy scheme received 122 applications, of which 73 were approved; agreed exits are planned by 30 September 2026. Recruitment to remaining vacancies will begin from the week commencing 7 September, with the new structure phased in from late September to November 2026. Support remains available through line managers, HR, trade unions, occupational health, wellbeing services and career-development resources.

3.2 Thirlwall Inquiry – Publication of final Report

The Thirlwall Inquiry, which was established to examine events at the Countess of Chester Hospital and their implications following the trial and subsequent convictions of former neonatal nurse Lucy Letby, published its final report on Tuesday, 15th September 2026.

The report detailed 17 NHS-wide recommendations, which can be viewed here: Chapter 45 – Recommendations | The Thirlwall Inquiry

Following publication, the government outlined plans to strengthen NHS safeguarding, accountability and neonatal safety. NHS Cheshire and Merseyside is committed to working closely with partners to respond to these plans and the inquiry's recommendations.

More information about the work of the inquiry – including the final report – is available online here: https://thirlwall.public-inquiry.uk/

3.3 Developing our Governance

As previously reported to the Board we have undertaken a staged and considered process reviewing and strengthening our governance. Further to the summary I previously provided the early part of our work in this area involved strengthening our Executive Committee and developing the ICB's response to our undertakings and more developmental and transformational actions contained within our Single Improvement Plan. This work was undertaken alongside a lengthy management of change process.

The next stage of this process has now been completed subject to final Committee approvals. All ICB committees have undertaken effectiveness surveys, reviewed their terms of reference (which are in final step of committee sign off) and an ICB Governance Handbook has been developed which has been reviewed and endorsed by the Audit Committee earlier this month. The Audit Committee also reviewed and considered a revised draft Risk

Management Strategy which better reflects our new organisational purpose and operating model. The Chair has also undertaken a process of reviewing committee membership, leadership and the portfolio of our assurance committees.

We expect to ask the Board to review and endorse the implementation of this documentation (as a full suite of documents) including minor updates to our SORD at the November meeting.

3.4 Neighbourhood Health Readiness Visit Feedback

NHS England has written to the ICB following the recent Neighbourhood Health Readiness Visit, recognising Cheshire and Merseyside as having a number of areas of good practice that demonstrate strong foundations for neighbourhood health delivery. The letter highlights the system's advanced digital and population health management capabilities, including the implementation of CIPHA across all nine Places and the use of linked data in Liverpool to support proactive care, which has delivered significant reductions in A&E attendances, emergency admissions and GP encounters. NHS England also cited examples of effective neighbourhood working in Wirral, Cheshire East and Cheshire West, commending the system's openness, engagement and progress to date.

The feedback identifies several priorities for the next phase of development, including establishing a sustainable and consistent approach to proactive care across Cheshire and Merseyside, embedding acute sector participation within neighbourhood governance, addressing community waiting times and elective care, strengthening medical leadership, revitalising place-based accountability and scaling successful neighbourhood models across the system. NHS England has encouraged the ICB to share the accompanying readiness assessment with the Board and system partners to support oversight of neighbourhood health priorities and delivery plans over the next 6 to 18 months.

3.5 Launch of Flu 2026 Vaccination Programme

NHS Chehsire and Merseyside 2026 Flu Vaccination Programme launches on 1st October. The flu vaccine helps protect against flu, which can be a serious or life-threatening illness. It is safe and effective and offered through the NHS every year in autumn or early winter to help protect children and people at higher risk of getting seriously ill from flu.

The flu vaccine is recommended for people at higher risk of getting seriously ill from flu. Frontline health and social care workers can also get a flu vaccine through their employer.

For more information about who is eligible and how to book an appointment visit: Flu vaccination - NHS Cheshire and Merseyside

3.6 Transfer of NHS England Direct Commissioning Functions and Office of Pan-ICB Commissioning (OPIC)

Progress continues across the North West in preparation for the transfer of NHS England direct commissioning functions to Integrated Care Boards from 1 April 2027, (subject to approval of the required legislation). The three North West ICBs and NHS England North West continue to make progress in developing the operating model, governance arrangements and workforce planning required to support the transition and establishment of the North West Office of Pan-ICB Commissioning (OPIC).

To support the next phase, a North West Transition Board comprising the three ICBs and NHS England North West has been established. The Board will oversee and drive the transition programme from October 2026 through to the formal transfer of responsibilities on 1 April 2027, ensuring appropriate governance and workforce readiness, operational continuity and risk management throughout the transition period.

In parallel, the three ICBs will establish an OPIC Management Group from November 2026. Working in partnership with the NHS England regional commissioning team, the group will shape the design, operating arrangements and organisational development of OPIC during 2026/27 to ensure a fully functioning office is in place for transfer to LSC ICB as the host from April 2027. The Group will provide executive oversight of planning, performance, workforce, finance, quality, governance and risk, supporting the safe and effective transition and delivery of commissioning functions across the region.

This programme represents a significant step towards establishing ICBs as strategic commissioners and ensuring robust regional arrangements are in place to commission specialised services, health and justice services, and screening and immunisation services at scale across the North West.

3.7 People across Cheshire and Merseyside to get faster mental health support closer to home with new NHS centres

People experiencing mental health problems across Cheshire and Merseyside will get faster, more joined-up care closer to home, as the government announced new mental health facilities for the region as part of a nationwide rollout of up to 159 sites across England.

NHS teams across the country are working towards delivering new mental health centres, offering walk-in support without a referral and without a months-long wait, and new mental health emergency departments, giving people in crisis specialist care in a place designed for them.

Backed by £343 million, the rollout is the biggest redesign of mental health services in a generation.

In Cheshire and Merseyside, plans are underway for five mental health neighbourhood centres and three mental health emergency department schemes. Final locations are subject to designs, procurement, and business case approvals.

Demand for mental health services has risen sharply, particularly among children and young people, with around one in five people experiencing a common mental health condition each year. Too often, people only receive support once they reach crisis point, leaving families without the help they need and placing greater pressure on NHS services.

The new centres will make it far easier for people to get the right help the first time they ask for it, by bringing mental health and specialist teams together under one roof – working alongside GPs, councils, the voluntary sector and families, with direct links into housing and employment support.

The first sites open from autumn this year, with further facilities following from March 2027.

Some of the community hubs will be newly built facilities, while others will be in libraries, banks and other community or high street locations to move care closer to where people live, improving access.

They will all be in the heart of the neighbourhoods they serve and designed as welcoming settings with a non-clinical appearance.

Alongside this, the new mental health emergency departments will provide fast, same-day specialist support for people experiencing a crisis who are medically fit and do not need treatment in A&E.

Working closely with ambulance and police services, they will provide a calm, therapeutic environment where people can be assessed quickly and connected to the right ongoing care, whether that's inpatient treatment, support at home or community services. The national rollout will more than double the number of dedicated emergency departments in England, taking the total to 82.

This is the first phase of a wider rollout set out in the 10 Year Health Plan, backed by £343 million in mental health facilities.

The announcement supports the government's mission to shift care from crisis to prevention, helping people get support earlier and closer to home. It forms part of the forthcoming Mental Health Strategy, which will look beyond the NHS to the role of schools, employers, local government and the voluntary sector in supporting good mental health.

The Mental Health Strategy will be informed by the upcoming recommendations from Professor Peter Fonagy's independent review into prevalence and support for mental health conditions, ADHD and Autism.

By intervening earlier, the government aims to help more children stay in education, more adults remain in or return to work, and reduce the number of people reaching crisis point, helping build a healthier and more resilient Britain.

3.8 More than 12,000 young people in North West vaccinated against MenB in first month

More than 12,000 young people across the North West have received their free Meningitis B (MenB) vaccination as we approach the end of the first month of the programme, demonstrating strong demand for protection against the potentially life-threatening disease.

Meningitis is an infection of the protective membranes that surround the brain and spinal cord, there are several types, and meningitis B can be very serious. It can affect anyone, but is most common in babies, young children, teenagers and young adults. Babies have been offered a vaccine against MenB since 2015, which means teenagers and young adults over the age of 11 have not received this jab.

With students having collected their A-level results in August and made decisions about which universities they would attend, it was important that they protected themselves ahead of the new academic year.

More than 1,000 community pharmacies in the North West have signed up to deliver the programme, helping ensure eligible young people can access the vaccine close to where they live ahead of starting university or college.

The one-off NHS vaccination programme launched on 20 July and offers the vaccine to:

- people born between 1 September 2007 and 31 August 2008;
- people born on or after 21 July 2001 and starting university for the first time this autumn;
- people born on or after 21 July 2001 who are starting in some residential further education colleges for the first time this autumn.

Eligible young people require two doses of the vaccine, given at least 28 days apart, for maximum protection. For those who got vaccinated in the first week of the programme, second doses are due now

MenB disease can develop rapidly and can be life-threatening. Young people starting university are at increased risk because the bacteria can spread through close and prolonged contact, including living and socialising in shared accommodation.

The NHS is encouraging all eligible young people who have not yet booked to take advantage of the free offer and get protected before the start of the new academic year. 17 to 18-year-olds can book via the NHS National Booking Service for appointments at community pharmacies.

All other eligible people are being encouraged to contact a participating pharmacy directly to book an appointment.

3.9 Supporting children and young people experiencing self-harm

Self-harm remains a significant problem for children and young people in Cheshire and Merseyside, resulting in 434.5 hospital admissions per 100,000 (ages 10-24) in 2022/23. This is 30% higher than the rate for England.

Professionals working with children and young people have a duty to support those at risk of self-harm. However, for professionals with no formal mental health training, this can feel like a difficult and overwhelming task.

To address this, Beyond - Cheshire and Merseyside's Children and Young People Transformation Programme - has produced a resource hub designed to help professionals support children and young people experiencing or at risk of self-harm.

Co-created with local mental health and education teams, the goal of the resource hub is to provide simple, accessible and actionable guidance that every professional can use, with or without formal mental health training.

To access the resource hub visit: Self-Harm Professional Resource Hub - NHS Cheshire and Merseyside

3.10 Collaborative working leads to significant improvement in 18-week Referral to Treatment performance across Cheshire and Merseyside

Collective efforts to improve waiting times in Cheshire and Merseyside have resulted in 18-week Referral to Treatment (RTT) performance significantly improving.

Latest data shows an increase in 18-week RTT, from 57% in April 2025 to 65% in June 2026. The statistics also reflect a considerable improvement to the Model Health System quartile that Cheshire and Merseyside sits in when benchmarked nationally.

With the 18-week period covering the entire elective pathway — from GP referral to the start of definitive treatment, these figures reflect the importance of whole system working.

This is a key aim of CMPCs Elective Reform and Transformation Programme, which oversees the co-ordination of performance outputs from CMPC provider trusts.

This includes leading performance meetings, supporting mutual aid and system capacity processes, supporting organisations to mobilise additional capacity and representing the system in national and regional NHS England meetings.

The improvement was supported by additional activity aimed at reducing RTT waiting times in Q4 of last year (up to April 2025) and additional focused clinical triage. An expansion of tier 2 services was supported by national funding secured through a business case submitted by CMPC.

This success shows that efforts by all system partners to streamline pathways and ensure patients are seen in the most appropriate setting at the right time, are resulting in improved waiting times and as a result, a better patient experience.

3.11 Cheshire and Merseyside ICB approves business case for Integrated Referral Model for Elective Care

The ICB has approved a business case supporting implementation of an Integrated Referral Model for elective care across Cheshire and Merseyside.

This includes an interim solution for the remainder of 2026/27 and the commissioning of a longer-term model from 2027/28 onwards. The investment will also support the wider rollout of the Accenda Referral Management System in general practice.

Led by CMPC, this 3-year system-wide programme aims to safely reduce demand on acute-based services by providing clinical triage and outpatient services as part of a new neighbourhood model of care.

This will help cut waiting times, improving patient access and health equity through more care being given closer to home. It will also support the delivery of national planning requirements to decrease waiting lists and improve Referral to Treatment 18-week performance targets.

CMPC's Design Workshop, held in July at Halton Stadium, has helped to support the programme's development of preferred operating models for services and shape service specifications.

With Ear Nose and Throat, Gynaecology, Dermatology, Musculoskeletal and Ophthalmology all part of the programme's first phase, the event focused on working through Single Points of Access and co-designing Tier 2 services across these specialties.

Featuring valuable patient experience and a range of speakers from across the system, with over 115 colleagues on the day, it was very well attended. Thank you to everyone who participated.

3.12 'Left Shift' funding to help build on success of Urgent Community Response services

Over the last 12 months, CMPC's Community Programme has been working to increase awareness and referrals into Urgent Community Response (UCR) services, supporting the left shift from hospital to community.

Across 2025/26, UCR services managed 62,607 referrals that would otherwise have resulted in an Emergency Department attendance. In May 2026 alone, there was a 92% increase compared to May 2027, reflecting the growing demand for urgent community-based care.

Now, following a business case developed by CMPC and ICB partners, Left Shift funding will enable an expansion of UCR service capacity and a further increase in referrals, via two Unscheduled Care Coordination Hubs.

Rather than navigating multiple local referral routes, health and care professionals will use the Hubs as a single point of access to seek urgent support for patients who might otherwise be referred to Emergency Departments. Following a clinical conversation, an experienced practitioner at the Hub will assess a patient's needs and identify the most appropriate onward pathway.

The scheme is expected to deliver a range of quality and performance benefits by reducing ambulance handover delays, 12-hour waits, incidences of 'corridor care,' and improving performance against the four-hour A&E standard.

A key principle is that community services must grow alongside referral increase. Workforce capacity will also be strengthened, enabling more patients to be safely managed at home or within community settings, supporting the left-shift cultural change.

CMPC is now liaising with providers to finalise implementation plans, which includes working with proposed Hub Providers Mersey Care and Wirral University Hospitals Foundation Trust, as well as addressing inequity in existing UCR provision.

3.13 CMPC updates toolkit supporting patient safety in temporary escalation spaces

Initiatives are ongoing across Cheshire and Merseyside to reduce and ultimately eradicate temporary escalation spaces (TES), including corridor care.

Despite trusts aiming to deliver the best possible care for our patients, overcrowding and a lack of capacity mean that some are still being treated in these areas.

A concept conceived in 2024 by CMPC Associate Director of Quality Julie Tunney, The Red Lines Toolkit is designed to ensure the safest, best possible

care for any patient not residing within designated clinical areas when escalation is ongoing, through a robust governance process.

A guide in the form of a checklist for providers during times when TES are used, and corridor care is in place, the toolkit should be followed when wards or emergency departments are escalated, or in additional areas for escalation outside of these locations.

Based around a Proactive Protection Bundle and co-ordinated by CMPC, the toolkit was co-created by healthcare professionals including Place senior leaders, acute providers, North-West Ambulance Service, members of the Care Quality Commission and Healthwatch.

Now, Julie has worked with provider trusts in collaboration with Cheshire and Merseyside System Quality Group (SQG) to bring it up to date, both with current challenges and key national priorities.

New sections include care of patients with mental health conditions, a revision of the assessment of patient risk and governance structures and a focus on managing moral injury amongst staff. Recording the correct evidence and procedures to de-escalate, are also explained.

Following these processes ensures that the experience, safety and well-being of patients and staff are captured, with compliance monitored through the provider Quality Schedules within the NHS Contract. Read the revised Red Lines Toolkit.

3.14 Executive Committee Activity – Covering meetings: 16 July, 23 July, 6 August and 20 August 2026

3.14.1 Purpose

To provide the Board with assurance on delivery, governance, finance, quality and system risk based on discussions and decisions taken by the Executive Committee, and to highlight matters requiring Board awareness or oversight.

3.14.2 Overall Themes

The Executive Committee's work throughout July and August considered a range of issues as follows:

- Agreement and prioritisation of Left Shift transformation programme.
- System-wide urgent and emergency care redesign.
- Financial sustainability and provider oversight.
- Digital transformation and productivity.
- Workforce resilience and organisational development.
- Mental health and children and young people's services.
- Governance, assurance and emergency preparedness.
- Development of 2027/28 commissioning intentions

3.14.3 Key Decisions – 16 July 2026

Board Assurance Framework- recommendation made which were reported to the Board in July

Left Shift Investment Programme – Approved a number of schemes as follows:

- Elastomeric Devices for Home Intravenous Therapy.
- Unscheduled Care Co-ordination / Clinical Assessment Service.
- Integration Referral Management and Expansion of Neighbourhood Care for Elective Services.
- Community Access to Care.
- Non-recurrent funding for Neuro Rehab Online through March 2027.

NICE Technology Appraisal - Approved NICE TA1143

Capital Schemes - Endorsed:

- Countess of Chester CT and MRI replacement programme.
- Ellesmere Port CDC ultrasound expansion.

National Trailblazer Programme - Approved submission of an Expression of Interest to the national Neighbourhood Trailblazer programme.

WorkWell Programme- considered and approved:

- Cheshire and Merseyside WorkWell proposal.
- Programme leadership arrangements.
- Strategic posts and analytical support.
- Procurement development.

PFI – approved alignment of PFI funding arsing from IFRS16 PFI reductions with national policy

3.14.4 Key Decisions – 23 July 2026

Diagnostics Transformation - Supported:

- Cheshire and Merseyside-wide phlebotomy redesign programme.
- System-wide point-of-care testing framework and governance model.

Transition Pathway Policy - Approved:

- Cheshire and Merseyside Transition Policy for young people moving into adult services.
- First-year implementation arrangements.

Emergency Preparedness - Approved:

- Updated Incident Response Plan.
- Revised EPRR Policy.

IACT Workforce Review - Approved:

- Recruitment to establishment during a period of management of change .
- Revised staffing structure.
- Continued transformation programme.

CHC Backlog Recovery Approved:

- Investment for backlog recovery.
- Community Fast Track pilot.
- Interim specialist review capacity.

3.14.5 Key Decisions – 6 August 2026

Digital Productivity Programme - Approved:

- Establishment of a Digital Productivity Programme.
- Phased rollout of Microsoft 365 Copilot and related tools.
- Managed approach to Copilot licence allocation.
- Identification of pilot teams and digital champions.

NICE Technology Appraisals – Approved NICE TA for Semaglutide and Sodium Zirconium Cyclosilicate

Financial Governance Review – considered

- Financial Governance Review findings.
- Associated improvement action plan.
- Continued monitoring through Finance and Investment Committee and Audit Committee.

Digital UEC Solutions - Approved:

- SHREWD
- STRATA ED Streaming

Community Diagnostic Centre (Blacon) - Endorsed support for the Countess of Chester Community Diagnostic Centre proposal, subject to further assurance regarding utilisation, productivity and cross-border impacts.

3.14.6 Key Decisions – 20 August 2026

North West IFR Service - Approved preferred option for NHS GM to host the North West Individual Funding Request and Policy Development Service, subject to final agreement on costs, governance and transition arrangements.

2027/28 Commissioning Intentions - Supported a focus on:

- Prevention.
- Neighbourhood health.
- Frailty.
- Community services.
- Primary care redesign.
- Use of commissioning levers to accelerate Left Shift transformation.

Children and Young People's Mental Health Plan

- Noted delivery against the 2024-26 plan.
- Endorsed the 2026/27 refreshed plan and supported its sharing with Board
- Requested stronger metrics, outcomes, health inequalities reporting and commissioning focus prior to Board approval.

Workforce Skills and Development Audit - Approved:

- Organisational capability and skills assessment programme.
- Alignment with appraisal, succession planning and workforce development processes.
- Future use of findings to shape organisational development priorities.

VCFSE Memorandum of Understanding – Supported

- Continued and stronger partnership working with the VCFSE sector.
- Requested further development and financial assessment before reconsideration.

Assurance business undertaken included:

Financial Position - Noted:

- ICB break-even Quarter 1 position.
- Continuing pressures in ADHD, reablement and continuing care.
- Pressures within the provider sector as reported to the Board through th finance report

Quality and Patient Safety considered:

- Growing mental health delays within Emergency Departments, including waits for specialist input exceeding 200 hours.

- Ongoing response to Operation Decker.
- Quality concerns related to a secure mental health site
- Strengthening escalation and governance arrangements for quality risks.

Urgent and Emergency Care - considered

- Strengthened oversight of winter planning.
- Supported formal reporting from locality UEC Boards.
- Prioritised frailty, mental health pathways, children's services and community capacity.
- Continued development of stakeholder engagement and communications.

Provider Oversight - Month 4 highlighted:

- Ongoing pressure from prescribing, ADHD, mental health packages and acute activity.
- Positive provider oversight meetings with major trusts.
- Development of a Performance Accountability Framework.
- Relaunched System Quality Oversight Group.

4. APPENDICES

N/A

5. Officer contact details for more information

Liz Bishop
Chief Executive

Laura Cassidy, Business Manager to Chair and Chief Executive,
laura.cassidy@cheshireandmerseyside.nhs.uk

NHS
Cheshire and Merseyside

Meeting of the Board (Public) of NHS Cheshire and Merseyside

24th September 2026

ICB Financial Position – Month 5

Agenda Item No: ICB/09/24/26/11

Responsible Director: Andrea McGee, Executive Director of Finance

ICB Financial Position – Month 5

1. Purpose of the Report

1.1 This report updates the Board on Cheshire and Merseyside ICB's financial performance at Month 5 of 2026/27.

2. Executive Summary

2.1 The ICB is reporting a breakeven position at Month 5.

2.2 The Cost Reduction and Efficiency Schemes (CRES) programme is reporting a £0.2m favourable variance year-to-date. The full £144m CRES target has now been identified, with schemes totalling £154m. Delivery is expected to continue throughout the remainder of the financial year; however, the risk-adjusted forecast indicates a small residual risk of £1.2m.

3. Financial Position as at Month 5

3.1 As per the summary table below, the ICB is reporting a breakeven position at Month 5. A brief commentary on the key lines of expenditure is provided below.

ICB Total	C&M ICB TOTAL - Month 5 Position		
	Budget £'m	Actual £'m	Variance £'m
Acute	1,581	1,580	1
Community	314	313	1
Mental Health - Contracts	253	255	(2)
Mental Health - Packages of Care	96	103	(7)
CHC	197	193	5
Delegated GP	264	262	2
Delegated Other - DOP	146	127	19
Prescribing	231	237	(5)
Primary Care Other	55	56	(1)
Other Commissioned Services	9	9	0
Other Programmes	14	18	(4)
Reserves	(7)	0	(7)
Specialised Commissioning	356	356	(0)
Sub Total - Programme Expenditure	**3,509**	**3,509**	**(0)**
Running Costs	18	18	0
TOTAL EXPENDITURE	**3,527**	**3,527**	**0**
Surplus / (Deficit) Plan	*0*	*0*	*0*
Sub Total - Net Surplus / (Deficit) Reported	***3,527***	***3,527***	***0***

- **Acute Services £1m favourable:**
  NHS Trusts are reporting an adverse variance of £0.2m, driven by overspends against Advice & Guidance and Urgent & Emergency Care activity. This is partially offset by lower-than-planned Elective and Diagnostic activity.

  Independent Sector providers are reporting a year-to-date underspend; however, they remain forecast to deliver activity in line with agreed annual plans.

- **Community Services £1m favourable:**
  Re-ablement budgets are overspent year-to-date, driven by increased expenditure on packages of care in Knowsley and Cheshire. This pressure is partially offset by favourable prior-year underspends within Intermediate Care and Community Equipment budgets.

- **Mental Health Contracts (£2m) adverse:**
  Overspend YTD due to new market entrants. Indicative Activity Plans (IAPs) have been issued to these providers to manage activity levels for the remainder of 2026/27.

- **Mental Health Packages of Care (PoC) (£7m) adverse:**
  The overspend is driven by an increase in patient numbers and higher expenditure on Mental Health inpatient care and Mental Health Act related (s117, MH & LD) placements.

- **Adult Continuing Care (AACC) £5m favourable:**
  Lower than budgeted patient numbers and underspends against Personal Health Budgets, Fast Track PoC, and Funded Nursing care are driving a favourable variance year-to-date.

- **Delegated Primary Medical Services £2m favourable:**
  Primary Care budgets are reporting a favourable variance, driven by a £1.5m one-off benefit brought forward from 2025/26 relating to activity-based payments, including QOF and Minor Surgery. A further £0.5m in-year underspend has arisen from the national patient list cleansing exercise and activity-based payments remaining consistent with those seen in 2025/26.

- **Pharmacy, Optometry and Dental (POD) £19m favourable:**
  Of the £19.0m underspend reported at Month 5, £6.0m relates to 2026/27 dental activity for which there are currently no confirmed contractual commitments. This position is being closely monitored, recognising that it remains early in the financial year and that a proportion of these funds may yet be required as commissioning plans and contractual arrangements are finalised.

  A further £12.0m relates to prior-year adjustments, reflecting actual activity levels that were lower than originally forecast.

- **Prescribing (£5m) adverse:**
  The prescribing position is based on Month 3 data, the latest information available. A year-to-date pressure of £5.3m is reported at Month 5, reflecting prescribing expenditure above plan. Key drivers include elevated concessionary prices, medicines returning to tariff, and wider prescribing cost pressures. These increases are partially offset by savings across several drug categories.

- **Other Programme (£4m) adverse:**
  The Grip and Control savings target is held within the Other Programme budget; however, delivery is expected to be reflected through underspends across other budget areas.

- **Reserves (£7m) adverse:**
  The adverse variance on reserves is driven by a combination of unidentified CRES at the planning stage (£29m) and expected savings from a balance sheet review (£3m).

4. Forecast Outturn

4.1 Year end forecasts have formed part of the formal reporting to the Finance, Investment, and Contracting Committee with effect from month 4. This is earlier than would typically be the case and provides greater assurance over grip, control and the robustness of financial reporting.

4.2 The forecasting model has been developed with Price Waterhouse Coopers (PwC) colleagues to validate the methodology and ensure the resulting output is robust and reliable.

4.3 The month 5 forecast outturn remains aligned to the ICB's 2026/27 Financial Plan, i.e. delivering a breakeven position.

4.4 Key forecast risks relate to a Contracts Review, Mental Health Packages of Care, and Prescribing. These budget areas will continue to be subject to active monitoring and management.

4.5 Senior commissioning colleagues and budget holders will be more closely involved in the forecasting and financial review process to strengthen ownership and accountability.

4.6 Any emerging headroom will be proactively managed to support the restoration of the left-shift allocation to its original planned level.

4.7 The forecast will continue to be reviewed and refined monthly to ensure emerging risks or opportunities are identified and addressed at the earliest opportunity.

5. CRES Delivery

5.1 The CRES reported as of 31st August 2026 is £0.2m favourable. This reflects the phasing of unidentified savings included in the ICB's original financial plan. All savings have now been identified and are profiled for delivery later in the financial year.

Programme / Workstream	CRES Target (Plan) (£000's)	Additional CRES Target (£000's)	Total CRES Target (£000's)	YTD Plan M5	YTD Actual M5	YTD Variance M5
ADHD	4,216	1,000	5,216	726	1,592	866
Contract and Investment Review	10,953		10,953	392	375	-16
Digital	1,000		1,000	10	365	355
Estates	2,246		2,246	453	170	-283
Grip & Control	12,500	5,873	18,373	4,943	10,414	5,471
Independent Sector Contract Management	5,000	4,000	9,000	781	1,563	782
Individual Patient Commissioning	23,794		23,794	6,059	6,661	602
Management Cost Reductions	21,897		21,897	7,056	6,972	-84
Mental Health Redesign	3,611		3,611	873	170	-703
Planned Care	2,000	3,000	5,000	0	0	0
Prescribing	25,512	22,354	47,866	12,581	17,601	5,020
Urgent & Emergency Care	3,000	2,000	5,000	0	0	0
Unidentified	28,302	-28,302	0	11,793	0	-11,793
Grand Total	**144,030**	**9,925**	**153,955**	**45,667**	**45,882**	**216**

5.2 The current forecast is £9.1m above plan. When risk-adjusted to reflect current delivery status, this reduces to a forecast risk of £1.2m below plan.

5.3 Work is on-going to continue to move schemes through the pipeline into fully implemented to ensure the plan is delivered.

6. 26/27 Contract Status

6.1 The main contracts being negotiated include:

- 15 - Local Acute, Community and Mental Health Providers
- 24 - Local Independent Sector (IS) Providers
- 16 - Out of Area Providers where the ICB is a 'co-commissioner'

6.2 All local contracts for Cheshire and Merseyside NHS providers have now been agreed.

6.3 All 24 Independent Sector provider contracts have now been agreed.

6.4 For out-of-area NHS Trust contracts, all contracts have now been agreed and are progressing through the signature stage.

6.5 Work is also progressing on negotiating all other contracts but is being prioritised as current resource allows based on contract size and risk, however due to the sheer volume involved, some contracts may continue implied terms for a period.

7. Cheshire & Merseyside ICS Position

7.1 From 2026/27, NHS trusts and ICBs are expected to deliver breakeven positions as individual organisations, replacing the previous emphasis on system-wide control totals. However, the financial position across the Cheshire and Merseyside system is still critical to ICB success and overall sustainability.

7.2 At month 5 there is a £24m adverse variance to plan. Two providers are reporting adverse variances, largely driven by the impact of Industrial Action and non-delivery of Cost Improvement Plans (CIP).

8. Risks and Mitigations

8.1 The key financial risks at Month 5 are as follows:

- 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 cost pressures relating to concessions / drug tariff increases continue at or above the levels seen year-to-date.
- 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.

8.2 Mitigating actions are in place. These include strengthened grip, control and oversight of the CRES programme, together with a revised approach to contract management and performance oversight. The ICB continues to be scrutinised through Financial Performance Review Meetings (FPRM's) with PWC and NHSE.

8.3 The Finance Committee is undertaking detailed reviews of key areas of financial risk. Risk and mitigations will continue to be actively monitored and reported through the Executive Committee, Finance Committee and FPRM process.

9. Recommendations

9.1 The board is asked to:

- Note the ICB and ICS financial position at month 5 (August 2026); and
- Acknowledge the financial risks highlighted within this report.

Andrea McGee
Executive Director of Finance and Contracting, NHS Cheshire and Merseyside.
andrea.mcgee@cheshireandmerseyside.nhs.uk

Meeting of the Board of NHS Cheshire and Merseyside

23rd July and 19th August 2026

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

Agenda Item No: **ICB/09/24/26/12**

Committee Chair: **Sue Lorimer**

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	23rd July and 19th August 2026

Key escalation and discussion points from the Committee meetings

Alert

Month 4 Financial Performance & Forecast Outturn

The ICB is reporting a break-even position at Month 4, however, there are some emerging financial risks, including ADHD activity above budgeted levels, an increase in the number and cost of Mental Health Packages of Care, and prescribing overspends.

A number of reasons for prescribing overspends were set out as beyond the control of the ICB and the Committee agreed that a deep dive into prescribing expenditure would be of value at the next meeting.

ADHD expenditure remains difficult to control as new independent providers can undertake activity before the ICB is aware.

Contract management for existing ADHD providers is operating effectively and a new specification is being developed to help manage the risk of new market entrants.

Underspends in Primary Care dental services were offsetting most of the overspends. The Committee agreed that wherever possible dental funding should be used for dental services.

To strengthen financial oversight and assurance, a year-end forecast position has been introduced from Month 4 onwards.

The forecast process indicates that, whilst the ICB remains at break-even at Month 4, significant risks remain in prescribing, ADHD services, mental health packages of care and community services. Forecasting capability will continue to be refined and used to drive corrective action where adverse trends emerge.

CRES Delivery

CRES delivery is ahead of plan YTD (£1.5m), delivery risk remains as 62% of savings are dependent on schemes scheduled to deliver on the second half of the year. Contract and investment reviews are delayed which may restrict the ability to release savings in 2026/27.

The committee continues to monitor progress at scheme level, and deep dives are taking place monthly, targeting high-risk areas.

Individual Assessment & Commissioning (IAC) Capacity

Workforce shortages continue to impact assessment performance, backlog reduction and delivery of associated financial efficiencies. Performance against the 28-day assessment target has deteriorated.

Investment in additional management capacity has been approved and is targeted at improving performance and an OD programme is under way.

Updates to the Operational Scheme of Reservation and Delegation (OSORD)

Members were advised that some of the existing categories and column headings no longer accurately reflected the organisation's revised structures and approval responsibilities.

It was explained that the separate category for ICB Executive Directed Clinical would be removed and replaced with a single category covering all ICB Executive Directors. Members noted that this was a clarification of existing arrangements and would not result in any changes to the current authorisation limits delegated to Executive Directors.

The committee agreed to recommend to the Board that the changes are implemented, pending a Board review of a suite of governance documents in November.

System Financial Risk

A System-wide financial deficit of c£16.6m is reported at Month 4, driven largely by industrial action cost and impact on activity income, and CIP under-delivery. This is an in-month deterioration of £10m which is accounted for by a single provider.

Advise

Specialised Commissioning

The committee received a report on Specialised Commissioning Financial Performance at Month 3. Q1 Performance is in-line with plan. All contracts are agreed with a small number of Indicative Activity Plans outstanding. Data quality and historic local pricing continue to limit clear service-level analysis.

The Committee concluded that a broader strategic review is required to ensure specialised commissioning expenditure aligns with population need, outcomes and wider system priorities, and has requested further work through the Executive Committee.

ICB Financial Performance Review (FPRMs)

A quantitative internal assessment indicated that the ICB should not currently be expected to remain within FPRM, but a final decision is subject to qualitative judgement and review of the Month 4 forecast.

Deconstructing Block Contracts (DtB) for Mental Health and Community

The committee received a report on a national exercise that is underway to deconstruct block contracts and better understand the relationship between activity, costs and funding.

Findings are expected to inform future commissioning approaches from 2027/28 and improve alignment between investment, activity and outcomes.

The final submission and findings are to be presented to the committee in September.

Sustainable Services (Southport & Ormskirk)

A formal programme has been established to support the transition to financially sustainable services through a managed tapering arrangement supported by NHSE and PwC oversight.

A formal governance group will be established. This will ensure the tapering plan demonstrates sustainable reductions in support requirements and maintains transparent governance over any significant decisions.

A detailed roadmap will be developed for Board consideration.

26/27 Budget Setting

The committee reviewed the budget setting process for 2026/27 and endorsed deeper review of community services, mental health contracts and commissioning arrangements. It also requested clearer evidence of how commissioning decisions translate into activity shifts, contract values and expenditure patterns.

Primary Care Commissioning Reform

A review of Local Enhanced Service schemes continues.

Future proposals will seek greater consistency, standardisation and alignment with neighbourhood health and out-of-hospital care ambitions whilst maintaining investment within primary care.

Financial Governance

The Financial Governance Review confirmed progress in strengthening controls, oversight, contract governance and programme management.

The focus is now shifting towards the development of a longer-term financial strategy.

Dental pathway and reinvestment

The Committee supported the principle that any dental underspends should, wherever possible, be reinvested to improve access, activity and outcomes across the whole pathway.

Left-shift investment

The Committee approved £5m non-recurrent investment from the left-shift reserve, linked to service improvements and access to additional external funding.

Assure

Contracts

The committee noted that contracts have been agreed with all 15 local NHS Trusts.

Members were advised that contracts had been agreed with all major independent sector providers and that approximately £9m of savings had been secured through contract management activity.

The Committee also noted that out-of-area contracts were progressing through signature stages

Capital Funding

The Committee approved letters of support for 2 schemes:

- The Countess of Chester CT & MRI replacement programme.
- The Blacon Community Diagnostic Centre after considering strategic fit, anticipated benefits, value for money and governance arrangements.

Third Sector Commissioning Review

Work is underway to establish a robust annual expenditure baseline and develop a clearer strategic commissioning model aligned to neighbourhood and prevention priorities.

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**

Corporate Risk Register risks	
Financial Sustainability / Recovery	Ongoing oversight of CRES delivery, system financial pressures, and provider risks. Emphasis on strengthening grip and control, increasing maturity of CRES schemes, and aligning recovery actions to strategic programmes.

Board Assurance Framework Risks	
Risk Title	**Key actions/discussion undertaken**
BAF risk P13	An updated Board Assurance Framework Risk P13 (Financial Sustainability and Productivity) was reviewed. The committee agreed controls remain effective and performance should continue to improve if current trajectory is maintained.

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	Enhanced forecasting arrangements introduced, and financial recovery programme monitored through monthly governance processes.
Contracting & Procurement	All material contracts agreed, supporting delivery of system financial plans and contractual certainty.
System Transformation	Continued oversight of demand management and service transformation initiatives designed to improve sustainability and shift activity into community settings.

Meeting of the Board of NHS Cheshire and Merseyside

24th September 2026

Integrated Performance Report

Agenda Item No:	**ICB/09/24/26/13**
Responsible Director:	**Jude Adams: Interim Executive Director of Strategy and Transformation (Turnaround)**

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 September 2026, see appendix one, provides an overview of key metrics drawn from the Operational plan, specifically covering Urgent Care, Planned Care, Diagnostics, Cancer, Mental Health, Learning Disabilities, Primary and Community Care, All Age Continuing Health 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.

2.3 The report has been enhanced as part of a wider piece of work to review the metrics, with the aim of providing clear assurance against statutory duties and strategic priorities.
The design of this report has been amended and aligns closely with best practice and has been made clearer where performance is not achieving plan. The report now also aligns with the ICB's life-course framework.

2.4 Exception reporting now follows best practice, incorporating a 'What, Why, How & When' approach. This is to provide greater assurance for the audience.

2.5 A considerable number of new metrics were recommended for inclusion following discussions with Exec Directors, Non-exec directors and subject matter experts from within the ICB. A working group was established to consider these, and new metrics are now included in the 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.

Implications and Comments

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 which also links to the Board Assurance Framework.

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 ICB Board.

15. Officer contact details for more information

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

16. Appendices

Appendix One: Integrated Quality and Performance report

NHS
Cheshire and Merseyside

Integrated Performance Report

ICB Board

24th September 2026

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Executive Summary

Areas showing improvement

- **Elective recovery continues to strengthen**, with CYP 52-week waits reducing significantly in July (down by 108 patients month-on-month), alongside continued improvement in overall long-wait performance.
- **Urgent and Emergency Care performance is showing some positive movement**, with ambulance handover times improving, emergency admissions for people aged 65+ remaining below plan, and bed occupancy continuing to reduce.
- **Cancer performance remains comparatively strong**, with the 62-day standard on track for year-end delivery and continuing to outperform the England average by around 5%.
- **Smoking prevalence continues to improve**, demonstrating ongoing special-cause improvement following targeted prevention and cessation interventions.
- **Breast screening improvement actions are beginning to demonstrate impact**, with evidence of significant uptake improvements in some programmes and practices.
- **The ICB remains financially on plan**, reporting a balanced year-to-date position and forecasting delivery of a breakeven position for 2026/27.
- **Oversight Framework ratings and rankings have improved across a number of providers**, indicating strengthening organisational performance across the system.

Areas of concern

- **Urgent and Emergency Care remains under significant operational pressure**, with A&E 12-hour waits deteriorating for three consecutive months and delayed discharge continuing to constrain flow across the system.
- **Diagnostic performance remains off trajectory**, with July performance worsening against plan and continued deterioration amongst independent sector providers offsetting gains made by NHS providers.
- **NHS dental access remains below trajectory**, with activity plateauing and national contract reforms not yet delivering the required increase in patient access.
- **Cancer Faster Diagnosis Standard performance remains below plan**, driven primarily by underperformance in breast and lower GI pathways at several providers.
- **Population health outcomes remain below ambition**, including smoking prevalence, cervical screening uptake, MMR vaccination coverage, hypertension control and cholesterol management, with persistent inequalities across places and population groups.
- **Frailty-related admissions remain above target**, continuing to place pressure on bed capacity, discharge pathways and urgent care services.
- **East Cheshire remains a mortality outlier**, with SHMI above the expected range for a sustained period and continued concerns regarding mortality following pneumonia, non-elective admissions and post-discharge outcomes.
- **Financial risks remain significant despite a balanced position**, particularly around prescribing costs, mental health packages, ADHD demand growth, non-elective activity and delivery of planned efficiencies.

Headlines by life course (1)

Starting Well

Areas of concern

Limited assurance available as key performance narratives and exception reporting are not yet fully populated

Areas showing improvement

Reporting framework and metrics continue to be developed to strengthen oversight and assurance

Growing Well

Areas of concern

CYP elective waits remain above standard

Recovery remains heavily dependent on performance improvement at AHCH

Demand continues to exceed capacity across key paediatric specialties

Areas showing improvement

CYP 52-week waits reduced significantly

Additional funding, validation activity & capacity management arrangements continue to support elective recovery

Living Well

Areas of concern

Diagnostic waits remain above trajectory

NHS dental access remains below trajectory

Several providers continue to dace operational and capacity constraints affecting elective recovery and long waits

Areas showing improvement

52-week RTT performance close to national standard than in previous reports

C&M ICB remain a strong performer nationally for diagnostics

Headlines by life course (2)

Ageing Well

Areas of concern

A&E 4 & 12 hour performance below trajectory and shows little sustained improvement

NCTR and discharge levels remain high continuing to constrain patient flow

Areas showing improvement

Ambulance handover performance has continued to recover

Bed occupancy has improved

Frailty programmes, discharge initiatives and community alternatives being expanded to support

Dying Well

Areas of concern

ECT remains a mortality outlier with SHMI above expected range and increasing

Higher than expected deaths occurring within 30 days of discharge require ongoing oversight

Sustained quality improvement action required to address the underlying drivers

Areas showing improvement

System wide mortality performance remains within expected levels across majority of providers

Enhanced governance and quality improvement activity in place to support recovery at ECT

Living Healthy Lives

Areas of concern

Cancer FDS remains below planned trajectory

Cervical screening and MMR uptake below national ambitions

Hypertension control and cholesterol management remain below ambitions

Areas showing improvement

Smoking prevalence continues to show special cause improvement

Breast screening programmes are demonstrating positive impact

Cancer 62-day performance outperforms England average

Starting Well

Starting Well

Starting Well - Summary Icon Table

Metric	Latest Month	Actual	Plan/Target	Variation	Assuarance	Plan Met	Region Value	National Value	ICB Rank
Still birth per 1,000 (rolling 12 months)	Jul-26	2.61	2.60				n/a	3.80	n/a
Pre Term Births (NEW)	Jul-26	139	TBC			TBC	n/a	n/a	n/a
Breast Milk at First Feed % (NEW)	Jul-26	66.5%	TBC			TBC	n/a	n/a	n/a

Growing Well

a) 52 week waits for CYP

Growing Well

Growing Well - Summary Icon Table

Metric	Latest Month	Actual	Plan/Target	Variation	Assuarance	Plan Met	Region Value	National Value	ICB Rank
Number of 52+ week RTT waits, of which children under 18 years.	Jul-26	445	0				n/a	n/a	n/a
Number of unique patients seen by an NHS Dentist – Children (12 month)	Jul-26	344,489	338,408				1,057,712	7,386,084	n/a

RTT 52-week waits for CYP

NHS
Cheshire and Merseyside

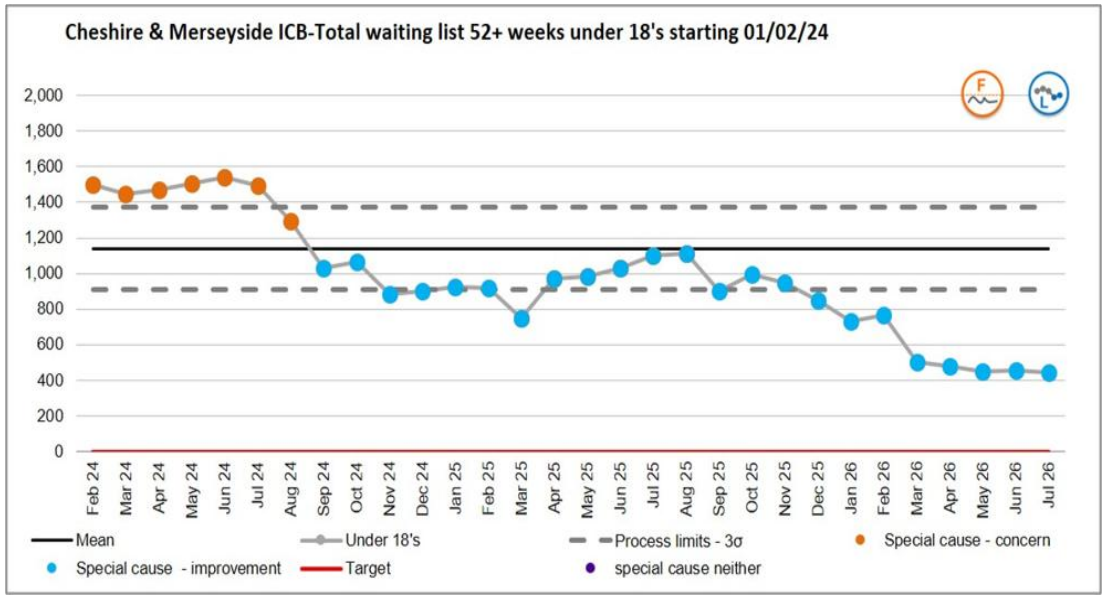
Outcome:

No patient should wait longer than 52 weeks for elective treatment, supporting timely care and better long-term outcomes

Measure of Progress:

Eliminating the children and young people under 18 waiting in excess of 52 weeks for elective care. The target for this metric is zero

Executive Lead: Jude Adams



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

1. Performance Gap ("The What")

- 337 CYP patients were waiting over 52 weeks at July 2026 month end, a decrease of 108 patients from the previous month.
- Performance remains above the national standard of zero 52-week waits.
- AHCH accounts for 157 patients (35%) of the cohort, representing the largest area of risk.
- Current recovery activity is not yet reducing the backlog quickly enough to offset new patients reaching 52 weeks.

2. Root Cause Analysis ("The Why")

- Demand in key paediatric specialties continues to exceed available capacity.
- 35% of long waits are concentrated at AHCH, making system recovery heavily dependent on a single provider.
- Workforce and theatre capacity constraints have limited activity growth.
- Specialist paediatric pathways offer limited opportunities for mutual aid across providers.
- Historical data quality and forecasting challenges reduced proactive management of long waits, while validation continues to identify pathways requiring review.

3. Impact & Risk ("The "So What")

- 337 CYP patients remain in breach of the constitutional standard, increasing the risk of delayed treatment and poorer patient experience.
- Continued non-compliance exposes the system to ongoing reputational risk.
- Recovery remains vulnerable due to the concentration of long waits at AHCH and the risk of new patients entering the 52-week cohort.

4. Recovery Plan & Trajectory (The "How & When")

- Six providers remain in the NHS England elective tiering framework with targeted recovery plans and fortnightly CMPC oversight.
- Additional NHSE funding is supporting clinical triage and validation of patients waiting over 27 weeks, delivering 20-30% pathway removals.
- System-wide capacity management and additional regional investment are being used to optimise capacity, increase activity and support inter-provider collaboration.
- Recovery efforts focus on reducing the existing 52-week cohort and preventing new breaches, with progress monitored through established C&M governance forums throughout 2026/27.

Living Well

a) 52-week waits
b) Diagnostics
c) NHS Dentist Adult Access

Living Well

Living Well - Summary Icon Table

Metric	Latest Month	Actual	Plan/Target	Variation	Assuarance	Plan Met	Region Value	National Value	ICB Rank
The % of people waiting less than 18 weeks on the waiting list (RTT)	Jul-26	65.7%	65.0%				64.5%	65.3%	17/36
The % of people waiting more than 52 weeks on the waiting list (RTT)	Jul-26	1.3%	1.1%				1.4%	1.5%	18/36
Patients waiting more than 6 weeks for a diagnostic test	Jul-26	13.2%	8.9%				13.5%	23.1%	6/36
Number of unique patients seen by an NHS Dentist – Adults (24 month)	Jul-26	956,751	966,320				2,693,840	18,464,234	n/a
% of urgent GP appointments seen within 24 hours (NEW)	Jul-26	79.8%	79.4%				78.1%	76.4%	n/a
Percentage of ICB inappropriate out of area placement bed days in Adult acute beds	Jun-26	2.0%	TBC			TBC	1.7%	2.0%	21/36

52-week waits

Cheshire and Merseyside

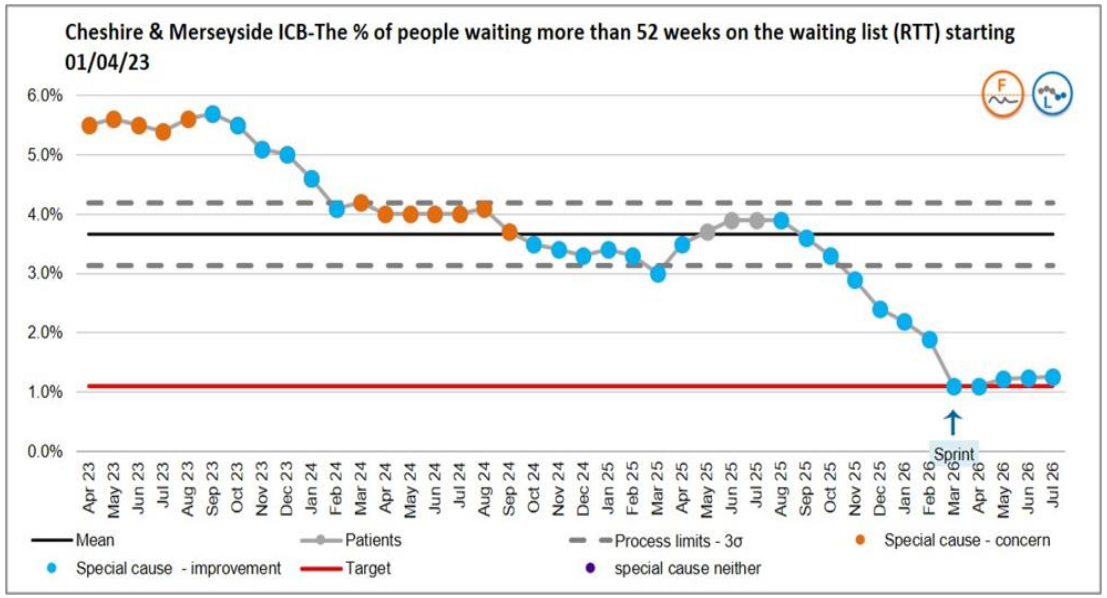
Outcome:

Patients receive planned hospital treatment in a timely manner, with the number and proportion of patients waiting longer than 52 weeks reduced to zero.

Measure of Progress:

A reduction in the percentage of patients on an incomplete RTT pathway who have been waiting more than 52 weeks from referral without starting treatment.

Executive Lead: Jude Adams



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

1. The Performance Gap (The "What")

- Performance remains slightly behind the planned trajectory.
- Despite the shortfall against plan, C&M performance has improved significantly and remains closer to the national standard of less than 1% than in previous periods.
- MWL is currently the most challenged provider while ECT continues to experience performance deterioration following implementation of its trust-wide EPR system.

2. Root Cause Analysis (The "Why")

- Ongoing operational capacity constraints across a number of providers have limited the pace at which long-waiting patients can be treated.
- ECT has experienced reduced productivity and pathway disruption following deployment of its new Electronic Patient Record (EPR) system.
- Variation in specialty-specific demand, combined with insufficient elective capacity in some organisations, has slowed the reduction of 52-week waiters.

3. Impact & Risk (The "So What")

- Failure to achieve the 52-week RTT standard increases the risk of continued non-compliance with national elective recovery expectations.
- Extended waits can adversely affect patient outcomes, experience & confidence in elective services.
- Continued underperformance may result in increased regulatory oversight, including NHSE tiering, and could impact wider elective recovery trajectories and waiting list reduction plans.

4. Recovery Plan & Trajectory (The "How & When")

- Six trusts are currently in NHSE Tiering and are delivering agreed improvement plans supported by regular oversight and performance review meetings.
- The CMPC Elective Team holds fortnightly review meetings with providers, with escalation processes in place to address emerging risks and delivery issues.
- The C&M Q4 recovery programme, supported by additional NHSE funding, is increasing clinical triage of patients waiting over 27 weeks, achieving 20-30% pathway removals.
- A System Capacity Management Process is being implemented to maximise elective hub utilisation and inter-provider support, while additional regional funding will provide further capacity to reduce long waiters and overall waiting list size during Q4 and beyond.
- Progress will be monitored through the C&M Clinical Operational Group, CMPC COO Group and Delivery Board, with expected trajectory improvement through the remainder of the financial year.

Diagnostic waits >6 weeks

NHS Cheshire and Merseyside

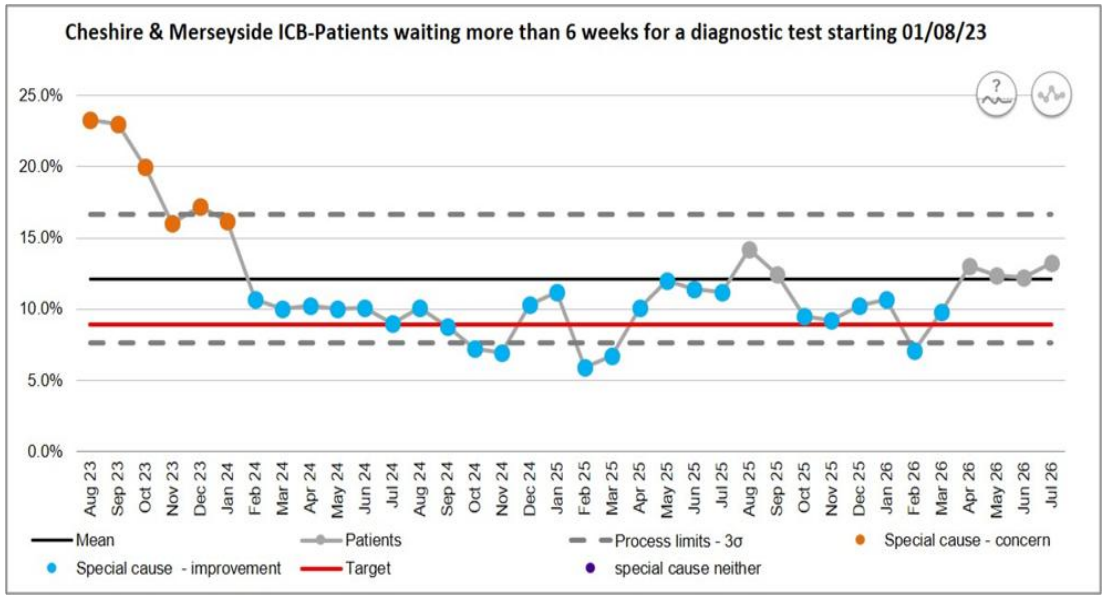
Outcome:

Patients receive timely access to diagnostic tests, enabling faster diagnosis, earlier treatment and improved clinical outcomes

Measure of Progress:

A reduction in the % of patients waiting over 6 weeks from referral to a diagnostic test. There are monthly trajectories towards the end of year target of 5.7%

Executive Lead: Jude Adams



Patients waiting more than 6 weeks for a diagnostic test

1. The Performance Gap (The "What")

- In July, 13.2% of patients were waiting more than 6 weeks for a diagnostic test, compared against a planned position of 8.9%.
- C&M ICB ranking reduced from 5th to 6th nationally. The only ICB ranking above C&M serving a similar sized population and waiting list volume is Greater Manchester.

2. Root Cause Analysis (The "Why")

- **Independent Sector Providers:** Performance amongst Independent Sector Providers contracted via the ICB through the AQP framework continues to deteriorate, with 30.8% of patients waiting 6+ weeks. This remains a significant contributor to the overall system performance gap.
- **Endoscopy Capacity Constraints:** Despite improvements to Endoscopy performance, this continues to be the most significant system wide challenge with Colonoscopy, Gastroscopy and Flexi-Sigmoidoscopy performance remaining below the required levels.
- **Mersey and West Lancashire Teaching Hospitals:** Most significant diagnostic performance challenge. Performance pressures are evident across several tests, most notably for NOUS, with the provider holding the largest cohort of patients waiting 6+ weeks for this test of any provider in the system.

3. Impact & Risk (The "So What")

- **Value for Money:** Independent sector providers contracted through the ICB to deliver tests for NHS funded patients are not demonstrating optimal value for money. Patients are experiencing longer waiting times for tests than those seen within local NHS providers.
- **Patient Pathway Delays:** Longer waiting times for patient diagnosis, increased patient anxiety and poor experience with an adverse impact on cancer and elective pathways.
- **System Risk:** Delivery of C&M planned performance trajectory remains at risk and continued deterioration within Independent Sector Providers is offsetting NHS provider improvements.

4. Recovery Plan & Trajectory (The "How & When")

- Independent sector provider underperformance continues to be escalated to ICB contracts team.
- System Endoscopy 6-4-2 improvement meeting to be implemented from the 17th September, with a focus on Endoscopy recovery and optimisation of Endoscopy Hub capacity. August reflected the highest reporting month for C&M Endoscopy Hub utilisation.
- Targeted support to MWL including a diagnostic performance review visit held on the 3rd September to review recovery actions and plans to drive performance improvement. Follow up meeting held with the MWL COO on the 9th September. Performance improvements evident from the 26th July onwards (WLMDS weekly dataset).

NHS Dentist Adult Access

NHS Cheshire and Merseyside

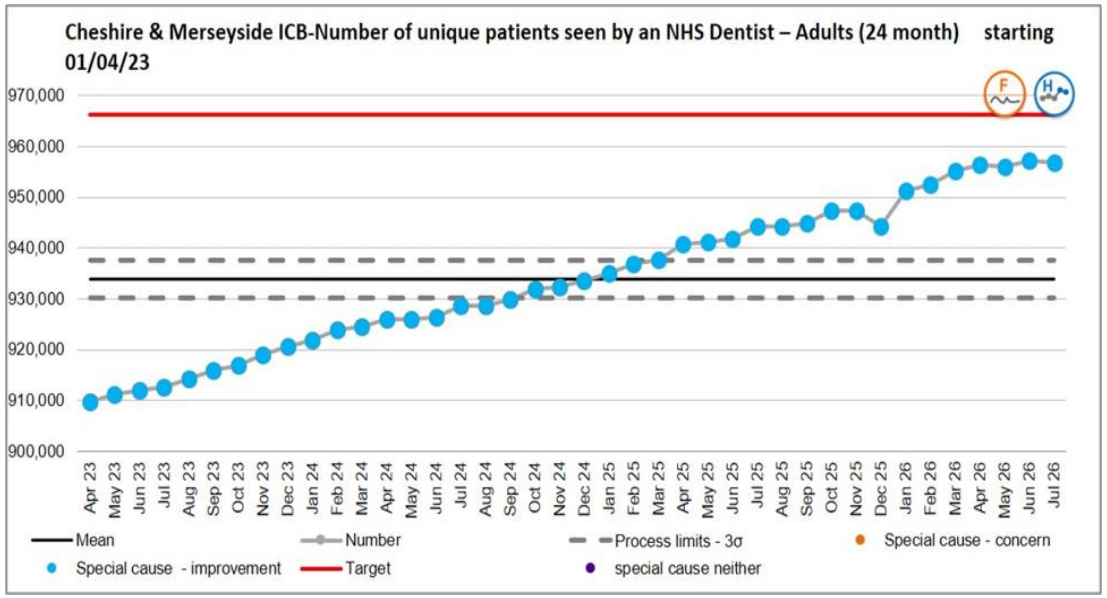
Outcome:

More adults are able to access NHS dental care

Measure of Progress:

An increase in the number of unique adult patients who have received NHS dental care within the last 12 months

Executive Lead: Clare Watson



Number of unique patients seen by an NHS Dentist – Adult (12 month)

1. **The Performance Gap (The "What")**
   - Figures are plateauing and not increasing to meet the target trajectory, over the last few months.

2. **Root Cause Analysis (The "Why")**
   - The national NHS Dental contract reform and activity is not impacting on activity to the desired level.
   - Locally commissioned schemes will not potentially address the core activity required to improve this by the required amount.

3. **Impact & Risk (The "So What")**
   - Dental access continues to be a challenge for patients across Cheshire and Merseyside.
   - Increased number of complaints and patient/external asks for assurance around this from key partners.

4. **Recovery Plan & Trajectory (The "How & When")**
   - The ICB is expanding its local quality access scheme for particular groups by a further six months for the remainder of the year and extending out to all dentists.

Living Healthy Lives

a) Cancer 62-day
b) Cancer 28-day FDS
c) Smoking
d) Cervical Screening Rate
e) Breast Screening Rate
f) MMR Uptake

Living Healthy Lives

Living Healthy Lives - Summary Icon Table

Metric	Latest Month	Actual	Plan/Target	Variation	Assuarance	Plan Met	Region Value	National Value	ICB Rank
2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Jul-26	76.2%	76.5%				n/a	71.2%	5/36
Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Jul-26	77.2%	80.9%				n/a	79.3%	24/36
Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems. (Aged 15+)	Aug-26	15.9%	12.0%				0.0%	12.7%	n/a
Cervical Screening Rate (NEW)	Jul-26	68.4%	80.0%				0.0%	0.0%	n/a
Bowel Screening Rate (NEW)	Jul-26	69.8%	62.0%				0.0%	0.0%	n/a
Breast Screening Rate (NEW)	Jul-26	69.9%	70.0%				0.0%	0.0%	n/a
MMRV Uptake (2 doses by fifth birthday) (NEW) (see Note)	Q4 25/26	83.1%	95.0%				84.6%	84.1%	34/42

Cancer 62-day waits

NHS Cheshire and Merseyside

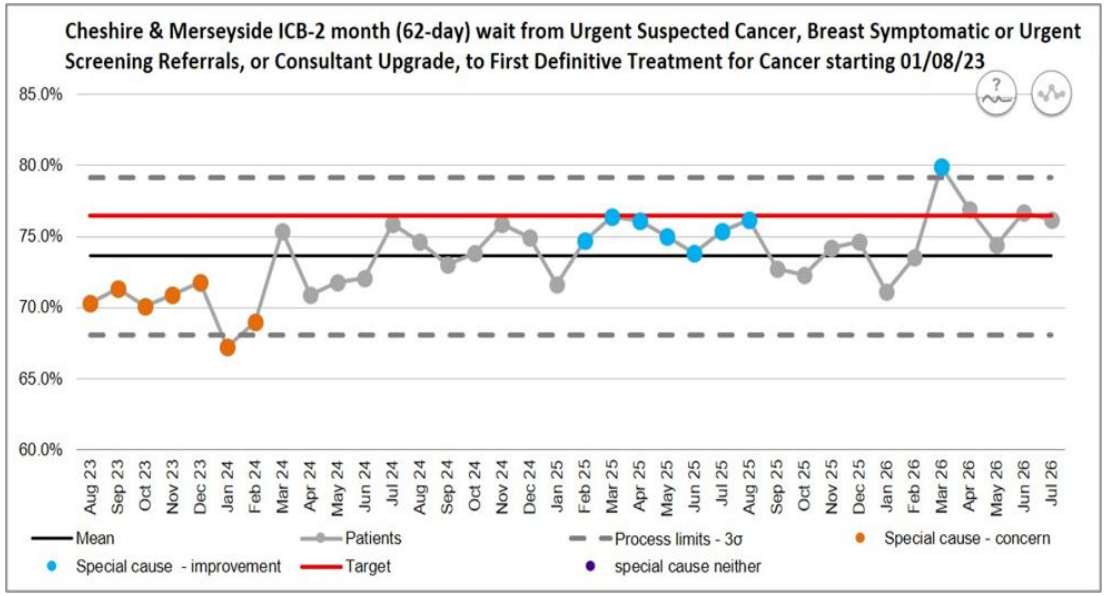
Outcome:

Patients referred urgently with suspected cancer start their first definitive treatment within 62 days of referral, improving outcomes and patient experience

Measure of Progress:

An increase in the % of patients who commence first definitive treatment for cancer within 62 days of an urgent suspected cancer referral.

Executive Lead: Fiona Lemmens



2 month (62-day) wait for First Definitive Treatment for Cancer

Latest Performance	76.2%

1. **The Performance Gap (The "What")**
- C&M is on track to meet the 62d ambition, outperforming England by 5%.
- **The figure of 76.2% is 0.3% behind plan for this point in the year, however it is expected that this ambition will be met for the year.**

2. **Root Cause Analysis (The "Why")**
- Challenges to FDS, particularly for breast, are creating a small onward impact for 62d which remains far stronger than England on plan, deviating by 0.3% only in this month.

3. **Impact & Risk (The "So What")**
- The change in performance poses no increased risk and is still on trajectory.

4. **Recovery Plan & Trajectory (The "How & When")**
- Monthly performance forums will continue throughout 2026/27, with targeted pathway transformation programmes in **lung, skin, gynaecology, breast, and lower GI cancers** supporting further improvements in 62-day performance.
- A radiotherapy improvement plan has been developed alongside the radiotherapy ODN with funded project management from CMCA, covering workforce and performance.

Cancer 28-day FDS

NHS
Cheshire and Merseyside

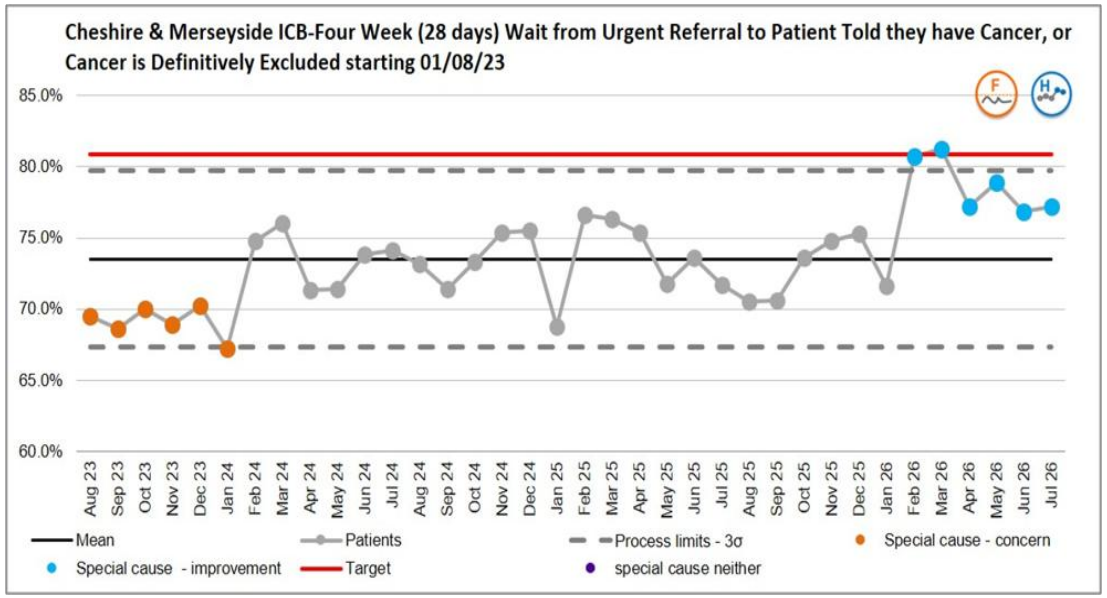
Outcome:

Patients are told whether they have cancer, or cancer is ruled out, within 28 days of an urgent referral

Measure of Progress:

An increase in the % of patients referred urgently for suspected cancer who receive a definitive diagnosis or have cancer ruled out within 28 days. The target is 80% as an average throughout the financial year

Executive Lead: Fiona Lemmens



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

Latest Performance	77.2%

1. The Performance Gap (The "What")

- The ICB is currently **3.1 percentage points behind the year-to-date planned trajectory** for the 28-day Faster Diagnosis Standard (FDS).
- C&M was 5.4% higher in July 26 than Jul 25. Whilst year on year progress is good, YTD progress against 26/27 plan is falling behind due to underperformance at LUHFT and MWL.

2. Root Cause Analysis (The "Why")

- Positively, seasonal FDS impacts are far reduced in this financial year as a result of business continuity planning in skin, led by CMCA.
- However, significant underperformance in high-volume tumour sites has emerged for LUHFT, MWL and ECT. These tumour sites are breast and Lower GI with some impact also seen in H&N for LUHFT (though with less impact on the overall system)

3. Impact & Risk (The "So What")

- Continued lower performance in FDS will make it more difficult to recover the average which is the target for the financial year.
- High volumes of patients will wait longer in Breast, Skin and Lower-GI for a ruling out of cancer primarily, and some cancer diagnoses will be delayed, leading to a delayed treatment.

4. Recovery Plan & Trajectory (The "How & When")

- CMCA continues to lead delivery of the FDS through **monthly performance forums with providers**, supporting improvement through pathway transformation, operational oversight, and targeted investment. Whilst there is a risk of some deterioration over the summer period, this is reflected within planned trajectories. Overall, performance is expected to recover to the **80% standard**, supported by continued pathway improvement and provider oversight.

158

Smoking

NHS
Cheshire and Merseyside

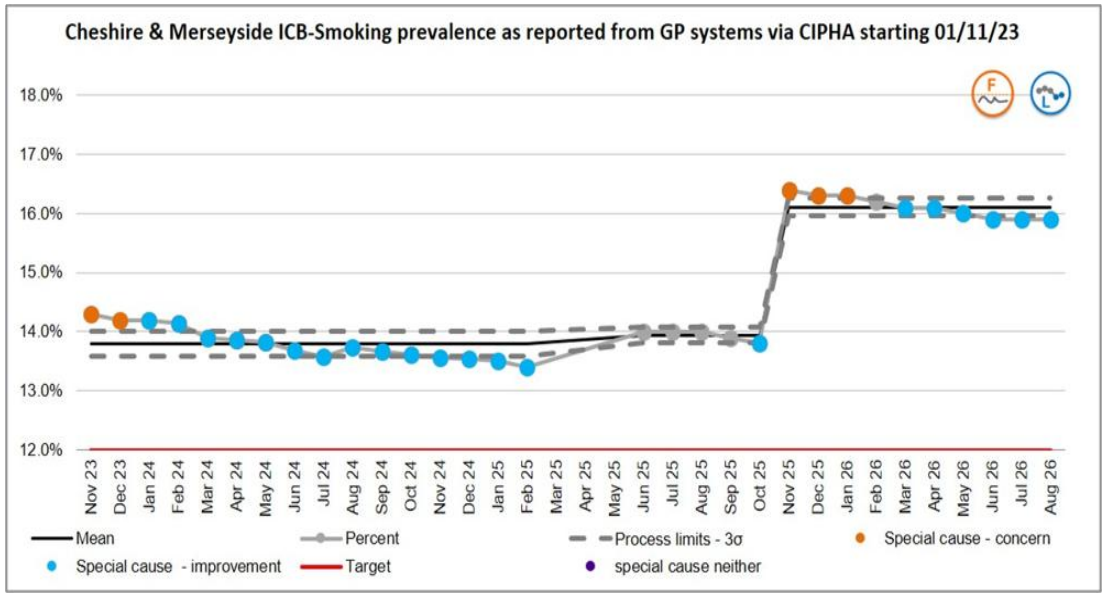
Outcome:

Fewer people are recorded as current smokers in GP systems, reflecting successful prevention, cessation support and improved public health

Measure of Progress:

A reduction in the % of patients registered on GP systems who are recorded as current smokers

Executive Lead: Clare Watson



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

1. The Performance Gap (The "What")

- 15.9% of registered patients aged 15+ are current smokers versus a 12% target. Ambitions remain unmet, but the three latest data points show special cause improvement.
- Rates vary by C&M Place; regional and peer benchmarks will follow.

2. Root Cause Analysis (The "Why")

- Prevalence is highest in deprived communities and among people with poorer mental health.
- Inconsistent Very Brief Advice (VBA) delivery and uptake reduce referrals.
- Disconnected care pathways reduce successful quit attempts.
- ATSF review actions on governance, pathways, monitoring and integration are being implemented.
- Target younger adults and light/social smokers to increase engagement and quit attempts.

3. Impact & Risk (The "So What")

- C&M's leading preventable cause of ill health and premature death, smoking drives cardiovascular, respiratory and cancer morbidity and health inequalities.
- Missing the target risks Living Healthy Lives, prevention, neighbourhood health and ICB health inequalities priorities.
- Higher downstream demand undermines improvement elsewhere in the IPR.

4. Recovery Plan & Trajectory (The "How & When")

- Strengthen referrals across acute, community mental health and smoking cessation services.
- Develop NCSCT improvement tools for the ICB and provider Trusts.
- Target digital and "Hero" campaigns at younger adults and high-prevalence communities.
- Use monthly SPC monitoring and place-level review.

Cervical Screening Rate

NHS
Cheshire and Merseyside

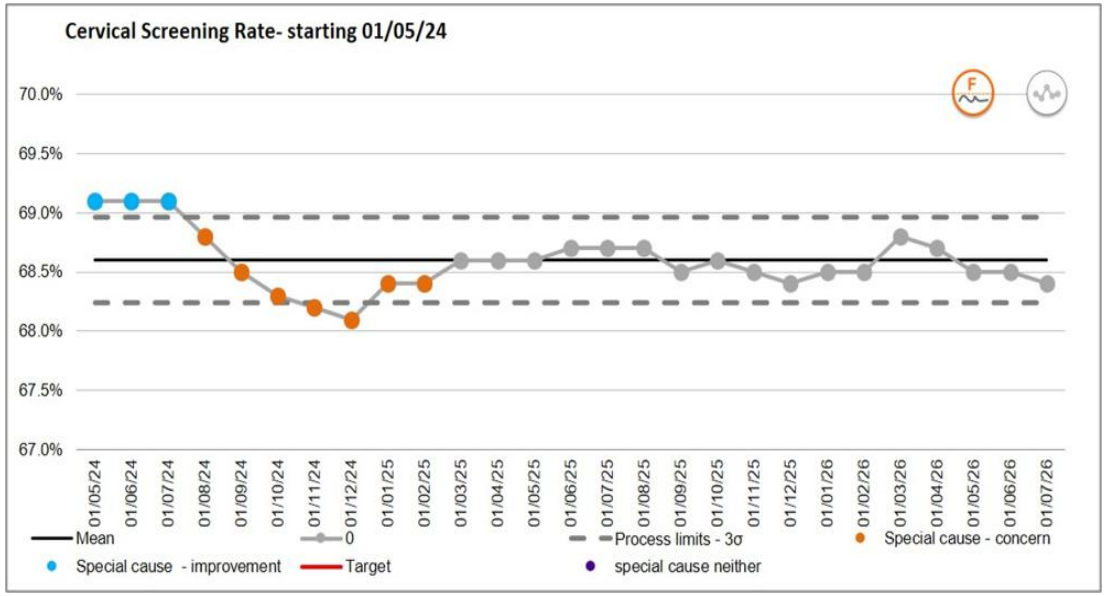
Outcome:

Eligible individuals participate in cervical screening at recommended intervals, enabling early detection and prevention of cervical cancer.

Measure of Progress:

An increase in the % eligible individuals who have had an adequate cervical screening test within the recommended screening interval.

Executive Lead: Fiona Lemmens



** Commissioning responsibility for this metric is with our NHSE NW team, however from April 2027, this will be transferred to the ICB*

Cervical Screening Rate *

1. The Performance Gap (The "What")

- Coverage remains below the national standard at 68–69%, declining from 69.1% in 2024 to 68.2–68.4% in 2026.
- Uptake varies across Places and is lowest in deprived and underserved communities.
- Current interventions are improving access but have not yet raised population-level coverage.

2. Root Cause Analysis (The "Why")

- Deprivation, low awareness, anxiety, cultural factors, previous experiences and practical barriers reduce participation.
- Traditional models, limited appointment flexibility and workforce capacity pressures restrict access, especially for working-age and underserved groups.

3. Impact & Risk (The "So What")

Impact

- Lower coverage reduces early detection and treatment of HPV and cervical abnormalities, widening inequalities and slowing progress towards eliminating cervical cancer by 2040.

Risks

- Uptake inequalities and poorer outcomes may worsen.
- Later detection may increase demand for diagnostic and treatment services.
- Persistent underperformance may increase regional and national assurance scrutiny.

4. Recovery Plan & Trajectory (The "How & When")

- The system-wide CM Cervical Screening Improvement Programme, informed by patient and public insight, targets underserved groups and non-responders.
- Delivery combines community sexual health, workplace, primary care and mobile outreach, supported by NHS, local authority and community partners.
- HPV self-sampling began in August 2026 for eligible people unlikely to attend traditional screening.
- Coverage data lag prevents a definitive recovery trajectory.
- Engagement, uptake and access will track progress, with population-level improvement expected over the medium to longer term.

160

Breast Screening Rate

NHS
Cheshire and Merseyside

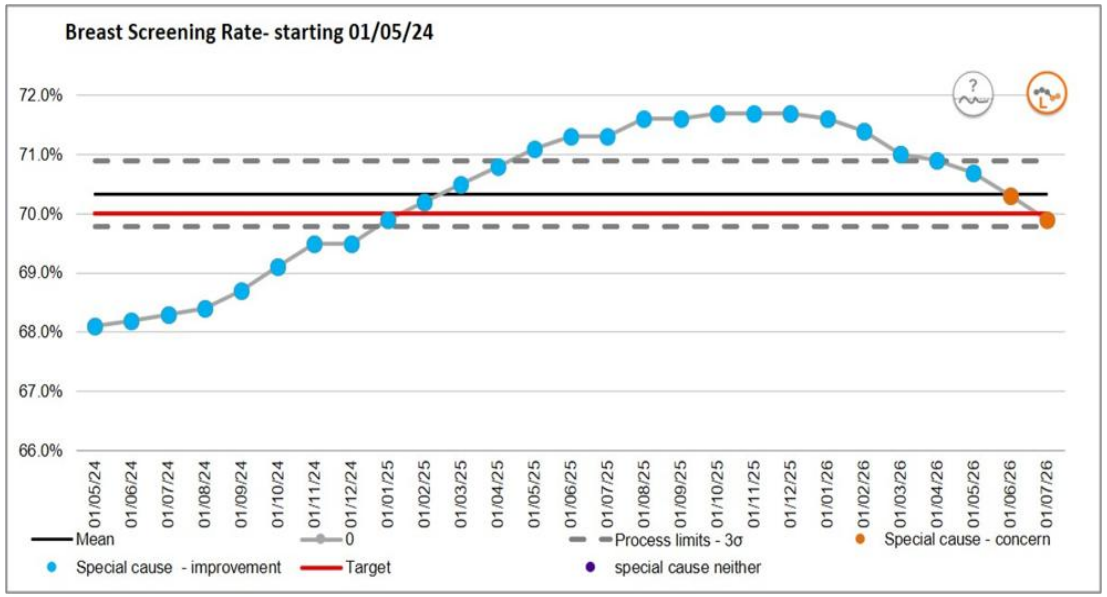
Outcome:

Eligible individuals attend routine breast screening, enabling earlier detection of breast cancer and improving long-term health outcomes

Measure of Progress:

The percentage of eligible individuals who have undergone breast screening within the recommended screening interval.

Executive Lead: Fiona Lemmens



** Commissioning responsibility for this metric is with our NHSE NW team, however from April 2027, this will be transferred to the ICB*

Breast Screening Rate *

1. The Performance Gap (The "What")

- Breast screening uptake remains below optimal levels, with performance recently declining towards the target threshold.
- Variation in participation persists across Places and population groups and inequalities in uptake are evident, particularly amongst underserved communities and first-time invitees.

2. Root Cause Analysis (The "Why")

- Lower uptake is associated with health inequalities, underserved populations and first-time invitees.
- Access barriers, including appointment availability and convenience, can influence attendance.
- Patient experience, engagement and awareness continue to affect participation rates.

3. Impact & Risk (The "So What")

- Lower uptake reduces opportunities for early detection of breast cancer and improved outcomes.
- Continued inequalities in attendance may widen health inequalities and result in later diagnosis for some groups.
- Failure to improve participation may place additional pressure on diagnostic and treatment services and impact programme performance.

4. Recovery Plan & Trajectory (The "How & When")

- Whilst changes in uptake may take time to be reflected in reported performance, a range of targeted interventions are in place to increase attendance, reduce inequalities and improve patient experience.
- System-wide breast screening improvement programme established across C&M.
- Dedicated Improving Uptake Workers supporting first-time invitees and populations least likely to attend.
- Expanded access through more flexible appointment options, including early morning, evening and weekend clinics.
- Targeted engagement and communications informed by patient feedback and population health intelligence.
- Strong partnership working across screening, diagnostics and cancer services to support pathway improvements.
- Evidence from the Wirral and Chester Breast Screening Programme, where the lowest-performing practice improved from 43% to 67% uptake, with six of twelve practices now exceeding the 70% acceptable uptake threshold and one exceeding 80%. That gives tangible evidence that the recovery actions are already having an impact.

MMR Uptake

NHS
Cheshire and Merseyside

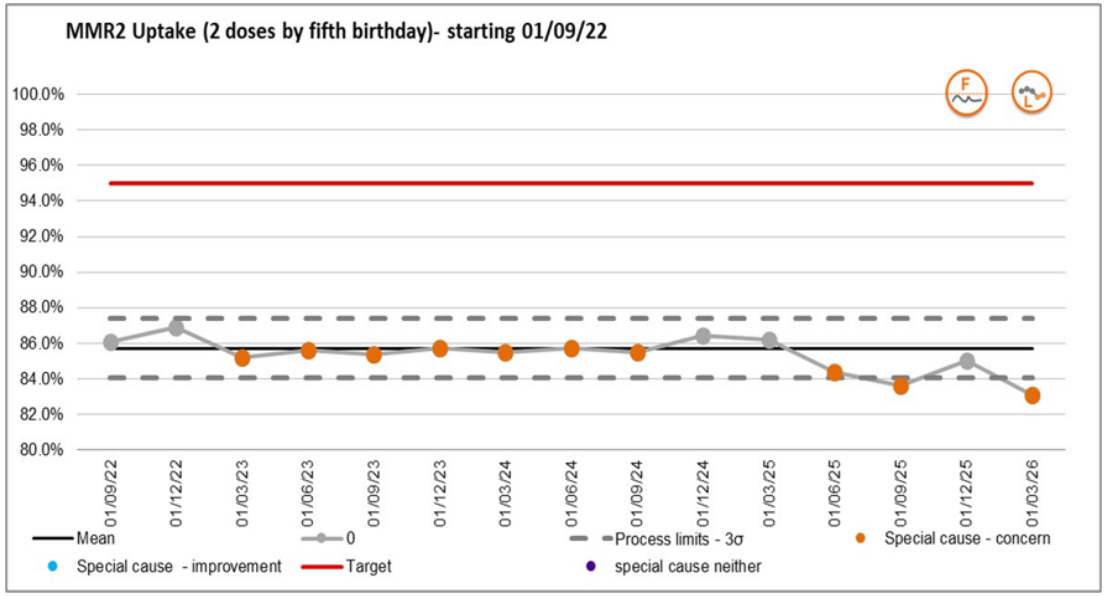
Outcome:

Eligible children receive both recommended doses of the MMR vaccine, reducing the risk of disease outbreaks and protecting population health

Measure of Progress:

An increase in the % of eligible children who have received the recommended MMR vaccination(s) by a specified age.

Executive Lead: Fiona Lemmens



** Commissioning responsibility for this metric is with our NHSE NW team, however from April 2027, this will be transferred to the ICB*

MMR Uptake (2 doses by fifth birthday) *

1. The Performance Gap (The "What")

- Two-dose MMR uptake by age five is 83–85%, below the 95% needed for population protection.
- Coverage remains below target and is worsening, with marked variation across C&M communities and population groups.

2. Root Cause Analysis (The "Why")

- Lower uptake is concentrated in deprived, mobile and underserved populations facing greater access and engagement barriers.
- Vaccine confidence, awareness and missed opportunities also reduce uptake.
- Previous approaches have not consistently reached children most at risk of remaining unvaccinated.

3. Impact & Risk (The "So What")

Impact

- Coverage below 95% increases outbreak and transmission risk, leaving unvaccinated children vulnerable to serious illness and widening inequalities in underserved communities.

Risks

- Continued underperformance increases outbreak risk and may disproportionately affect communities with lower uptake.
- Outbreak management and further catch-up programmes may require additional healthcare and public health resources and attract greater scrutiny

4. Recovery Plan & Trajectory (The "How & When")

- A Cheshire and Merseyside multi-agency partnership brings together NHS, local authority, education and provider partners.
- School-readiness work identifies unvaccinated children earlier and expands catch-up opportunities.
- Place-based investment and population health intelligence target areas with lower uptake and greater need.
- Coverage data lag means a definitive recovery trajectory cannot be predicted, but evidence-based interventions aim to improve uptake and reduce inequalities.

Ageing Well

a) A&E 4-hour waits
b) A&E 12-hour waits
c) NCTR
d) Reduction in emergency admissions for people aged 65+
e) Reduction in non-elective admissions for patients with frailty

Ageing Well

Ageing Well - Summary Icon Table

Metric	Latest Month	Actual	Plan/Target	Variation	Assuarance	Plan Met	Region Value	National Value	ICB Rank
4-hour A&E waiting time (% waiting less than 4 hours)	Aug-26	73.7%	78.2%				73.4%	75.0%	23/46
A&E 12 hour waits from arrival (Type 1 & 2)	Aug-26	17.3%	15.6%				12.9%	9.7%	35/36
Percentage of beds occupied by patients no longer meeting the criteria to reside (Rolling 7-day average last week of month)	Aug-26	19.9%	TBC			n/a	n/a	n/a	n/a
Percentage of people who are discharged from acute hospital to their usual place of residence (NEW)	Apr-26	83.3%	TBC			TBC	0.0%	81.9%	n/a
Reduction in emergency admissions for people aged 65+ (NEW)	Jul-26	12,249	11,731				n/a	n/a	n/a
Reduction in non-elective admissions for patients with frailty (10% reduction against baseline) (NEW)	Jul-26	5,620	5,437				0	0	n/a

A&E 4-hour waits

NHS
Cheshire and Merseyside

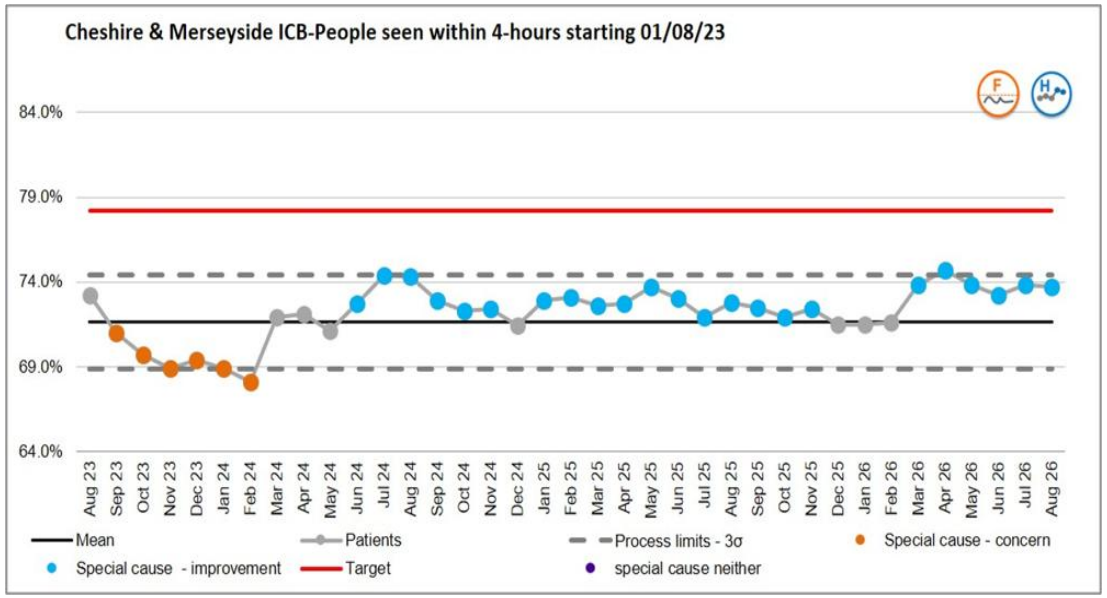
Outcome:

Patients receive timely assessment, treatment and admission/discharge from ED & elimination of long waits to improve safety and experience

Measure of Progress:

An increase in emergency department (ED or A&E) performance towards overall 4-hour target of 85%. We aim for an interim trajectory of 82% by March 2027

Executive Lead: Jude Adams



A&E 4-hour waits

1. The Performance Gap (The "What")

- In August 2026, around **74% of patients were admitted, transferred or discharged within four hours**, remaining above the system average but below the planned trajectory of 78%.
- Performance has remained broadly stable over recent months, avoiding deterioration despite continued operational pressures.
- While recovery has begun in some aspects of urgent care, sustained improvement towards the interim ambition of 82% by March 2027 has not yet been achieved.

2. Root Cause Analysis (The "Why")

- Demand for urgent and emergency care remains high across the system.
- Flow through emergency departments continues to be constrained by delayed discharges, high bed occupancy and variability in specialty response times.
- Variation in utilisation of Same Day Emergency Care (SDEC) and front-door streaming models continues to affect performance.

3. Impact & Risk (The "So What")

- Performance below trajectory increases the risk of extended waits, crowding and poorer patient experience.
- Although performance remains comparatively resilient, ongoing flow pressures create a risk of deterioration during winter.
- Failure to improve flow across the system will limit further gains in 4-hour performance.

4. Recovery Plan & Trajectory (The "How & When")

- Continue implementation of Model ED and First 72 Hours standards across providers.
- Expand digital streaming, SDEC utilisation and early senior clinical review.
- Strengthen discharge processes and community alternatives to admission.
- Sustain current performance through autumn and deliver incremental improvement towards the March 2027 trajectory through provider-level recovery plans overseen by Locality UEC Boards.

Trajectory

- Sustain performance at or above 74% through autumn, prevent winter deterioration and deliver progressive improvement towards the 78% standard, supported by provider-level trajectories and locality oversight via Locality UEC Boards

160

A&E 12-hour waits

NHS
Cheshire and Merseyside

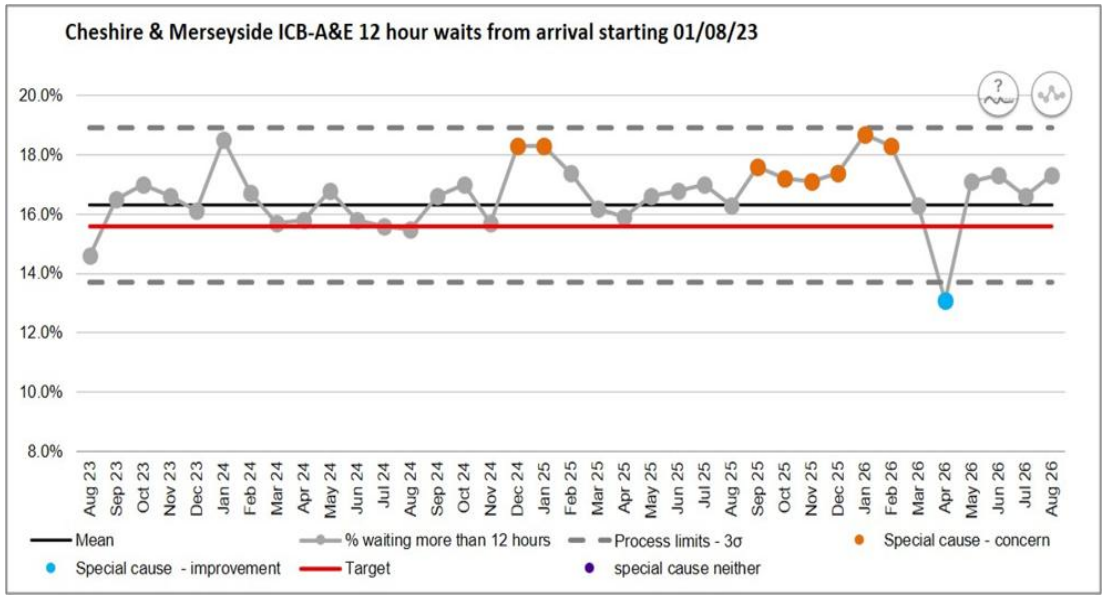
Outcome:

Patients receive timely assessment, treatment and admission/discharge from ED & elimination of long waits to improve safety and experience

Measure of Progress:

A reduction in the number of patients waiting in emergency department (ED or A&E) for over 12 hours.

Executive Lead: Jude Adams



A&E 12-hour waits

1. **The Performance Gap (The "What")**
- Approximately **17.3% of patients experienced a 12-hour wait in August 2026**, above both the planned trajectory and system average.
- Performance has deteriorated for three consecutive months following improvements earlier in the year.
- Long waits remain a significant area of concern within overall UEC performance.

2. **Root Cause Analysis (The "Why")**
- Persistent flow challenges continue to drive prolonged stays within emergency departments.
- High bed occupancy, delayed discharges and elevated NCTR levels are constraining access to inpatient beds.
- Delays in specialty decision-making and variation in SDEC utilisation also contribute to extended waits.

3. **Impact & Risk (The "So What")**
- Extended waits increase the risk of patient harm, deterioration, corridor care and poorer patient experience.
- Continued deterioration threatens wider UEC recovery and increases pressure on ambulance handovers and emergency department flow.
- Winter demand presents a substantial risk to further performance deterioration

4. **Recovery Plan & Trajectory (The "How & When")**
- Locality UEC Boards and the System Coordination Centre will oversee targeted provider recovery plans.
- Continue systematic review of all 12-hour breaches to identify recurring causes and actions.
- Strengthen specialty response, discharge processes and out-of-hours decision-making.
- Reverse recent deterioration during autumn and deliver sustained reductions in 12-hour waits over the remainder of 2026/27.

Trajectory
- Reverse the current deterioration, return below 15.6% during autumn and deliver sustained monthly reductions, with the longer-term ambition of fewer than 10% of patients waiting over 12 hours.

NCTR

NHS
Cheshire and Merseyside

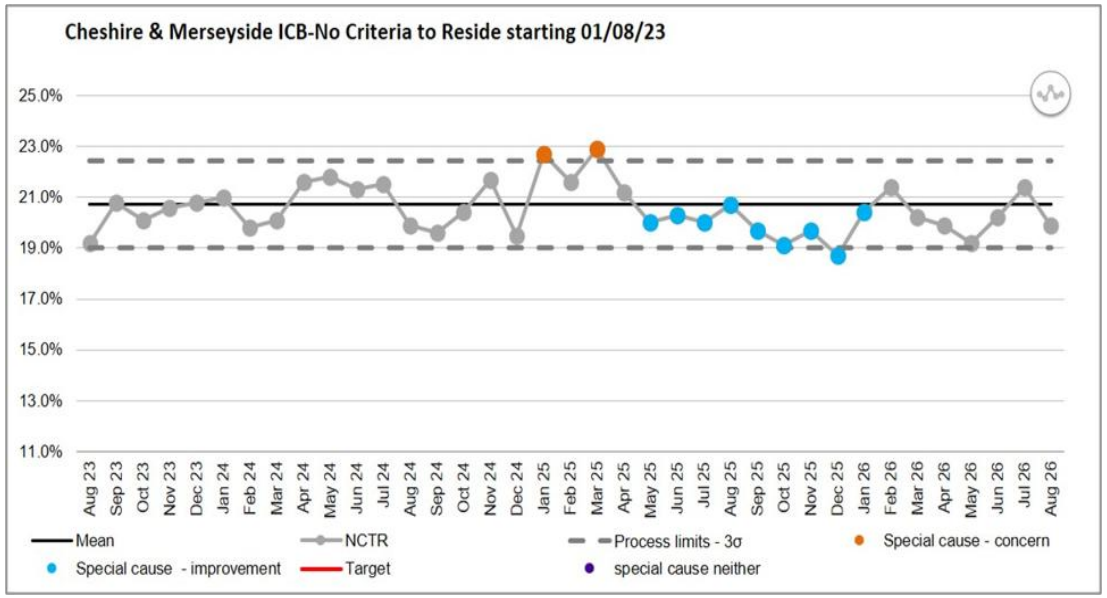
Outcome:

Patients are cared for in the most appropriate setting without delay

Measure of Progress:

A reduction in the % of patients remaining in hospital who do not require to be in hospital.

Executive Lead: Jude Adams



Percentage of beds occupied by patients no longer meeting the criteria to reside

1. **The Performance Gap (The "What")**
- NCTR decreased to approximately **20% in August 2026**, reversing improvements achieved earlier in the year.
- Performance remains above both the system average and national expectations.
- Delayed discharge continues to represent a major constraint on patient flow across the system

2. **Root Cause Analysis (The "Why")**
- Delays in discharge planning, assessment processes and access to community support continue to impact performance.
- Capacity constraints within home care, intermediate care and complex placement pathways remain evident.
- Variation in implementation of Home First and discharge-to-assess approaches persists across localities.

3. **Impact & Risk (The "So What")**
- Patients experience avoidable time in hospital, increasing the risk of deconditioning and loss of independence.
- Elevated NCTR contributes directly to high bed occupancy, delayed admissions from ED and ambulance handover delays.
- Failure to improve discharge performance will constrain wider UEC recovery.

4. **Recovery Plan & Trajectory (The "How & When")**
- Continue strengthening daily review and escalation arrangements for all NCTR patients.
- Expand Home First, discharge-to-assess and Pathway 0 utilisation.
- Deliver the community beds best practice programme and frailty thermometer initiative.
- Return performance below 20% during autumn and achieve sustained improvement through locality-based discharge recovery plans.

Trajectory
- Reverse the recent deterioration, return below 20% during autumn and then achieve sustained monthly reductions towards the national benchmark, with provider and locality trajectories monitored through UEC governance.

162

Reduction in emergency admissions for people aged 65+

NHS Cheshire and Merseyside

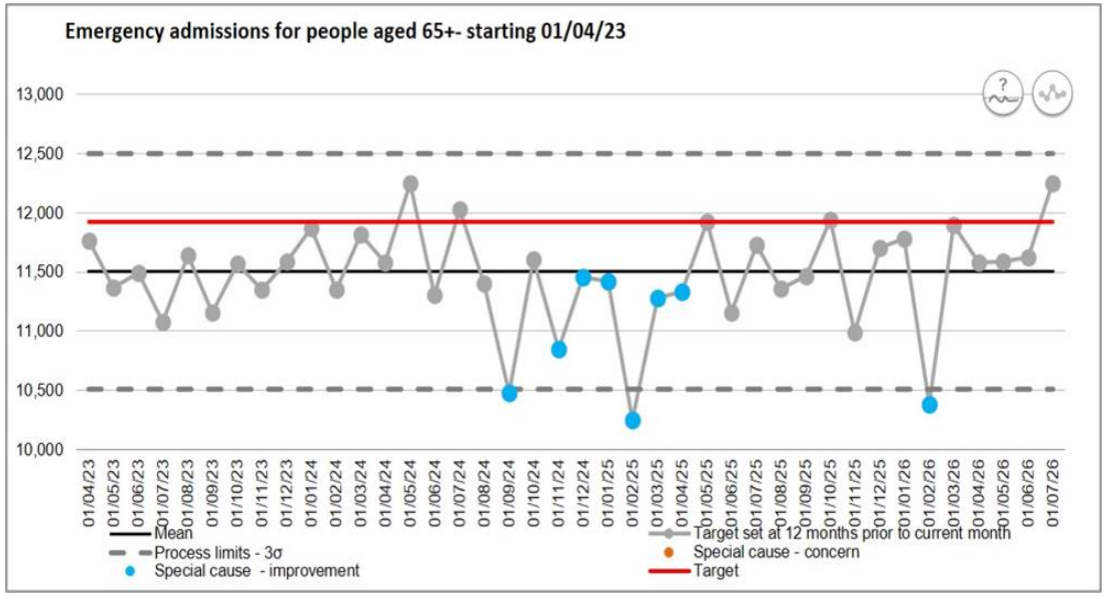
Outcome:

Older people receive timely preventative, community, and integrated care, resulting in fewer emergency hospital admissions and better health outcomes.

Measure of Progress:

The reduction in the number or rate of emergency admissions for people aged 65 years and over compared with a baseline period or agreed target

Executive Lead: Jude Adams



Reduction in emergency admissions for people aged 65+

1. **The Performance Gap (The "What")**
- Emergency admissions for people aged 65+ remained at approximately **12,250 in July 2026**, below the planned trajectory of 11,y00.
- Performance continues to compare favourably with plan and reflects improving management of frailty and urgent community support.
- Whilst month-to-month variation remains, admissions have remained below target.

2. **Root Cause Analysis (The "Why")**
- Expansion of community alternatives, frailty pathways and proactive support is helping mitigate demand.
- Admissions continue to be influenced by frailty, falls, respiratory illness and care-home pressures.
- Variability remains in utilisation of urgent community response, virtual wards and proactive care models.

3. **Impact & Risk (The "So What")**
- Maintaining admissions below plan reduces pressure on emergency departments and inpatient capacity.
- Avoiding unnecessary admission helps reduce deconditioning and supports independence for older people.
- Winter pressures could reverse recent gains if community capacity is insufficient.

4. **Recovery Plan & Trajectory (The "How & When")**
- Continue delivery of the Frailty Programme and proactive care initiatives.
- Launch unscheduled care coordination hubs from October 2026 to improve access to community alternatives.
- Expand UCR, virtual wards and same-day frailty services.
- Sustain performance below trajectory throughout winter and continue reducing avoidable admissions.

Trajectory
- Maintain admissions below 11,900, avoid winter deterioration and deliver a sustained reduction through consistent frailty and community alternatives, monitored through locality UEC boards.

168

Reduction in non-elective admissions for patients with frailty

NHS Cheshire and Merseyside

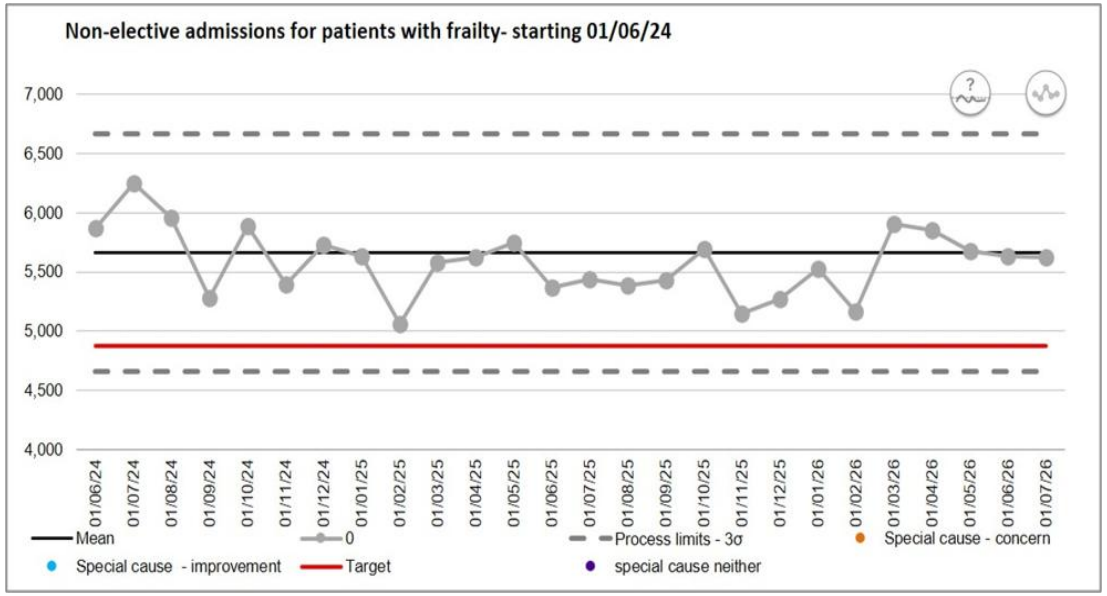
Outcome:

People with frailty receive timely preventative and coordinated care, resulting in fewer emergency hospital admissions and improved quality of life.

Measure of Progress:

A reduction in the number or rate of non-elective admissions for patients with frailty compared with a baseline period or agreed target.

Executive Lead: Jude Adams



Reduction in non-elective admissions for patients with frailty

1. **The Performance Gap (The "What")**
- Frailty-related non-elective admissions were approximately **5,600 in July 2026**, around 200 above the planned level.
- Performance remains relatively stable but has not yet shown sustained improvement towards target.
- Admissions continue to represent a significant contributor to system demand and bed occupancy.

2. **Root Cause Analysis (The "Why")**
- Access to early frailty identification, assessment and intervention remains variable across the system.
- Community response capacity and alternatives to admission are not yet consistently available.
- Falls, care-home demand and avoidable conveyance continue to drive admissions.

3. **Impact & Risk (The "So What")**
- Hospital admission increases risks of deconditioning, delirium and loss of independence for people living with frailty.
- Higher admission levels contribute to bed occupancy pressures, delayed discharge and emergency department crowding.
- Continued performance above trajectory limits progress across wider UEC recovery metrics.

4. **Recovery Plan & Trajectory (The "How & When")**
- Establish the Frailty Programme Board from October 2026 to oversee delivery of the six frailty workstreams.
- Expand frailty SDEC, virtual wards, urgent community response and rapid reablement services.
- Develop the Frailty Academy to improve workforce capability across health, social care and voluntary sectors.
- Deliver sustained reductions through strengthened frailty pathways, increased community capacity and improved alternatives to hospital admission.

Dying Well

a) Reduction in the proportion of our population dying in hospital
b) SHMI

Dying Well

Dying Well - Summary Icon Table

Metric	Latest Month	Actual	Plan/Target	Variation	Assuarance	Plan Met	Region Value	National Value	ICB Rank
Reduction in the proportion of our population dying in hospital - All ages (NEW) *	Jul-26	48.7%	46.8%				n/a	42.8%	n/a
Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation	Apr-26	1.007	0.887 to 1.127			n/a	0.000	1.000	n/a

*** Reduction in the proportion of our population dying in hospital:** The ICB Quality team are reviewing the data that sits behind the recent change in this indicator and will provide a more detailed narrative for the next report.

SHMI

NHS
Cheshire and Merseyside

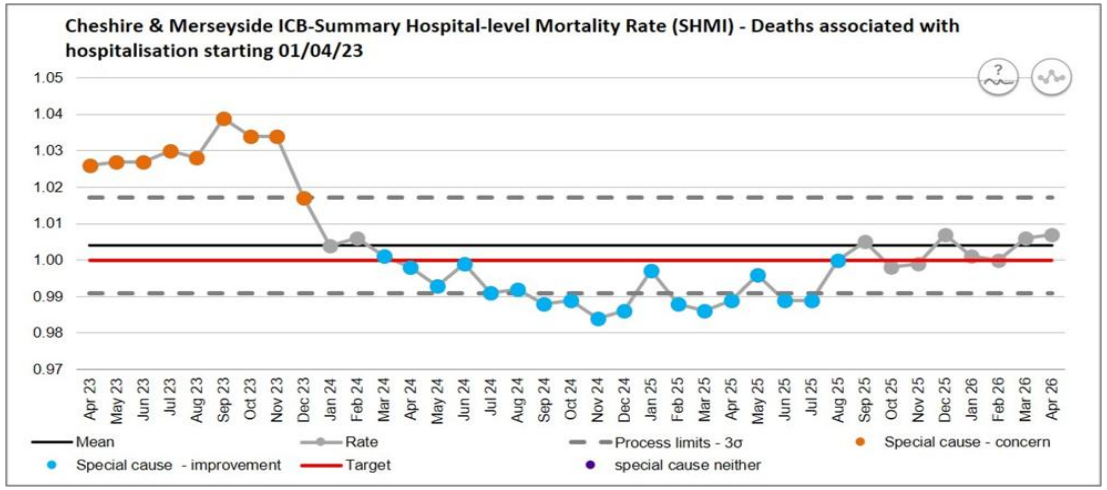
Outcome:

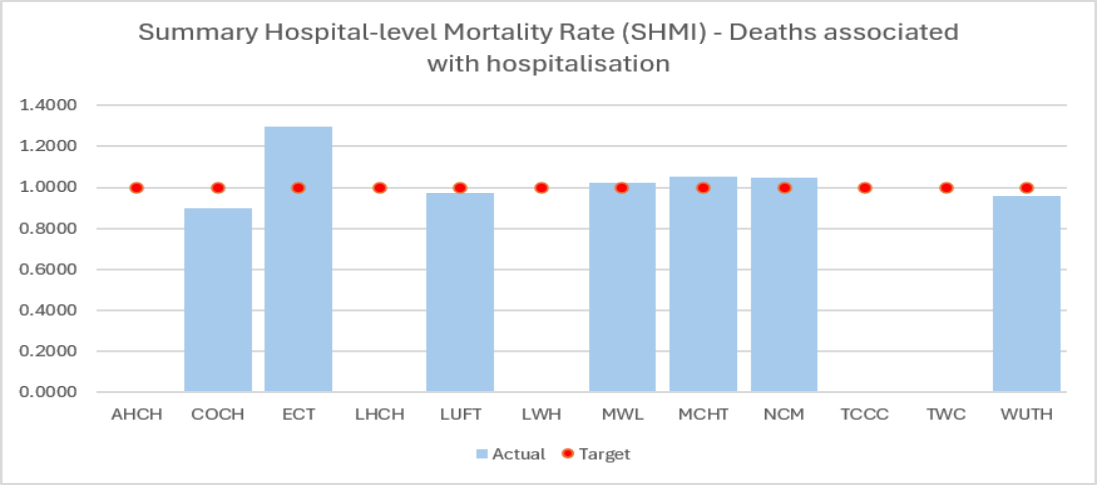
Hospital mortality is in line with or better than expected levels, reflecting safe, high quality care and effective clinical practices

Measure of Progress:

The ration of observed deaths to expected deaths for patients admitted to hospital

Executive Lead: Fiona Lemmens





Summary Hospital-level Mortality Indicator (SHMI)

1. 1. The Performance Gap (The "What")

- One of the main benchmarking indicators for mortality is Summary Hospital Level Mortality Indicator (SHMI)
- Providers are identified as within, higher than or lower than expected ranges
- All providers within the ICB, other than East Cheshire Trust, are within the expected range.
- East Cheshire Hospital Trust is currently higher than expected with a SHMI of 1.2944 against an upper control limit of 1.1864, the Trust has been above the expected range for most of the last 3 years.

2. Root Cause Analysis (The "Why")

- Current SHMI specifically highlights a statistical higher than expected mortality in relation to pneumonia.
- Contextual indicators suggest higher than average mortality for non-elective admissions and deaths within 30 days of discharge. With a lower than average percentage of deaths with palliative coding.

3. Impact & Risk (The "So What")

- There remains a concern about mortality rate at ECT as this higher than expected range is not fully understood. The lack of clarity presents a risk that patients could be subject to avoidable death.

4. Recovery Plan & Trajectory (The "How & When")

- A review of mortality at the provider / following discharge from the provider is taking place and requested reporting via the Clinical Effectiveness Group under Quality and Performance Committee oversight.

Organisational Health (Finance & Workforce)

a) ICB Financial Position
b) Sickness Absence Rate

Organisational Health

Finance - Summary Icon Table

Metric	Latest Month	Actual	Plan/Target	Variation	Assuarance	Plan Met	Region Value	National Value	ICB Rank
Variance between ICB Financial Position v Plan £000 (YTD) (NEW)	Jul-26	£ -	£ -	H	F	✓	n/a	n/a	n/a
Variance between Capital Spend v Plan £000 (YTD) (NEW)	Jul-26	£ -	£ -		P	✓	n/a	n/a	n/a
Variance between CRES v Plan £000 (YTD) (NEW)	Jul-26	£ 1,464	£ -	H	?	✓	n/a	n/a	n/a

Workforce - Summary Icon Table

Metric	Latest Month	Actual	Plan/Target	Variation	Assuarance	Plan Met	Region Value	National Value	ICB Rank
Workforce - total turnover rate (NEW)	Jun-26	19.9%	10.0%			✗	0%	0%	n/a
Workforce - sickness absence rate	Jun-26	4.1%	2.5%	L	F	✗	4%	5%	n/a
Appraisal compliance rate (NEW)	Jun-26	58.8%	95.0%			✗	0%	0%	n/a
Mandatory training compliance rate (NEW)	Jun-26	86.2%	95.0%			✗	0%	0%	n/a

ICB Financial Position

NHS Cheshire and Merseyside

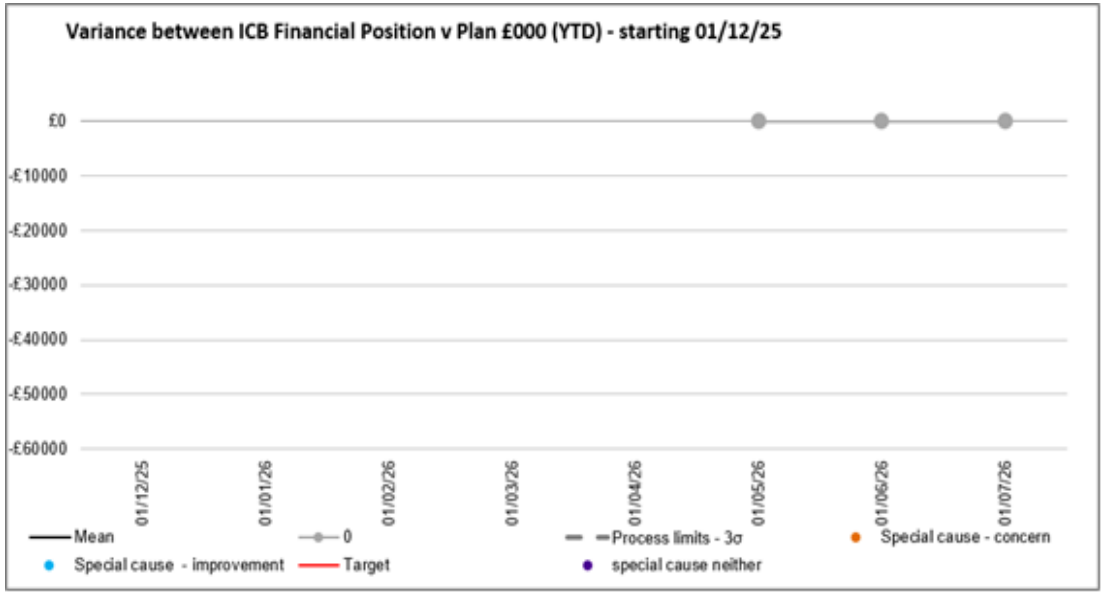
Outcome:

The ICB delivers its planned financial position, demonstrating effective financial management and maintaining system sustainability

Measure of Progress:

This is a financial performance metric that compares the ICB's actual financial position against its planned position.

Executive Lead: Andrea McGee



Variance between ICB Financial Position v Plan

1. **The Performance Gap (The "What")**
- The ICB reported a balanced Year-to-Date position for M4 and a Forecast breakeven position.
- The financial plan for 2026/27 is a breakeven position so this is in line with plan at this stage.

2. **Root Cause Analysis (The "Why")**

Key YTD overspends in following areas:
- Mental Health contracts - £1.2m
- Mental Health Packages of care -£5.3m
- Prescribing -£2.3m
- Other Programmes/Reserves /Balance sheet review/CRES pressure (Grip & Control) partially offset by other underspends) -£13.4m

Offset by the following overspends
- Acute underperformance £2.4m
- Continuing Healthcare £3.7m
- Delegated dental, ophthalmology and pharmacy & medical budgets £16.2m

3. **Impact & Risk (The "So What")**
- Although a breakeven financial position is reported – in line with plan. The financial risks below are noted:
- Provider activity plans
- Non Elective over-performance is above planned contingency.
- Prescribing/High Cost Drugs – national price changes and increase in weight management drugs
- AACC/MH & Complex Packages of Care cost increase above local planning assumptions
- ADHD continues to grow due to increase in demand including expansion of IS providers in the market CRES schemes do not deliver efficiencies required in year – current risk based on development status £5.5m compared to plan.

4. **Recovery Plan & Trajectory (The "How & When")**
- Financial position reported to NHSE, FICC and Board with appropriate mitigations discussed and actioned.

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Sickness Absence Rate

NHS
Cheshire and Merseyside

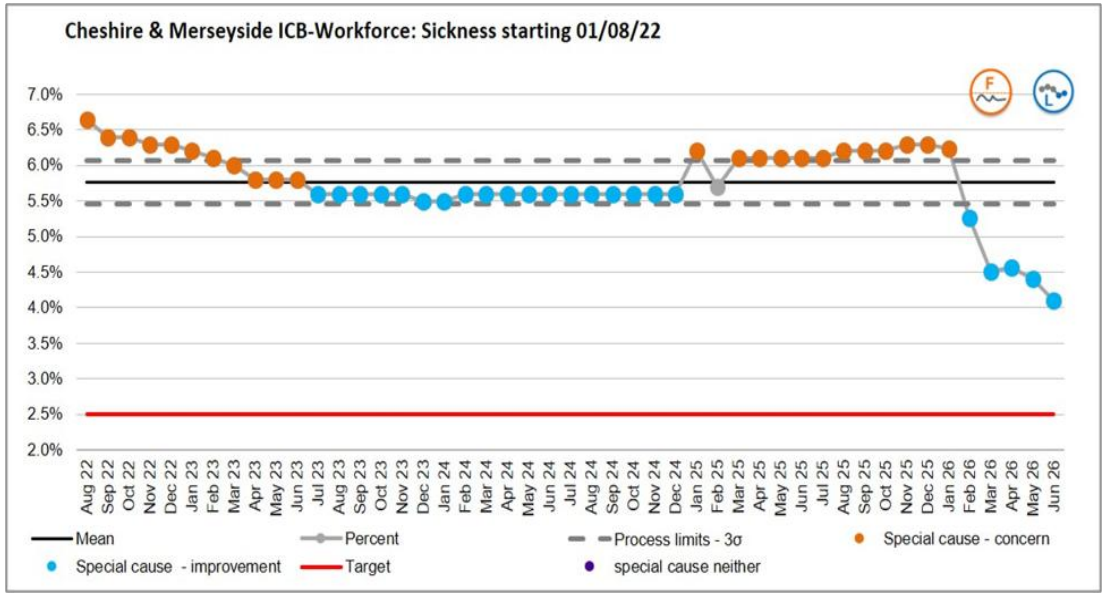
Outcome:

The organisation maintains a healthy and supported workforce, minimising sickness absence and ensuring safe, effective, and sustainable service delivery.

Measure of Progress:

The percentage of total available working time lost due to employee sickness absence during a reporting period. The target is <2.5%.

Executive Lead: Liz Bishop



Sickness Absence Rate

1. **The Performance Gap (The "What")**
- Sickness absence has sat above target for the duration of the ICB establishment (1 July 2022 onward) and has been attributable to a variety of reasons.
- The ICB has a specific attendance management policy concerning attendance and sickness which covers short-term and long-term sickness, and the process to manage such cases.
- A target of 2.5%, when the organisation headcount fluctuated around 1100-1200 staff for most of its establishment, would attribute to 27.5 to 30 or less individuals being absent at any one time.

2. **Root Cause Analysis (The "Why")**
- The main two attributable reasons for sickness related to ‘stress/anxiety/depression’ (work and/or non work related) and musculoskeletal problems. These are not dissimilar to other NHS organisations.
- From March 2025, sickness increased and we believe this to be attributable to uncertainty regarding ICB running costs and post reductions, coupled with absences that naturally occur regardless of organisational state.

3. **Impact & Risk (The "So What")**
- A change of approach in policy in early 2026 enabled a differing approach to managing sickness cases. This enabled quicker progress through the differing absence management stages, whilst maintaining an ability to manage cases compassionately and with care.
- Since the update, the absence rate has started to reduce (January 2026 onward) and remains at a lower rate month-on-month.
- Whilst this policy change has had a visible impact, we also believe the commencement of the organisational wide management of change has lowered the absence rate due to individuals wishing to remain in work to keep across progress of this change.

4. **Recovery Plan & Trajectory (The "How & When")**
- Following conclusion of the management of change (September to October 2026), we expect sickness to rise and for some cases, be mainly or wholly attributable to workplace uncertainty, or outcomes.
- A range of staff health and wellbeing resources remain accessible to assist throughout this time, with additions to this support being continually reviewed.
- Line managers are, and will continue to be reminded, of the requirement to record staff absence from day one to enable early interventions from the line manager, HR team, Occupational Health, and other support services.

Integrated Performance Report

Appendix

a) 13-month trend
b) Provider Capability & Segmentation Ratings
c) Guidance
d) SPC Guidance

ICB Aggregate Position - 13 month trend

NHS Cheshire and Merseyside

Metric	Latest Month	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Target	Regional	National	Ranking
Still birth per 1,000 (rolling 12 months)	Jul-26	2.54	2.56	2.60	2.65	2.69	2.51	2.39	2.70	2.70	2.70	2.56	2.61		2.6	n/a	3.8	n/a
Pre Term Births (NEW)	Jul-26	126	161	145	122	135	140	110	127	132	169	146	139		TBC	n/a	n/a	n/a
Breast Milk at First Feed % (NEW)	Jul-26	63.4%	65.2%	67.6%	67.2%	66.3%	64.1%	66.4%	68.4%	67.5%	66.5%	68.4%	66.5%		TBC	n/a	n/a	n/a
Number of 52+ week RTT waits, of which children under 18 years.	Jul-26	1,114	899	992	947	847	731	767	501	478	451	454	445		0	n/a	n/a	n/a
Number of unique patients seen by an NHS Dentist – Children (12 month)	Jul-26	336,440	337,729	338,502	338,564	340,663	340,812	341,643	343,051	343,629	344,053	344,650	344,489		338,408	1,057,712	7,386,084	n/a
The % of people waiting less than 18 weeks on the waiting list (RTT)	Jul-26	58.4%	59.2%	59.4%	59.1%	58.7%	58.8%	60.7%	64.5%	64.7%	65.2%	65.6%	65.7%		65.0%	64.5%	65.3%	17/36
The % of people waiting more than 52 weeks on the waiting list (RTT)	Jul-26	3.9%	3.6%	3.3%	2.9%	2.4%	2.2%	1.9%	1.1%	1.1%	1.2%	1.2%	1.3%		1.1%	1.4%	1.5%	18/36
Patients waiting more than 6 weeks for a diagnostic test	Jul-26	14.2%	12.4%	9.5%	9.2%	10.2%	10.7%	7.1%	9.8%	13.0%	12.4%	12.2%	13.2%		8.9%	13.5%	23.1%	6/36
Number of unique patients seen by an NHS Dentist – Adults (24 month)	Jul-26	944,511	946,089	947,758	947,371	950,458	951,752	952,810	955,218	956,282	956,039	957,107	956,751		966,320	2,693,840	18,464,234	n/a
% of urgent GP appointments seen within 24 hours (NEW)	Jul-26	75.4%	76.1%	74.3%	74.3%	76.6%	75.6%	74.7%	75.3%	77.6%	79.0%	79.7%	79.8%		79.4%	78.1%	76.4%	n/a
Percentage of ICB inappropriate out of area placement bed days in Adult acute beds	Jun-26	2.0%	3.0%	3.0%	2.0%	3.0%	3.0%	2.0%	2.0%	1.9%	2.0%	2.0%			TBC	1.7%	2.0%	21/36
2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Jul-26	76.2%	72.7%	72.3%	74.2%	74.6%	71.1%	73.5%	79.9%	76.9%	74.4%	76.7%	76.2%		76.5%	n/a	71.2%	5/36
Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Jul-26	70.5%	70.6%	73.6%	74.8%	75.3%	71.6%	80.7%	81.2%	77.2%	78.9%	76.8%	77.2%		80.9%	n/a	79.3%	24/36
Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems. (Aged 15+)	Aug-26	14.0%	13.9%	13.8%	16.4%	16.3%	16.3%	16.2%	16.1%	16.1%	16.0%	15.9%	15.9%	15.9%	12.0%		12.7%	n/a
Cervical Screening Rate (NEW)	Jul-26	68.7%	68.5%	68.6%	68.5%	68.4%	68.5%	68.5%	68.8%	68.7%	68.5%	68.5%	68.4%		80.0%			n/a
Bowel Screening Rate (NEW)	Jul-26	69.7%	69.8%	69.9%	69.9%	69.7%	69.7%	69.7%	69.7%	69.6%	69.5%	69.7%	69.8%		62.0%			n/a
Breast Screening Rate (NEW)	Jul-26	71.6%	71.6%	71.7%	71.7%	71.7%	71.6%	71.4%	71.0%	70.9%	70.7%	70.3%	69.9%		70.0%			n/a
MMRV Uptake (2 doses by fifth birthday) (NEW) (see Note)	Q4 25/26			85.0%			83.1%								95%	84.6%	84.1%	34/42

ICB Aggregate Position - 13 month trend

NHS Cheshire and Merseyside

Metric	Latest Month	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Target	Regional	National	Ranking
4-hour A&E waiting time (% waiting less than 4 hours)	Aug-26	72.8%	72.5%	71.9%	72.4%	71.5%	71.5%	71.6%	73.8%	74.7%	73.8%	73.2%	73.8%	73.7%	78.2%	73.4%	75.0%	23/46
A&E 12 hour waits from arrival (Type 1 & 2)	Aug-26	16.3%	17.6%	17.2%	17.1%	17.4%	18.7%	18.3%	16.3%	13.1%	17.1%	17.3%	16.6%	17.3%	15.6%	12.9%	9.7%	35/36
Percentage of beds occupied by patients no longer meeting the criteria to reside (Rolling 7-day average last week of month)	Aug-26	20.7%	19.7%	19.1%	19.7%	18.7%	20.4%	21.4%	20.2%	19.9%	19.2%	20.2%	21.4%	19.9%	TBC	n/a	n/a	n/a
Percentage of people who are discharged from acute hospital to their usual place of residence (NEW)	Apr-26	84.1%	82.8%	83.6%	82.0%	82.2%	80.9%	82.1%	83.2%	83.3%					TBC		81.9%	n/a
Reduction in emergency admissions for people aged 65+ (NEW)	Jul-26	11,358	11,467	11,937	10,987	11,707	11,783	10,385	11,893	11,578	11,589	11,628	12,249		11,731	n/a	n/a	n/a
Reduction in non-elective admissions for patients with frailty (10% reduction against baseline) (NEW)	Jul-26	5,384	5,428	5,696	5,149	5,270	5,527	5,167	5,909	5,857	5,676	5,632	5,620		5,437			n/a
Reduction in the proportion of our population dying in hospital - All ages (NEW)	Jul-26	47.6%	47.9%	46.1%	48.3%	46.9%	49.0%	46.8%	47.0%	49.3%	46.8%	47.6%	48.7%		46.8%	n/a	42.80%	n/a
Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation	Apr-26	1.000	1.005	0.998	0.999	1.007	1.001	1.000	1.006	1.007					0.887 to 1.127		1.000	n/a
Variance between ICB Financial Position v Plan £000 (YTD) (NEW)	Jul-26	(2,430)	(1,033)	(979)	(962)	(7,129)	(18,231)	(29,749)	(50,334)	n/a	£ -	£ -	£ -		£0			n/a
Variance between Capital Spend v Plan £000 (YTD) (NEW)	Jul-26	£ 700	£ 700	£ 700	£ 700	£ 700	£ 700	£ -	£ 24,012	n/a	£ -	£ -	£ -		£0			n/a
Variance between CRES v Plan £000 (YTD) (NEW)	Jul-26	(2,863)	(3,432)	(10,674)	(9,636)	(5,583)	(4,236)	(5,511)	(9,327)	n/a	(693)	(575)	£ 1,464		£0			n/a
Workforce - total turnover rate (NEW)	Jun-26	7.1%	6.5%	6.6%	6.3%	5.7%	5.4%	5.1%	17.4%	17.5%	19.5%	19.9%			10%			n/a
Workforce - sickness absence rate	Jun-26	6.2%	6.2%	6.2%	6.3%	6.3%	6.2%	5.3%	4.5%	4.6%	4.4%	4.1%			2.5%	4.4%	5.1%	n/a
Appraisal compliance rate (NEW)	Jun-26	67.2%	65.8%	65.1%	65.5%	68.0%	68.4%	67.4%	66.7%	64.2%	61.6%	58.8%			95%			n/a
Mandatory training compliance rate (NEW)	Jun-26	87.6%	88.9%	89.3%	89.1%	89.2%	89.8%	89.9%	88.7%	87.8%	87.3%	86.2%			95%			n/a

Oversight Framework - Capability, Segmentations and Ratings

NHS Cheshire and Merseyside

C&M Acute and Specialist Trusts

	Latest Capability Rating	2025/26 Published Ratings				2026/27	2025/26 Published League Table Position				2026/27
Trust		**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1***
Liverpool Heart and Chest Hospital NHS Foundation Trust	Green	1	1	1	1	1	4/134	3/134	5/134	4/134	1/134
The Clatterbridge Cancer Centre NHS Foundation Trust	Green	1	1	1	1	1	8/134	9/134	7/134	10/134	4/134
Alder Hey Children's Hospital NHS Foundation Trust	Green	1	1	1	1	1	16/134	10/134	14/134	15/134	11/134
The Walton Centre NHS Foundation Trust	Green	1	1	1	1	2	7/134	5/134	13/134	14/134	20/134
Liverpool Women's NHS Foundation Trust	Amber/Red	3	4	3	3	3	68/134	109/134	93/134	72/134	50/134
Mersey and West Lancashire Teaching Hospitals Trust	Amber/Green	3	3	3	3	3	56/134	51/134	83/134	56/134	51/134
Mid Cheshire Hospitals NHS Foundation Trust	Amber/Red	3	4	4	3	3	96/134	115/134	118/134	94/134	65/134
Countess of Chester NHS Foundation Trust	Red	4	4	4	3	3	133/134	132/134	122/134	98/134	95/134
North Cheshire & Mersey NHS Foundation Trust	Amber/Red	4 (as Warrington & Halton)				3	118/134	125/134	106/134	102/134	97/134
Wirral University Teaching Hospitals NHS Foundation Trust	Red	4	4	4	4	3	107/134	110/134	124/134	123/134	99/134
East Cheshire NHS Trust	Amber/Green	3	4	4	4	4	99/134	119/134	122/134	126/134	120/134
Liverpool University Hospitals NHS Foundation Trust	Amber/Red	4	4	4	4	4	116/134	111/134	113/134	109/134	126/134

Notes:

i) Green text indicates an improvement in rating/ranking between Q4 of 2025/26 and Q1 of 2026/27, Red text indicates a deterioration

ii) North Cheshire & Mersey were previously rated as Segment 4 for each quarter of 2025/26, as Warrington & Halton NHS Foundation Trust

iii) *Trusts are ordered by their 2026/27 Q1 ranking

iv) The 2026/27 Oversight Framework uses a refreshed set of metrics and methodology. Further information can be found at https://www.england.nhs.uk/nhs-oversight-framework/

Oversight Framework - Capability, Segmentations and Ratings

NHS Cheshire and Merseyside

C&M Non Acute Trusts

	Latest Capability Rating	2025/26 Published Ratings				2026/27	2025/26 Published League Table Position				2026/27
Trust		**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1***
Mersey Care NHS Foundation Trust	Amber/Red	2	2	2	2	2	25/61	22/61	23/61	24/61	**14/58**
Wirral Community Health and Care NHS Foundation Trust	Green	1	1	1	1	**2**	12/61	9/61	9/61	10/61	**16/58**
Cheshire and Wirral Partnership NHS Foundation Trust	Amber/Green	4	3	3	3	**2**	49/61	44/61	47/61	45/61	**29/58**
Bridgewater Community Healthcare NHS Foundation Trust	Amber/Green	3	3	3	4	N/A	39/61	30/61	37/61	61/61	N/A

Ambulance Trust - for info only

	2025/26 Published Ratings				2026/27	2025/26 Published League Table Position				2026/27
Trust	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
North West Ambulance Service NHS Trust		1	1	1	**2**		1/10	1/10	3/10	tbc

Notes:

i) Green text indicates an improvement in rating/ranking between Q4 of 2025/26 and Q1 of 2026/27, Red text indicates a deterioration

ii) Bridgewater were previously rated during 2025/26, however for 2026/27, please refer to North Cheshire & Mersey NHS Foundation Trust

iii) *Trusts are ordered by their 2026/27 Q1 ranking

iv) The 2026/27 Oversight Framework uses a refreshed set of metrics and methodology. Further information can be found at https://www.england.nhs.uk/nhs-oversight-framework/

Integrated Quality & Performance Report – Guidance:

NHS Cheshire and Merseyside

Provider Acronyms:

CHESHIRE & MERSEYSIDE TRUSTS

AHCH	ALDER HEY CHILDREN'S HOSPITAL NHS FT
COCH	COUNTESS OF CHESTER HOSPITAL NHS FT
CWP	CHESHIRE AND WIRRAL PARTNERSHIP NHS FT
ECT	EAST CHESHIRE NHS TRUST
LHCH	LIVERPOOL HEART AND CHEST HOSPITAL NHS FT
LUFT	LIVERPOOL UNIVERSITY HOSPITALS NHS FT
LWH	LIVERPOOL WOMEN'S NHS FT
MWL	MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST
MCFT	MERSEY CARE NHS FT
MCHT	MID CHESHIRE HOSPITALS NHS FT
NCM	NORTH CHESHIRE AND MERSEY NHS FT
TCCC	THE CLATTERBRIDGE CANCER CENTRE NHS FT
TWC	THE WALTON CENTRE NHS FT
WCHC	WIRRAL COMMUNITY HEALTH AND CARE NHS FT
WUTH	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT

KEY SYSTEM PARTNERS

NWAS	NORTH WEST AMBULANCE SERVICE NHS TRUST
CMCA	CHESHIRE AND MERSEYSIDE CANCER ALLIANCE
CMPC	CHESHIRE AND MERSEYSIDE PROVIDER COLLABORATIVE

OTHER

OOA	OUT OF AREA AND OTHER PROVIDERS

Key:

Data formatting

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

C&M National Ranking against the 42 ICBs

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

C&M National Ranking against the 22 Cancer Alliances

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

Notes on interpreting the data

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

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

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

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

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

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

Integrated Quality & Performance Report – Interpreting SPC Charts:

NHS Cheshire and Merseyside

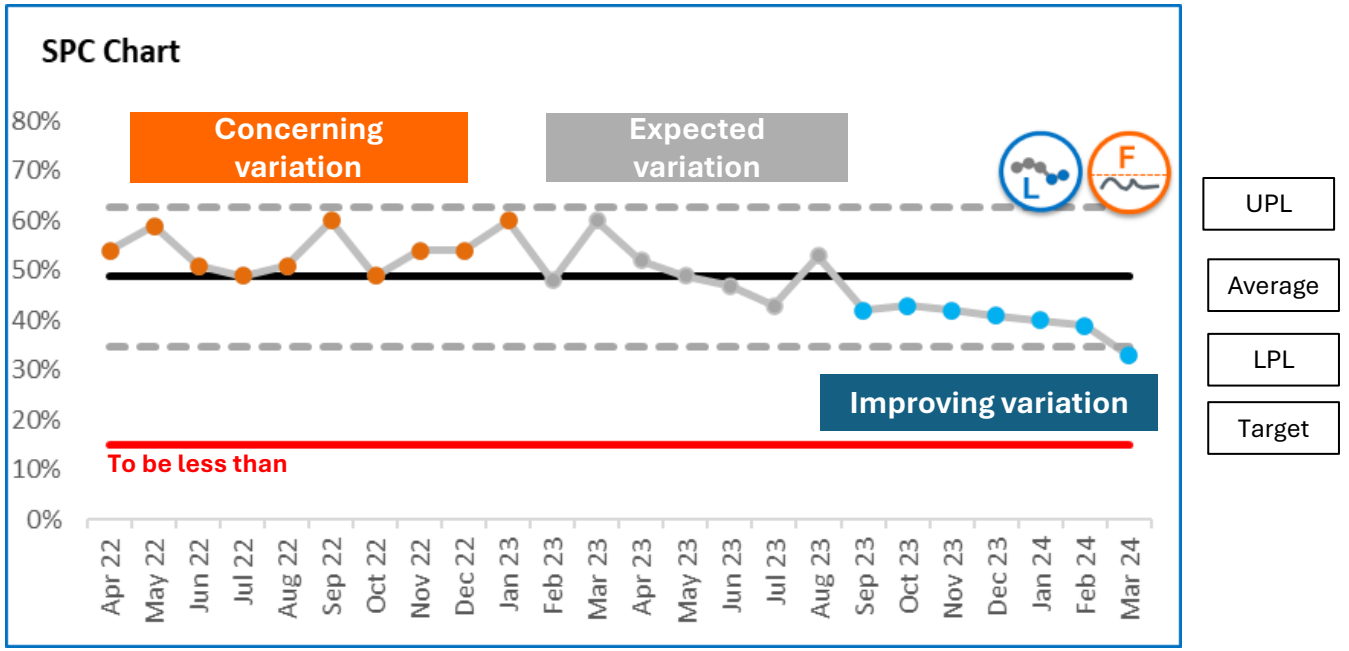
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

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

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

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

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



UPL

Average

LPL

Target

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

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

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

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

Integrated Quality & Performance Report – Interpreting summary icons:

NHS Cheshire and Merseyside

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

	Variation / performance icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of a CONCERNING nature.	**Something's going on!** Something, a one-off or a continued trend or shift of numbers in the wrong direction	**Investigate** to find out what is happening or has happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an IMPROVING nature.	**Something good is happening!** Something, a one-off or a continued trend or shift of numbers in the right direction. Well done!	Find out what is happening or has happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Assurance icons		
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is the target will be achieved or missed at random.	Consider whether this is acceptable and, if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	If a target lies **outside of those limits in the wrong direction** then you know the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	If a target lies **outside of those limits in the right direction** then you know the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Meeting of the Quality & Performance Committee of NHS Cheshire and Merseyside

Date: 9th July

Highlight report of the Chair of the Quality & Performance Committee

Agenda Item No: **ICB/09/24/26/14**

Report completed by: **Tony Foy**

Committee Chair: **Tony Foy**

Highlight report of the Chair of the Quality & Performance Committee July Meeting

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

Key escalation and discussion points from the Committee meeting

Alert

Paediatric Audiology

- The Committee reviewed the situation regarding the ongoing national Paediatric Audiology improvement programme and concerns relating to one Trust's delays in compliance with the requirements of the review process, noting a prolonged period of engagement by the ICB to remedy the concerns. A formal letter has now been received from NHS England Region requiring an ICB-led Incident Management Group (already established by ICB) and further escalation. The Committee agreed to the requirement for:
  - An externally led Child Hearing Impairment Audit.
  - External subject matter experts to review the full waiting list and patient records.
  - Access to records to be provided by the end of July 2026.
  - Completion of the review process by September 2026, with a full report expected to return to Committee in October 2026.

Advise

The Committee advises the Board of the following matters:

Risk Review

- The Committee undertook a detailed review of the current Quality Risk Register and the proposed changes to risk scores. Members supported the move towards a more consistent Cheshire and Merseyside-wide approach to risk management, with greater reliance on subject matter expertise and organisational oversight rather than historic place-based scoring methodologies. Members did not agree to several proposed reductions in risk scores (see later section), with a strong emphasis on ensuring that risk ratings remain focused on potential harm to patients and population outcomes.

System Quality Group

- The principal focus of the SQG meeting was care home quality and the wider system support available to care homes. Presentations were received from a number of partners, including Healthwatch, to help SQG better understand the challenges facing the sector and the importance of care homes within wider patient flow and discharge pathways
- Escalations Two issues were formally escalated through SQG.
  - *Neurodevelopmental Assessment Delays* **-** Ongoing concerns were highlighted regarding excessive waiting times for neurodevelopmental assessments.
  - *Care Home Residents During Hospital Admission* **-** Care home staff accompanying residents can sometimes be overlooked within acute settings, resulting in poor access to support facilities and appropriate communication.
- *Key Areas Identified for System Improvement*

  1. Variation in Community and Primary Care Support. Considerable variation has been identified in the services that support care homes across Cheshire and Merseyside.
  2. Discharge Communication and Placement Decisions. Challenges relating to patient discharge and placement decisions
  3. Early Identification of Escalating Care Needs. The identification of residents whose needs are escalating beyond those that can be safely managed within residential care settings where individuals experienced a deterioration in health, required acute hospital admission and subsequently required nursing care placement, leading to

delays in discharge and prolonged hospital stays. Earlier identification of deteriorating residents would provide opportunities to intervene sooner, potentially avoiding avoidable admissions and improving discharge flow across the system.

- Committee members welcomed the increasing connectivity between the System Quality Group and the Quality and Performance Committee. It was noted that SQG has become an effective mechanism for engaging partners and identifying emerging quality concerns across the system before they become more significant risks.

End of Life Care – Population Needs Assessment and Strategy

- Population Based Needs Assessment was completed during 2025 and involved detailed analysis of mortality, demographics, service utilisation and inequalities across Cheshire and Merseyside. The assessment predicts that annual deaths across Cheshire and Merseyside will increase from approximately 27,000 to around 34,000 over the next decade. Around 80% of these individuals are expected to require, or benefit from, palliative and end of life care. The assessment identified significant inequalities in outcomes and experiences for patients depending on deprivation, geography, ethnicity and disability.
- The strategy is being developed alongside the Population Based Needs Assessment rather than duplicating it. Three strategic priorities were presented:
  1. Early Identification and Advance Care Planning
  2. Right Care, Right Time, Right Place
  3. Coordination and Continuity of Care

  The Committee noted that a public engagement exercise involving 227 respondents had been undertaken. Feedback identified several priorities, including earlier identification of people approaching end of life, better coordination between services, reduced delays in hospital discharge, improved communication, greater emotional and practical support for families and carers and improved bereavement support following a person's death.
- Members discussed the concept of preferred place of care and preferred place of death. It was advised that it is increasingly challenging to assume that hospices can meet demand from everyone expressing a preference for hospice-based end of life care. Hospices were described as specialist environments that should primarily support individuals with the most complex needs whilst extending their expertise into community settings. The Committee noted that greater emphasis needs to be placed on supporting people to receive high-quality palliative care in their own homes and communities rather than focusing solely on inpatient hospice provision.

Assure

Maternity

Positive Performance against national indicators.

- Stillbirth rates, Hypoxic Ischaemic Encephalopathy (HIE) rates, pre-term birth rates, Babies born in the right place, third- and fourth-degree tear rates and smoking at time of delivery.

Challenges

- Persistently low rates of women booking with maternity services within the first ten weeks of pregnancy. Concerns were raised regarding performance at Liverpool Women's Hospital and East Cheshire. Delayed booking is associated with poorer maternity outcomes and therefore remains an important area of focus. In East Cheshire, it was suggested that some of the reported issues may relate to data quality, further validation work is required before this can be confirmed. Liverpool Women's Hospital are undertaking focused quality improvement work to improve these figures.
- Delays relating to induction of labour continue to present operational pressures across maternity units. Weekly system-wide command/control arrangements are now in place

to monitor pressures and support mutual aid across providers. Concerns were raised that current approaches to induction planning may not always adequately reflect wider capacity and demand across maternity services. A detailed review of induction of labour pathways is underway and that a more comprehensive report will be presented to a future Committee meeting.

Triage - Cheshire and Merseyside has previously undertaken significant work through the implementation of the Birmingham Symptom-Specific Obstetric Triage System (BSOTS). Local measurement standards are more stringent than national reporting requirements, with breaches being monitored at earlier intervention points. Whilst triage breaches continue to occur within some trusts, members were assured that providers are actively reviewing and responding to identified issues through quality improvement initiatives.

Home birth service - Suspensions across the region, particularly within North Cheshire and Mersey Trust are influenced by workforce pressures and by positive actions taken following a previous safety incident. Providers have implemented more stringent criteria for maintaining home birth services and that forthcoming national home birth guidance may assist in providing greater consistency across services.

Integrated Performance Report
The Committee received the revised Integrated Performance Report (IPR) and welcomed the significant redesign of the Quality Performance Dashboard noting that the report is currently in transition and forms part of a wider programme to align performance reporting with the ICB's strategic objectives, statutory responsibilities and emerging life-course framework.

- Urgent and emergency care performance has shown signs of stabilisation Four-hour performance has become less volatile (73.8% in May, below the national expectation ranked 23/26). Ambulance handover delays have improved – mean handover time in May was 30:45 against the expectation of 15:00 – improvements at CoCH ECT and NCM. These improvements have been supported by work across discharge pathways, patient flow initiatives and wider system actions designed to improve operational resilience.
- Cancer standards were highlighted as a continued success story for Cheshire and Merseyside. April's 62 Day Waits was at 76.9% which is above the national performance of 69.8%

Several preventative health indicators were reported as improving, including:

- Hypertension control.
- Cholesterol management.
- Smoking prevalence reduction.
- Members recognised these as important indicators of the ICB's broader population health ambitions and preventative care agenda

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**
Qu05 Neurodevelopmental Assessment Delays	Reduction not agreed when impact of delays was considered
Qu08 Quality Capacity and Process	Reduction Agreed

Corporate Risk Register risks	
Qu09 ECT SHMI	Reduction not agreed noting that a strategic approach required beyond local improvements
Qu10 Children Looked After IHAs	Reduction Agreed
Qu16 Safeguarding capacity	Reduction Agreed subject to continuing oversight
Qu17 SEND Inspections	Reduction agreed following strengthened arrangements
Cu18 AACC budget	Refer to FICC
Cu19 AACC workforce	Reduction Agreed
Cu 20&21 FNC and AACC	Reduction based on financial impact alone not agreed. Committee view was that clinical and family impact needed evaluation – revised risk narrative to be agreed.

Board Assurance Framework Risks	
Risk Title	**Key actions/discussion undertaken**
P4 potential for major quality failures	Referred to in Maternity, End of Life Care reports

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	
Maternity	
End of Life Care	

Meeting of the Quality & Performance Committee of NHS Cheshire and Merseyside

Date: August 13th 2026 Annual Review Session

Highlight report of the Chair of the Quality & Performance Committee

Agenda Item No: **ICB/09/24/26/14**

Report completed by: **Tony Foy**

Committee Chair: **Tony Foy**

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/

Key escalation and discussion points from the Committee meeting

Purpose: To provide the Board with a summary of key discussions, decisions, and actions from the Quality and Performance Committee meeting.

ALERT – Key Risks, Concerns and Issues Requiring Escalation

No alerts – the meeting was an annual review and reset session. Formal reports were deferred to September.

ADVISE – Key Points for Board Awareness and Action

The session was a strategic reset: a structured opportunity to reflect on the past year, identify persistent and emerging risks, and agree the forward agenda for the next 12 months. It repositioned the committee within its strategic commissioning role, emphasising pathway-based oversight, population health, inequalities, proactive surveillance, and alignment with the five-year plan.

The renewed focus for the committee in summary was agreed as, the organisation now operates as a strategic commissioner, and the committee must adapt accordingly. This means:

- Focusing on pathways rather than isolated providers.
- Prioritising population health, inequalities, and outcomes.
- Ensuring surveillance is proactive, not reactive.
- Understanding how national and regional oversight frameworks will interact with local responsibilities.

Key risks to be evaluated for future agenda planning included:

- Changes to maternity oversight and uncertainty around regional frameworks.
- Fragile and hidden services across the system.
- Mental health delays and bed pressures.
- Variation in outcomes across geography, deprivation, ethnicity and other population groups.
- The future of patient experience intelligence and Healthwatch involvement.

ASSURE – Positives, Progress and Areas of Strength

Significant Agreements for future work

- Assurance and Oversight of Persistent Risks: The committee acknowledged that while it had undertaken deep-dive assurance on major issues—such as the East Cheshire mortality concerns—follow-up had not always been sufficiently sustained.

- Shift from Provider-Focused to Pathway-Focused Oversight: A key reflection was that the committee had sometimes become drawn into important single-provider issues/risks which although productive was at the expense of focusing on whole pathways/populations.

- Surveillance of Fragile and Hidden Services: The committee reflected on several service failures during the year such as palliative care closures and issues in supported living that emerged without early warning. Members recognised that current surveillance arrangements do not reliably identify fragility in smaller or non-NHS providers. The discussion emphasised the need for more proactive intelligence

gathering, earlier identification of organisational instability, and better use of system partners to detect emerging risks.

- Escalation Frameworks and the Role of Strategic Commissioners: Members discussed the National Quality Board's escalation framework and noted that while the committee had used elements of it effectively, the new operating environment requires clarity on:
  - when issues should be escalated locally, regionally or nationally,
  - how strategic commissioners maintain active oversight not passive observers,
  - regional involvement does not dilute local responsibility for population outcomes

- Maternity Assurance and System Governance: A significant reflection concerned maternity oversight. The committee noted that previous joint oversight arrangements had been effective, relationships and surveillance had improved markedly, but the forthcoming regional framework was unclear and posed risks to local assurance.

- Recognition of Patient Experience as a Core Component of Quality. The committee reflected that patient experience must be treated as a fundamental part of the quality agenda, alongside safety and clinical effectiveness. Members acknowledged that while patient experience is referenced within the five-year plan, it has not yet been consistently embedded across all committee discussions and reporting. The discussion emphasised that patient experience should not be an adjunct to quality assurance but a central pillar informing commissioning decisions, pathway design and performance oversight.

Actions on all of the above will be followed through at September and October meetings. Mental Health system delays report is scheduled for November

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**
Future risk review	• Changes to maternity oversight and uncertainty around regional frameworks. • Fragile and hidden services across the system. • Mental health delays and bed pressures. • Variation in outcomes across geography, deprivation, ethnicity and other population groups. • The future of patient experience intelligence and Healthwatch involvement.

Board Assurance Framework Risks	
Risk Title	**Key actions/discussion undertaken**

Board Assurance Framework Risks	

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

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

1st September 2026

Highlight report of the Chair of the ICB Audit Committee

Agenda Item No: **ICB/09/24/26/15**

NHS
Cheshire and Merseyside

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	1st September 2026

This report summarises the Audit Committee's key alerts, advice and assurances from its September 2026 meeting, during a period of organisational transition.

Key escalation and discussion points from the Committee meeting

Alert

- **Committee Risk Register Report:** The Committee reviewed its four assigned risks and noted that Risk G5 (inconsistent adherence to governance, financial and operational policies) remains rated as Critical (20). Risk G5 remains rated 'critical' (20). While NHS England undertakings remain in place, the Committee noted evidence of a strengthening control environment through organisational improvements, external audit findings and the Annual Governance Statement, but requested clearer evidence of progress to support future review of the risk rating.
- **Freedom of Information (FOI) Q1 2026/27 Report:** The Committee noted a reduction in statutory compliance, with performance falling to 78.5%. Members were advised that the decline largely reflects organisational change, staffing pressures and delays in obtaining information from operational teams. The Committee requested a further report analysing breaches, underlying causes and improvement actions.

Advise

- **Risk Management Strategy:** The Committee reviewed the draft revised Risk Management Strategy and supported the proposed direction of travel. Members highlighted the importance of clearly articulated risk appetite statements, strong links to the evolving operating model and ensuring that committees retain appropriate oversight of risks within their remit. The final strategy will be presented to the Board in November 2026 following wider engagement.
- **Corporate Governance Handbook:** The Committee welcomed development of the Governance Handbook as a single reference source for governance, assurance and accountability arrangements. Members recognised its potential value in supporting ongoing improvement activity, organisational learning and compliance with NHS England undertakings. Further enhancements to audit and assurance sections were recommended prior to Board approval.

Assure

- **Cyber Security Update:** The Committee received assurance regarding continued progress in developing a coordinated Cheshire and Merseyside

cyber security programme. Members supported the establishment of a 'Digital Data and Technology Office' and noted strengthened arrangements for cyber resilience, incident response, assurance and safe-by-design governance across partner organisations.

- **Information Governance Q1 2026/27 Report:** The Committee received assurance that the ICB successfully achieved a "Standards Met" assessment for the Data Security and Protection Toolkit (DSPT) and continues to make progress in information governance arrangements. Members noted ongoing work to improve staff compliance with IG training and strengthen system-wide learning from data incidents and breaches.
- **Declarations of Interest:** The Committee received assurance that robust arrangements remain in place for managing conflicts of interest, gifts and hospitality declarations, although further improvement is required in mandatory conflicts of interest training compliance.
- **Internal Audit Progress Report:** The Committee noted that the ICB's assurance profile has improved to 'Moderate Risk', representing an improvement on previous years. Members also welcomed MIAA's achievement of a 'Generally Conforms' rating against the Global Internal Audit Standards, the highest level of external assessment available.
- **External Audit Progress Report:** The Committee received assurance that all planned external audit activity for 2025/26 has been completed, with ongoing work focused on governance and information management improvements
- **Anti-Fraud Progress Report:** The Committee received assurance that counter fraud arrangements remain effective, with performance rated green overall. Members noted continued delivery of awareness, prevention and investigation activity together with compliance monitoring and collaboration with internal audit colleagues.

The next meeting of the Committee is scheduled for **1st December 2026.**

Appendices

Audit Committee Annual Report

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

Audit Committee Annual Report 2025-26

Agenda Item No: **ICB/09/24/26/15**

Responsible Director: Ben Vinter, Director of Corporate Services and Governance

1. Report Purpose

1.1 The reports presents the Committee with its draft Annual Report for the 2025-26 period for its review and approval.

2. Executive Summary

2.1 As per the Committees Terms of Reference, the Committee is required to produce an Annual Report to present to the ICB Board. The Annual Report outlines the key areas the Committee has reviewed in its last year's business, key decisions it has made, the Chair's opinion on how the Committee has met its duties within year and attendance details. Incorporated into the annual report is the findings of the annual committee effectiveness self- assessment survey.

2.2 Committee members were asked to review the draft annual report and outline whether any further changes should be made. This took place on 1st September and none were made.

2.3 The Committee Chair is asked to review the draft Chairs statement and outline whether any further changes should be made.

2.4 The Committee supported the Annual Report being submitted to the ICB Board at its next meeting.

3. Ask of the Board and Recommendations

3.1 Audit Committee is asked to:

- **Note** that the Committee's Annual Report

4. Officer contact details for more information

Ben Vinter, Director of Corporate Services and Governance

5. Appendices

Appendix One: Audit Committee Annual Report 2025-26

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NHS
Cheshire and Merseyside

Audit Committee

Annual Report 2025 - 2026

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1. Introduction

The Audit Committee (the Committee) has been established by NHS Cheshire and Merseyside Integrated Care Board ('ICB') as a Committee of the ICB in accordance with its Constitution.

The Committee is a non-executive committee of the ICB and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

This report sets out the work undertaken by the Audit Committee during the 2025-26 year (01 April 2025 – 31 March 2026). This demonstrates how the committee has met the responsibilities set out for it by the ICB within its constitution, its compliance with the committees Terms of Reference (TOR), its effectiveness and the impact of the Committee.

In addition to it being a formal report to the Committee, the evidence contained in this report will be shared with the Board of the ICB.

The Committee's membership requirements are set out in its TOR. The TOR was last approved by the Board of the ICB in September 2023.

2. Membership

The membership of the Committee between 01 April 2025 and 31 March 2026 was:

- Tony Foy, Non-Executive Member (Deputy Chair) *(Chair from 01 March 2025 until 20 April 2025)*
- Erica Morris, Non-Executive Member
- Prof. Hilary Garratt, Non-Executive Member
- Dr Ruth Hussey, Non-Executive Member.
- Mike Burrows, Non-Executive Member (Chair) (*Chair from 21 April 2025)*

3. Meetings

From 01 April 2025 to 31 March 2026, the Committee met on six occasions and was quorate at each meeting. The Committee met on the following dates:

08 April 2025
06 May 2025 – Meeting cancelled
10 June 2025
02 September 2025
02 December 2025
03 March 2026

Details of the attendance of Committee members at all of these meetings are enclosed at **Appendix One** for information.

4. Committee Responsibilities and Duties

The Committee's main purpose is to contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.

In summary, the Committee's duties for and on behalf of the ICB and its functions can be categorised as follows:

- Integrated governance, risk management and internal control
- Internal Audit
- External Audit
- Counter Fraud
- Conflicts of Interest
- Information Governance
- Freedom to Speak Up
- Financial Reporting
- Other assurance functions to the Board.

The Audit Committee is authorised by the Board to:

- investigate and approve any activity as outlined within its terms of reference
- seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference
- commission any reports it deems necessary to help fulfil its obligations
- obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice
- create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD) but may/ not delegate any decisions to such groups.
- commission, review and approve policies where they are explicitly related to areas within the remit of the Committee as outlined within the TOR, or where specifically delegated to the Committee by the ICB Board.

The Audit Committee is authorised to:

- approve the ICBs counter-fraud and security management arrangements
- appoints the ICBs Internal Auditors and approves the Internal Audit Plan
- appoints the ICBs External Auditors and approves the External Audit Plan
- review, approve and monitor counter fraud work plans
- seek assurance on the financial reporting arrangements of the ICB
- approve the arrangements for managing conflicts of interest and declarations of Gifts and Hospitality

- approve the policies and arrangements for ensuring appropriate and safekeeping and confidentiality of records and for the storage, management and transfer of information and data.

5. Review of Committee Activities

Between 01 April 2025 and 31 March 2026, the Committee reviewed the following areas: -

8 April 2025

- ICB Financial Policies Update
- IG Service Q4 Report
- Q3 SAR Update Report
- Annual Report and Accounts 2024/25 Update
- Internal Audit Plan 2025/26
- Anti-Fraud Annual Work Plan 2025/26
- External Audit Progress Report

10 June 2025

- ICB Financial Procurement Waivers
- Cheshire & Merseyside Cyber Security Update
- CAF-aligned Data Security and Protection Toolkit (DSPT) Update
- FOI Q4 Report
- SAR Annual Report 2024/25
- Risk Management Process Report
- Declarations of Interest Q4 Report
- Annual Report and Accounts 2024/25
- Audit Findings Report / Letter of Representation
- Head of Internal Audit Opinion 2024/25
- Internal Audit Plan Progress Report
- Internal Audit Follow-Up Summary
- Internal Audit Charter
- Global Internal Audit Standards Briefing
- Anti-Fraud Annual Report 2024/25
- Anti-Fraud Progress Report
- MIAA Fraud Referrals Analysis Insight Briefing
- Auditors' Annual Report

9 September 2025

- Freedom to Speak Up Quarterly Update
- IG Service Quarter 1 Update
- Cheshire & Merseyside Cyber Security Update
- FOI Q1 2025/26 Report
- SAR Q1 2025/26 Report
- Declarations of Interest Q1 2025/26 Report
- Audit Committee Annual Report 2024/25
- Internal Audit Plan Progress Report
- Internal Audit Follow-Up Summary
- Anti-Fraud Progress Report

- Feedback from NHSCFA following the Counter Fraud Functional Standard Return
- External Audit Progress Report
- Risk Register Report

2 December 2025

- Risk Register
- Audit Committee Terms of Reference Review
- ICB Procurement Waivers
- Cheshire & Merseyside Cyber Security Update
- IG Service Quarter 2 Update Report
- Updated Section 75 Policy
- FOI Q2 2025/26 Report
- SAR Q2 2025/26 Report
- Declarations of Interest Report
- Freedom to Speak Up Quarterly Report
- Internal Audit Progress Report
- Internal Audit Follow-Up Summary
- Anti-Fraud Progress Report
- External Audit Progress Report and Winter 2025 Sector Update

3 March 2026

- Annual Report and Accounts 2025/26 Update
- Cheshire & Merseyside System-Wide Cyber Security Update
- Finance Governance Review Update
- Board Assurance Framework Risk Report
- FOI Q3 2025/26 Report
- SAR Q3 2025/26 Report (deferred)
- Declarations of Interest Q3 2025/26 Report
- IG Service Quarter 3 Update Report
- Internal Audit Plan Progress Report
- Internal Audit Follow-Up Summary
- Anti-Fraud Progress Report
- External Audit Plan 2025/26

21 April 2026

- Annual Report and Accounts 2025/26 Update
- ICB Standards of Business Conduct Policy
- Internal Audit Progress Report
- Internal Audit Follow-Up Summary
- Draft Head of Internal Audit Opinion 2025/26
- Draft Internal Audit Workplan 2026/27
- Internal Audit Charter
- Anti-Fraud Workplan 2026/27
- External Audit Sector Update Report
- Mental Health Investment Standard Compliance Statement Report

18 May 2026 (Extraordinary Meeting)

- Annual Report and Accounts 2025/26 Update (further review following NHSE and auditor feedback)

Decisions undertaken by the Committee during 01 April 2025 – 31 March 2026 included:

08 April 2025

ICB Financial Policies Update The Audit Committee NOTED and APPROVED the update and changes to the Financial Policies. .

Internal Audit Plan 2025-2026. The Audit Committee NOTED and APPROVED the Draft Internal Audit Plan 2025/26.

Anti-Fraud Annual Work Plan 2025-26. The Committee NOTED and approved the Anti-Fraud 2025-2026 workplan.

10 June 2025

Cyber Assessment Framework (CAF) aligned Data Security and Protection Toolkit (DSPT) Update to Audit Committee. The Audit Committee NOTED all the above and Approved the submission of the DSPT Audit to NHSE.

Annual Report and Accounts 2023-24. The Audit Committee endorsed the report subject to minor changes

03 September 2025

Committee Annual Report 2023-24. The committee APPROVED the Annual report and supported the proposed amendments, with the final version to be submitted to the Board.

02 December 2025

Audit Committee TOR . The Audit Committee ACCEPTED the proposed changes and RECOMMENDED the ICB Board approve the updated TOR.

Updated Section 75 Policy. The Audit Committee APPROVED the updated Section 75 Policy subject to the addition of the wording as discussed.

Cheshire and Merseyside System Wide – Cyber Security Update. The Audit Committee NOTED the ongoing Cyber Risk Management, and the decision taken by the ICB Executive Team to protect the full allocation of national Revenue for the Cyber Security Strategy, and also NOTED the NHS Regional Blueprint as outlined.

03 March 2026

Finance Governance Review Update. The Audit Committee NOTED the interim report and emphasised the importance of incorporating its feedback into the final recommendations.

Board Assurance Framework Risk. The Audit Committee NOTED the report, emphasising the need for closer scrutiny of mitigation effectiveness and accuracy of risk scoring.

6. Conduct of the Committee

The Committee administrative support minuted the proceedings of all meetings of the Committee, including recording the names of those present and in attendance. Where any declarations where made these were recorded within the minutes of the meeting. The Committee reported to the Board after each Committee meeting via a Committee Chairs report.

Committee members have also been asked to undertake an Annual Committee effectiveness self-assessment survey so as to help inform where improvements may need to be made to the Committee as well as if there are any gaps. The results of this survey (Appendix Two) indicate that Committee members and regular attendees who completed the survey believe that the Committee is well Chaired and supported, members have the opportunity to contribute to the issues on the agenda, and it acts in accordance to its Terms of reference. Comments for improvements focussed largely on how to improve the format and effectiveness of the in-camera meeting between Committee Members and the Auditors that is undertaken following each Committee meeting.

7. Conclusions from the Audit Chair

The Committee was in a position to recommend to the Board at its meeting in June 2026 that the Annual Report and Accounts 2025 – 2026 should be approved, and recognised the considerable work that had been achieved by the ICB over that year in delivering against its statutory responsibilities.

1. Conduct of the Committee
The Committee administrative support minuted the proceedings of all meetings of the Committee, including recording the names of those present and in attendance. Where any declarations where made these were recorded within the minutes of the meeting. The Committee reported to the Board after each Committee meeting via a Committee Chair's report.

Committee members have also been asked to undertake an Annual Committee effectiveness self-assessment survey so as to help inform where improvements may need to be made to the Committee as well as if there are any gaps. The results of this survey (Appendix Two) indicate that Committee members and regular attendees who completed the survey believe that the Committee is well Chaired and supported, members have the opportunity to contribute to the issues on the agenda, and it acts in accordance to its Terms of reference. Comments for improvements focussed largely on how to improve the format and effectiveness of the in-camera meeting between Committee Members and the Auditors that is undertaken following each Committee meeting.

2. Conclusions from the Audit Chair
The Committee was in a position to recommend to the Board at its meeting in June 2026 that the Annual Report and Accounts 2025 – 2026 should be approved, and recognised the considerable work that had been achieved by the ICB over that year in delivering against its statutory responsibilities.

The Committee has met its regularity obligations, as well as performing those other functions delegated to it by the Board. The Committee has met when required to discharge these functions.

The Committee has applied best practice in its deliberations and decision making processes, and it has conducted its business in accordance with national guidance and relevant codes of conduct and good governance practice.

The Committee will continue to seek improvements in how it operates and will seek to address the areas for improvements as identified within the Committees annual effectiveness survey.

Appendix One - 01 April 2025 – 31 March 2026 Meeting attendance details

		Meeting dates 2025-2026						
Name	**Position**	**08.04.25**	**06.05.25**	**10.06.25**	**02.09.25**	**02.12.25**	**03.03.26**	
Mike Burrows	Non-Exec (Chair)	Not in post	No Meeting	☒	☑	☑	☑	
Erica Morriss	Non-Exec	☒	No Meeting	☒	☑	☑	☑	
Tony Foy	Non-Exec (Deputy Chair)	☑	No Meeting	☑	☑	☑	☑	
Hilary Garratt	Non-Exec	☑	No Meeting	☑	☑	☑	☒	
Ruth Hussey	Non-Exec	☑	No Meeting	☑	☑	☑	☑	

☑ Present
☒ Apologies received

Meeting of the System Primary Care Committee of NHS Cheshire and Merseyside

20 August 26

Highlight report

Agenda Item No: **ICB/09/24/26/16**

Highlight report of the Chair of the SPCC Committee

Committee Chair	*Erica Morriss*
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	*20 August 26*

Key escalation and discussion points from the Committee meeting

Alert

Local Commissioning – Enhanced Services Review

The Committee was presented with options in relation to the outcomes of the review of existing Enhanced Services - which covers general practice 'non core' commissioned services. There are currently differential approaches to service detail and funding based on previous 9 place arrangements. In reaching a decision the committee noted ICB staffing and resource pressures and the need for a detailed funding plan to address the spend differentials with sound reasoning. Future specifications will need to reflect the future commissioning and contracting landscape including neighbourhood health, new contracting forms and our life course/population health needs. The Committee agreed that therefore the new enhanced service approach and specifications should be live from **April 2028** with notice served during **2027 on all existing specifications.** Some limited areas of decommissioning may occur prior to that where required. An update on the next phase will be presented to the Committee in December, to give time to finalise the project approach, governance and onward communications. It was noted that communication and collaboration with providers will be essential to the success of the new strategic commissioning approach.

Prescribing expenditure

Above plan (circa 3m) at the early stage of the financial year, with continued close monitoring required to manage potential year-end financial pressures with joint oversight from Finance & Contracting and System Primary Care. Good progress being made with CRES which is on target.

Advise

Finance

Financial performance remains under close review, with delegated medical primary care forecasting an underspend of £1.65m attributable to prior year benefits and active management of pressures across all other areas.

Commissioning and Performance

Work is progressing to strengthen primary care commissioning arrangements, including the transition to two commissioning groups and the development of updated governance arrangements.

Plans are under discussion for improving dental services, to maximise activity, improve access and align future commissioning with population needs as part of the commissioning intentions.

New performance reporting arrangements are being introduced to provide improved oversight of primary care services aligned to the board performance report.

Updates on these areas will be given in October.

Assure

Risks
The Committee reviewed risks across primary care services and approved the addition of a new risk relating to GP collective action, which will continue to be monitored alongside wider system risks. Further work outside of the committee to transfer the risks onto the new arrangements was noted as ongoing.

GP Patient Survey
The Committee received an update on the GP Patient Survey results and noted the favourable and improved results, consistency with the national average and how patient access services across the ICB in terms of digital and telephone. It was also noted that individual practice results forms part of the national general practice dashboard and therefore variation at practice level would be picked up as part of the variation work outlined to the committee as part of the primary care action plan.

Update from Healthwatch
Bi-meeting opportunity for the Committee to hear & understand the voice of the resident, presentation circulated to all members covering Primary Care Access. Key themes dental escalation points, GP access and praise for staff.

Primary Care Quality
An update on quality was presented and interim arrangements were noted and a deep dive on patient complaints. Further work in terms of quality indicators as part of the new operating model were noted as part of a wider discussion and need to return to the committee for review.

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.

Service Programme / Focus Area	Key actions/discussion undertaken
Primary Care Action Plan	ICB's approach to variation, managing contracts and improving access across all 4 contractor groups.
Enhanced Services Review	ICBs approach to aligning x9 arrangements and delivering the population health improvement plan.

Meeting of the NW Specialised Services Committee Part A

2nd July 2026

Highlight report of the Chair of the NW Specialised Services Committee

Agenda Item: **ICB/09/24/26/17**

Committee Chair: **Steve Spill**

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

Committee Chair	Steve Spill
Terms of Reference	
Date of meeting	2nd July 2026

Key escalation and discussion points from the Committee meeting
Alert

• Ongoing performance concerns relating to:
  ○ Cardiac surgery waiting lists at Blackpool Teaching Hospitals.
  ○ Spinal surgery waiting times at Northern Care Alliance (NCA).
  ○ Capacity pressures within complex gynaecology and endometriosis services.
• National concerns regarding renal dialysis capacity, with growing demand outstripping existing provision however work already in place in NW addressing this.
• Continued neonatal service review risks, particularly following publication of the Ockenden and Amos reports, requiring alignment with maternity service planning.
• Ongoing quality concerns regarding complex spinal surgery services at NCA, including patient safety findings from retrospective case reviews.
• Fragility within paediatric rheumatology services at East Lancashire Hospitals following clinician departures.

Advise
• Specialised commissioning contract values have now been agreed with all providers, with Indicative Activity Plans (IAPs) nearing completion. • OPIC development continues to progress, supported by a governance task and finish group focusing on implementation from October 2026. • Greater Manchester specialist cardiac and vascular surgery reconfiguration programme has successfully completed NHS England Stage 2 assurance and entered public consultation. • Urology reconfiguration programme has recommenced following earlier delays, with a compliant service model expected by the end of summer 2026. • Committee members supported bringing a detailed update on neonatal review options and implications to a future meeting. • Finance and Contract Subgroup continues to oversee contract deconstruction, contract management and performance monitoring arrangements, with Phase 1 expected to complete by the end of summer.
Assure
• Month 2 financial position remains on plan, reporting an overall surplus against allocation.

• Renal dialysis quality concerns at NCA are now being managed through established quality oversight arrangements within the wider system. • Strengthened governance arrangements have been introduced for spinal surgery services at NCA, including enhanced MDT and mortality review processes. • Collaborative quality governance arrangements between NHS England, ICBs and providers continue to provide oversight of specialised commissioning quality concerns. • Significant progress has been made in the national contract deconstruction programme, with acute contract reviews well advanced and provider validation underway.	
Regional Director Update	Progress reported on OPIC development and governance arrangements. All provider contract values agreed and IAPs nearing completion. Updates received on St Andrew's Healthcare, renal dialysis capacity planning, mental health contract reviews, and implications of the Ockenden and Amos maternity/neonatal reviews.
ICB update	GM cardiac and vascular reconfiguration programme progressed to consultation phase. Committee discussed neonatal review complexities, maternity pathway implications, Blackpool cardiac service resilience and urology service reconfiguration.
Items for decision/endorsement	No items presented for decision or endorsement.
Quality Update	Updates received on renal dialysis incidents, spinal surgery concerns at NCA and paediatric rheumatology services at East Lancashire Hospitals. Committee sought assurance regarding quality governance arrangements across organisations.
Finance & Planning Update	Month 2 financial position remains on plan. Progress reported on IAP completion, contract deconstruction and future contract management arrangements.
Risks	Principal risks relate to cardiac surgery, spinal surgery, complex gynaecology capacity and neonatal review delivery. Workforce risks have been consolidated into a single organisational capacity risk.

OPIC Development Update	Governance task and finish group established to develop OPIC arrangements for October implementation and future governance requirements. Progress across the programme was reported as positive, although there remains work to do to address the financial and staffing risks, with a paper going to each of the ICB board meetings in July to set out the issues and challenges in more detail.
AOB	No substantive items raised.

NHS
Cheshire and Merseyside

Meeting of the Remuneration Committee of NHS Cheshire and Merseyside

23 July 2026

Highlight report of the Chair of the ICB Remuneration Committee

Agenda Item No: ICB/09/24/26/18

NHS
Cheshire and Merseyside

Highlight report of the Chair of the ICB Remuneration Committee

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	23 July 2026

Key escalation and discussion points from the Committee meeting

Alert

The Committee noted that, following Phase 2 of the organisational change programme, a number of employees remain at risk of redundancy. Whilst all reasonable efforts are being made to secure redeployment opportunities through local and national processes, successful redeployment may be challenging due to the specialist nature of a number of the affected roles. The Committee also noted that pension implications remain under review and that redundancy notices will not be issued until confirmation is received from NHS Pensions.
https://cheshireandmerseysidenhsuk-my.sharepoint.com/personal/sallyanne_hunter2_cheshireandmerseyside_nhs_uk/_layouts/15/Doc.aspx?sourcedoc={D13B2A19-AB50-476E-A0C1-D0870B4AF4E9}&file=Draft Rem Com minutes 23 July 2026.docx&action=default&mobileredirect=true

The Committee further noted that implementation of the nationally announced 3% Very Senior Manager (VSM) pay uplift remains subject to formal NHS England approval and therefore cannot currently be applied.

Advise

The Committee advises the Board that robust governance arrangements continue to be applied throughout the organisational change programme, with all reasonable measures being taken to minimise compulsory redundancies and support affected staff. These measures include consideration of suitable alternative employment, regional redeployment arrangements and outplacement support.
https://cheshireandmerseysidenhsuk-my.sharepoint.com/personal/sallyanne_hunter2_cheshireandmerseyside_nhs_uk/_layouts/15/Doc.aspx?sourcedoc={D13B2A19-AB50-476E-A0C1-D0870B4AF4E9}&file=Draft Rem Com minutes 23 July 2026.docx&action=default&mobileredirect=true

The Committee also advises that VSM salary arrangements remain aligned to NHS England guidance and the VSM Pay Framework. A salary cap of £150,000 has been applied to VSM roles reporting to Executive Directors, as part of the Management of Change process.

Assure
The Committee was assured that: • The organisational change programme is being conducted in accordance with relevant legislative requirements, organisational policy and NHS guidance. • No special severance or discretionary payments are proposed in relation to current Management of Change arrangements. • The appointment of the Clinical Director has been completed appropriately and arrangements for maintaining clinical registration do not impact contractual duties or working hours. • All VSM salary proposals considered are compliant with the NHS England VSM Pay Framework. • The ICB has completed the 2026 Fit and Proper Persons Test process in line with NHS England requirements, with no matters requiring escalation identified.

The next meeting of the Committee is scheduled for **5 August 2026.**

Appendices

None

NHS
Cheshire and Merseyside

Meeting of the Remuneration Committee of NHS Cheshire and Merseyside

5 August 2026

Highlight report of the Chair of the ICB Remuneration Committee

Agenda Item No: **ICB/09/24/26/18**

NHS
Cheshire and Merseyside

Highlight report of the Chair of the ICB Remuneration Committee

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	5 August 2026

Key escalation and discussion points from the Committee meeting
Alert
The Committee noted that the Organisational Change Programme is progressing as planned and that a small number of workforce changes remain to be concluded before the programme is complete.
Advise
The Committee considered the implications of the latest workforce change proposals and the progress made towards achieving the organisation's workforce and financial objectives. Members emphasised the importance of maintaining organisational capacity, supporting affected staff and ensuring appropriate equality considerations throughout the process.
Assure
The Committee was assured that workforce change processes had been undertaken in a fair, transparent and robust manner, with appropriate engagement and governance oversight. The Committee approved the recommendations presented and noted that the Voluntary Redundancy Scheme had delivered significant progress towards the organisation's savings requirements while minimising the need for compulsory redundancies.

The next meeting of the Committee is scheduled for **8 September 2026.**

Appendices

None

NHS
Cheshire and Merseyside

Meeting of the Remuneration Committee of NHS Cheshire and Merseyside

4th September 2026

Highlight report of the Chair of the ICB Remuneration Committee

Agenda Item No: **ICB/09/24/26/18**

NHS
Cheshire and Merseyside

Highlight report of the Chair of the ICB Remuneration Committee

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	4 September 2026

Key escalation and discussion points from the Committee meeting

Alert

Advise

Voluntary Redundancy

The Committee met to approve VR applications following appeals from a number of employees. It reviewed progress against the organisation's workforce reduction programme and considered the implications for delivery of the required financial savings. Members noted that the programme continues to support the organisation's wider financial objectives and that a range of measures are being utilised to achieve the required efficiencies.

The Committee approved recommendations presented within the report, subject to the appropriate governance arrangements. The Committee noted that the voluntary redundancy programme remains subject to the completion of the necessary external approval processes before implementation can be finalised. The Committee will continue to monitor the impact of the programme on workforce arrangements and organisational delivery.

Assure

The Committee received assurance that the voluntary redundancy process has been undertaken in accordance with agreed organisational procedures and governance requirements. Members were assured that the process has been applied consistently and that appropriate controls are in place to support decision-making. The Committee also received assurance that the programme remains aligned to the organisation's financial plans and that no issues requiring escalation to the Board were identified.

The next meeting of the Committee is scheduled for **8 December 2026.**

Appendices

None