NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside

Annual General Meeting 2025

25 September 2025

13:00pm

Authority Chamber, No 1 Mann Island, Liverpool, L3 1BP

Time	Agenda item	Speaker
13:00pm	Welcome, introductions and housekeeping	**Raj Jain,** Chair
13:05pm	Annual Report on the performance of NHS Cheshire and Merseyside in 2024-25	**Cathy Elliott,** Chief Executive
13:15pm	Annual Report on the financial performance of NHS Cheshire and Merseyside in 2024-25	**Andrea McGee,** Director of Finance & Contracting (Interim)
13:20pm	Looking Forward in 2025-26	**Cathy Elliott,** Chief Executive
13:25pm	Q&A and Public Speaking time	**Raj Jain,** Chair
14:05pm	Close of AGM	**Raj Jain,** Chair

Please note on this occasion we are combining the AGM Q&A section and Board meeting Public Speaking Time. Further detail on submitting questions can be found at:
https://www.cheshireandmerseyside.nhs.uk/get-involved/upcoming-meetings-and-events/nhs-cheshire-and-merseyside-integrated-care-board-september-2025/

NHS
Cheshire and Merseyside

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

25 September 2025
14:15pm

Authority Chamber
No 1 Mann Island,
Liverpool, L3 1BP

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. The Board meeting is live streamed and recorded.

NHS
Cheshire and Merseyside

Agenda

AGENDA NO & TIME	ITEM	Format	Lead or Presenter	Action / Purpose	Page No
14:15pm	**Preliminary Business**				
ICB/09/25/01	Welcome, Apologies and confirmation of quoracy	Verbal	Raj Jain *ICB Chair*	For information	-
ICB/09/25/02	Declarations of Interest *(Board members are asked to declare if there are any declarations in relation to the agenda items or if there are any changes to those published on the ICB website)*	Verbal		For assurance	-
ICB/09/25/03	Chair's announcements	Paper		For information	Page 6
ICB/09/25/04	Experience and achievement story	Film	-	For Information	-
14:25pm	**Leadership Reports**				
ICB/09/25/05	Report of the ICB Chief Executive	Paper	Cathy Elliott *Chief Executive*	For assurance	Page 8
ICB/09/25/06 **14:40pm**	Cheshire and Merseyside ICS Finance Month 3 Report and Month 4 Summary Update	Paper	Andrea McGee *Interim Director of Finance*	For assurance	Page 22
ICB/09/25/07 **14:50pm**	Highlight report of the Chair of ICB Finance, Investment and Our Resources Committee	Paper	Mike Burrows *Non-Executive Member*	For assurance	Page 68
ICB/09/25/08 **14:55pm**	NHS Cheshire and Merseyside Integrated Performance Report	Paper	Anthony Middleton *Director of Performance & Planning*	For assurance	Page 72
ICB/09/25/09 **15:05pm**	Highlight report of the Chair of ICB Quality and Performance Committee	Verbal	Tony Foy *Non-Executive Member*	For assurance	-
ICB/09/25/10 **15:10pm**	Highlight report of the Chair of ICB Audit Committee	Paper	Mike Burrows *Non-Executive Member*	For assurance	Page 113
ICB/09/25/11 **15:15pm**	Highlight report of the Chair of System Primary Care Committee	Paper	Erica Morriss *Non-Executive Member*	For assurance	Page 117
ICB/09/25/12 **15:20pm**	Highlight report of the Chair of the Remuneration Committee	Paper	Tony Foy *Non-Executive Member*	For assurance	Page 120
ICB/09/25/13 **15:25pm**	Highlight report of the Chair of the Children's and Young People Committee	Paper	Raj Jain *ICB Chair*	For assurance	Page 122

AGENDA NO & TIME	ITEM	Format	Lead or Presenter	Action / Purpose	Page No
ICB/09/25/14 **15:30pm**	Highlight report of the Chair of the North West Specialised Services Joint Committee	Paper	Dr Ruth Hussey *Non-Executive Member*	For assurance	Page 125
ICB/09/25/15 **15:35am**	Highlight report of the Women's Hospital Services in Liverpool Committee Chair of the Committee	Paper	Prof. Hilary Garratt *Non-Executive Member*	For assurance	Page 131
15:40pm	**ICB Business Items**				
ICB/09/25/16	Cheshire and Merseyside Urgent and Emergency Care Improvement Update	Paper	Mandy Nagra *Chief System Improvement and Delivery Officer* Dr Fiona Lemmens *Deputy Medical Director*	For assurance	Page 134
ICB/09/25/17 **16:00pm**	Cheshire and Merseyside Winter Plan 2025-26	Paper	Anthony Middleton *Director of Performance & Planning*	For approval	Page 154
ICB/09/25/18 **16:20pm**	Cheshire and Merseyside Work and Health Strategy and 'Get Britain Working' Plans	Paper	Clare Watson *Assistant Chief Executive* *Ian Ashworth* *Director of Population Health*	For approval	Page 182
ICB/09/25/19 **16:30pm**	Proposed draft NHS Cheshire and Merseyside Board Assurance Framework Strategic Risks for the 2025-2028 period	Paper	Clare Watson *Assistant Chief Executive*	For approval	Page 296
16:50pm	**Meeting Governance**				
ICB/09/25/20	Minutes of the previous meeting: • July 2025.	Paper	Raj Jain *ICB Chair*	For approval	Page 304
ICB/09/25/21	Board Action Log	Paper	Raj Jain *ICB Chair*	To consider	Page 315
16:55pm	**Reflection and Review**				
ICB/09/25/22	Closing remarks and review of the meeting	Verbal	Raj Jain *ICB Chair*	For information	-
17:00pm	**CLOSE OF MEETING**				

Consent items

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

Consent items			
AGENDA NO	**ITEM**	**Reason for presenting**	**Page No**
ICB/09/25/23	Board Decision Log (CLICK HERE)	For information	-
ICB/09/25/24	Confirmed Minutes of ICB Committees: • Audit Committee • Children and Young Peoples Committee • Finance, Investment and Our Resources Committee • Quality and Performance Committee • System Primary Care Committee • North West Joint Specialised Commissioning Committee	For assurance	Page 316

Date and start time of future meetings

27 November 2025. 14:00pm, Venue tbc

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 of the Board of NHS Cheshire and Merseyside

25 September 2025

Report of the Chair of NHS Cheshire and Merseyside

Agenda Item No: ICB/09/25/03

Responsible Director: Raj Jain, ICB Chair

Report of the Chair of NHS Cheshire and Merseyside (September 2025)

1. Introduction

1.1 This report covers some of the work which takes place by the Integrated Care Board which is not reported elsewhere in detail on this meeting agenda.

2. Ask of the Board and Recommendations

2.1 **The Board is asked to:**

- **note** the updates within the report.

3. Key updates of note

3.1 **Partner Member Update**. I would like to take opportunity to express my gratitude to Ann Marr who, having being a Board member since the establishment of the ICB, has recently decided to step down from the Board and her role as Executive Lead of Merseyside Provider Collaborative. As you are aware, Ann has worked her entire career, spanning more than 45 years in Cheshire and Merseyside. During this time Ann has led a number of programmes and contributed to the achievement of some significant improvements for local people, including the best stroke outcomes in the country and a significant improvement in cancer survival rates. I am sure that you will join me in thanking Ann for all her support over the years and wish Ann well for the future.

3.2 Following Anns departure, it has been agreed with the Collaborative that Janelle Holmes will replace Ann as being one of the ICBs Partner Members on the Board. Janelle is the Joint Chief Executive for Wirral Community Health and Care NHS Foundation Trust (WCHC) and Wirral University Teaching Hospital NHS Foundation Trust (WUTH). I would like to welcome Janelle to her first meeting today and wish her well as a Board Member of the ICB.

3.3 Furthermore, as work continues with regards the Model ICB Blueprint and future composition of the Board which will need to be considered by the incoming Chair, so as to help with stability on the Board and to maintain continuity of expertise and experience, I have agreed a further six month term extension for Adam Irvine as Partner Member (Primary Care).

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 September 2025

Report of the Chief Executive

Agenda Item No: ICB/09/25/05

Responsible Director: Cathy Elliott
Chief Executive

Report of the Chief Executive (Sept 2025)

1. Introduction

1.1 This report covers highlights of the work which takes place by the Integrated Care Board at a senior level and also key developments in health and care for Board information which is not reported elsewhere in detail on this meeting agenda.

1.2 Our role and responsibilities as a statutory organisation and system leader are considerable. Through this paper we have an opportunity to recognise the breadth of work that the organisation is accountable for or is a key partner in the delivery of.

2. Ask of the Board and Recommendations

2.1 **The Board is asked to:**

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

3. Setting strategy and delivering long-term transformation

Two Cheshire and Merseyside 'Places' become neighbourhood health 'pioneers'

Sefton and St Helens have both been confirmed as national 'pioneer' areas for the development of neighbourhood health.

A key priority of the recently-published 10 Year Health Plan, neighbourhood health is central to the Government's ambition to shift care from hospitals to community, analogue to digital and sickness to prevention. The fundamental aim is to deliver better care closer to home.

Backed by £10m of national funding, wave one of the National Neighbourhood Health Implementation Programme (NNHIP) will provide 43 successful applicants, including Sefton and St Helens, with access to national support - with an initial focus on developing neighbourhood health systems which better support adults with multiple long-term conditions.

Initially targeted at areas with higher levels of deprivation, the programme will accelerate the move to a 'neighbourhood health service' to deliver more care at home or closer to home, improve people's access, experience and outcomes, and ensure the sustainability of health and social care delivery.

We will continue to keep the Board updated on progress around the implementation of the Neighborhood Health Framework as approved at the July 2025 Board, including the learning from the two pioneer sites.

New Blueprint publications

The 'Model Region Blueprint[1] has now been published nationally by NHS England and shared with ICBs and Trusts. The Model Region Blueprint sets out a high-level mandate for the seven health regions. It articulates their purpose, core functions and activities and identifies some of the key enablers that will need to be in place to achieve the desired outcomes. The Model Region Blueprint is also designed to support the implementation of the Model ICB and reinforces the role of ICBs as strategic commissioners, the transition of commissioning responsibilities from regions to ICBs by April 2027 and reiterates the increased accountability for ICBs around population health and health inequalities.

The Model Region Blueprint defines the following core functions for NHS regions, namely:

- Strategic leadership and planning.
- Oversight of performance and governance.
- Support for reform, innovation and workforce development.
- Coordination of digital transformation and data analytics.
- Management of commissioning transitions and professional leadership.

It also outlines the establishment of two key programmes and timelines of note with regards to the transition to the Model Region, namely:

- New Operating Model Programme Board - Oversees the transition of functions between regions, ICBs, and providers. Enhanced regional performance oversight begins in the second half of 2025/26.
- DHSC/NHS England Transformation Programme - Leads the design and implementation of the redesigned centre.
- Seven 'Offices of Pan ICB Commissioning' will be established during 2025/26 to support the transfer of commissioning responsibilities.

The ICB will work with our regional colleagues towards the successful transition to the Model Region and Model ICBs forms and ensure the safe transfer of functions and responsibilities. The Board will continue to be updated with progress at subsequent Board meetings, supported by regular oversight by the ICB Executive Team and our Model ICB Transition Group set up in May this year under Model ICB guidance.

In addition to the publication of the Model Region Blueprint, a series of Model ICB 'Good Practice' guides have also been published this month. These 'Good Practice' guides covered Medicines Optimisation, SEND, All Age Continuing Care and Safeguarding, and provide updates in relation to the legalities of transferring functions, case studies of how these functions have been managed across other systems and key areas for consideration. The ICB is working through these guides to see how it can progress further the organisation's response to the Model ICB for Cheshire and Merseyside with oversight from our Model ICB Transition Group of the Chair and Non Executive Directors.

[1] https://tinyurl.com/2wuup7bv

4. Driving high-quality and sustainable outcomes

Addressing delays in Cancer diagnosis

The Cheshire and Merseyside NHS Provider Collaborative has been successful in attracting investment from the National Histopathology Automation Programme to tackle significant delays in cancer diagnosis. The proposal developed by the Cheshire and Merseyside Pathology Network means £1.9m in NHSE capital funding to purchase five automated machines for the most challenged trusts (UHLG and MWL). Currently, both Trusts are failing to meet the national Faster Diagnosis Standard (FDS) target of providing 75% of cancer diagnoses within 28 days, with biopsy reporting turnaround times also below the 98% standard.

Moving away from manual biopsy processing towards automation offers the opportunity to speed up biopsy processing whilst reducing handling errors. As referrals and demand increase it will address capacity issues support workforce resilience and productivity. Overall, the impact is expected to improve turnaround times and enhance both patient safety and experience by speeding up their results, which as a result will help achieve and sustain compliance with the FDS and reporting standards.

This initiative aligns with the national 10-Year Health Plan to transition from analogue to digital processes, helps to advance locally the national digital pathology agenda, and has the backing of ICB and NHSE performance teams. Evidence from other implementations of the automated machines supports confidence in achieving these benefits. Progress and assurance on delivery will be monitored via the Pathology Network, Diagnostics Programme and Provider Collaborative.

Cheshire and Merseyside Valproate Patient Safety Programme

In December 2023, ICBs were tasked with co-ordinating the implementation of a National Patient Safety Alert focused on the safe prescribing of valproate. Valproate is a drug commonly used to treat epilepsy and bipolar disorder, which carries significant risks when taken during pregnancy, including serious birth defects and developmental complications.

In response to the alert, the ICB has worked collaboratively with teams from neurology, psychiatry, paediatrics and primary care, as well as with national colleagues to implement the new regulatory requirements and develop a Cheshire and Merseyside Valproate Prescribing Guidance Document.[2]

This guidance, along with supporting tools and resources, was officially launched through a well-attended webinar, with over 300 colleagues joining across primary and secondary care. The webinar is available here for those who wish to view the recording.[3]

This work has been recognised nationally with presentations delivered to Neurology and Epilepsy Networks and the Medicines Safety Improvement Programme Board Meeting. The project team is now focused on transitioning this work into business as usual and establishing an assurance framework to confirm full adoption of the guidance and ongoing

[2] https://tinyurl.com/4c8hzhk9
[3] https://tinyurl.com/4wtyd7cy

compliance. For more information, please visit the Cheshire and Merseyside Valproate webpage.[4]

Europe's first MRI scanner of its kind arrives at Alder Hey

Alder Hey Children's Hospital has become the first paediatric hospital in Europe to install a ground-breaking 3-Tesla MRI research scanner, dedicated to research, a major step forward for medical research in the region and beyond. This state-of-the-art scanner is only the second of its kind in the world and will provide faster, more detailed imaging and improve patient comfort. It will primarily support research and will be used to improve diagnosis and treatment for patients of all ages, from newborns to older adult

This new scanner, funded by the National Institute for Health and Care Research (NIHR) offers increased capacity for research scans at a time when clinical demand for MRI continues to grow. Its availability enables researchers to conduct vital studies, including early-phase clinical trials and high-intensity experimental medicine research, without competing with routine clinical imaging needs. The scanner also strengthens Alder Hey's ability to collaborate with academic institutions, clinical researchers and industry partners.

Designed with children in mind, the new MRI suite offers a calm, child friendly environment with features such as:

- An immersive scan room with lighting, sounds, and video projections.
- In-bore entertainment, allowing children to watch their favourite shows during scans.
- Lightweight, more comfortable equipment.

One of the first studies will involve scanning newborns during natural sleep to explore how early life and environment affect brain development.

Cheshire and Merseyside ICB Awarded New Primary Care Commercial Research Delivery Centre

Building on the success of the Cheshire and Merseyside ICB Commercial Research Delivery Centre (CRDC), the ICB has now been awarded a Primary Care Commercial Research Delivery Centre (PC-CRDC). This new centre will work closely with the existing CRDC to strengthen the region's capacity to deliver innovative commercial research across primary care in the region.

The PC-CRDC will serve a population of approximately 2.7 million people across nine local authority areas. Its initial delivery footprint includes three geographically and demographically diverse practices: Marine Lake (Wirral), Vauxhall (Liverpool), and Ashfields (Sandbach, Cheshire East). Together, these sites cover urban, coastal, and semi-rural communities, ensuring coverage across the ICB's footprint. The centre will also have the capability to deploy mobile research units to communities with historically low participation and high disease burden.

The PC-CRDC has been established to:

- accelerate the delivery of commercial clinical trials in primary care.

[4] https://www.cheshireandmerseyside.nhs.uk/your-health/prescribing/statements/valproate/

- increase capability within practices to deliver commercial research.
- act as an access point to a network of commercially active sites, offering gold-standard set-up times, streamlined performance, and standardised costing and contracting through the General Practice National Contract Value Review (NCVR).
- provide dedicated staff and facilities to ensure consistency of practice across sites.
- serve as a hub to support decentralisation and diversification of trial delivery, focusing on practices with no current research activity and those with the greatest potential to expand commercial trial delivery.
- enhance inclusion, ensuring people from all eligible communities, including those living with the greatest burden of disease, can participate in commercial clinical trials.
- provide training to strengthen skills and workforce development, building further capacity and expertise for the delivery of commercial contract research.

Through this structured, data-driven approach, the PC-CRDC will accelerate commercial trial delivery in primary care, build site capability, and serve as a hub for decentralised and diversified research delivery.

The Centre will also work with Civic Health Innovation Labs (CHIL) and local universities to link population health data to its transparent prioritisation framework. By ensuring both geographic spread and alignment with local health needs, the PC-CRDC will deliver greater inclusion, efficiency, and equity—ensuring commercial research opportunities are accessible to all eligible communities across Cheshire and Merseyside.

Cheshire and Merseyside Hydration Project

NHS England Antimicrobial Resistance Programme commissioned a series of hydration pilots initially aimed to test and evidence how hydration-related interventions affect Urinary Tract Infections among older people. The hydration-related interventions included training care home staff on the importance of hydration, structured drinks rounds, smart cups for measuring fluid intake, personal hydration plans and distribution of educational resources for the public.

Within Cheshire and Merseyside there were pilots in both Wirral and Sefton places. The pilots led to a decrease in antibiotic prescribing (4.78% and 4.51% respectively) and a reduction in emergency admissions for both UTIs (28.55% and 24.47% respectively) and falls for care home residents (21.32% and 10.34%). All three valuable outcomes to the local system.

Whilst pilot outcomes varied in pilots across different systems, the interventions led to statistically significant improvement in four of the seven systems hosting pilot sites.

5. Providing robust governance and assurance

Welcome to Andrea McGee

I would like to welcome Andrea McGee who joined the ICB on 15 September 2025 as our Interim Executive Director of Finance and Contracting. Andrea's appointment will help us to retain and bolster grip on financial recovery and turnaround. I am sure that

you will join me in extending her a warm welcome to our organisation. To note, the Executive Director of Finance is a statutory role required for all ICBs at Board level.

Mark Bakewell will be joining NHS Lancashire and South Cumbria ICB – on secondment - as their Chief Finance Officer from mid-September 2025. On behalf of everybody at NHS Cheshire and Merseyside, I would like to place on record our thanks to Mark for his leadership, dedication and hard work in roles, including as our Interim Director of Finance, Deputy Director of Finance and Place Director for Liverpool.

Oversight and Tiering Update

NHS England has recently published a new oversight framework. This places Trusts into one of five segments (lower numbered segment = better performance); five of our providers (specialist trusts) are in segment 1, one is in segment 2, five are in segment 3, and five are in segment 4. Appendix One provides an overview of NHS provider Trusts in our system.

A financial override is applied, which downgrades the segmentation where the provider is deemed to be financially challenged. Due to the challenged financial position in Cheshire & Merseyside, this impacts on nine of our 16 providers (Bridgewater, Cheshire and Wirral Partnership, East Cheshire, Liverpool University Hospitals, Liverpool Women's, Mersey and West Lancashire Teaching Hospitals, Mid Cheshire, Warrington & Halton and Wirral University Teaching Hospitals).

Alongside this, NHS England publishes league tables (rankings) of trusts. Tiering is a method NHS England uses to identify NHS providers whose performance in Urgent and Emergency Care, Elective or Cancer is below expectations, and then to apply more intense support / oversight. NHS England has placed seven of our providers in tiering for one or more of the three areas, which entails more challenge and more support / intervention (Appendix One). The ICB is closely involved in this ongoing work.

The ICB as the commissioner is held to account by NHS England for system delivery on a monthly basis, and the ICB, along with NHS England as the regulator, manages the oversight of NHS Provider Trusts, taking a risk based approach based on the national oversight framework.

Improvement

In relation to the three areas of performance that are being prioritised through the tiering process, the ICB has, in conjunction with NHS Provider Trusts, the Cheshire and Merseyside Provider Collaborative, and the Cheshire & Merseyside Cancer Alliance, put in place robust improvement plans aimed at ensuring a consistent and evidence based approach to improvement and to achieving the best possible performance in year for UEC, Electives and Cancer. System wide improvement work is undertaken continually

Quality

It should be noted that the majority of NHS Trusts in Cheshire & Merseyside are delivering Good or Outstanding care according to the most recent published CQC reports. LUFT has not had a recent full inspection, but the recent well-led inspection was rated as Good. This is a significant achievement and demonstrates that our NHS Trusts are focused on delivering the best possible care under challenging circumstances. Where NHS Trusts are rated RI or other CQC warning notices are in

force, we work closely with these providers to support quality improvement. It should also be noted that CQC no longer carry out “full inspections” - they are all service specific or Well Led.

6. Building a trusted relationship with partners and communities

Exploring allocated NHS funds to address health challenges in the North of England

We have been working collaboratively during this summer with ICBs across the North of England on assessing allocated NHS funds. The Board has previously discussed NHS funding allocations and the impact convergence reductions has on Cheshire and Merseyside health and care system and the broader North of England. We continue to work with NHS England, local stakeholders and commissioning partners in the North West to ensure the region’s allocated funds address the health challenges that have historically affected communities in our region and the currently identified health inequalities in Cheshire and Merseyside as part of our intentions as a strategic commissioner. We will keep the Board updated as discussions continue.

Cheshire and Merseyside UEC / Winter Communications

NHS Cheshire and Merseyside is currently refreshing its winter communications strategy for 2025-26 - aligning with NHS England. As part of this work, a winter resource toolkit has already been issued to health providers across Cheshire and Merseyside. Last year’s winter campaign, which centred on creating a positive image of ‘Home’ as the centre of health and wellbeing in winter, is being refreshed for 2025-26 and will – once again - feature preventive messaging to help avoid hospital admissions (such as vaccination, falls, and hydration) - as well as interventional messaging related to hospital discharge and preparing the home for a loved one who is being discharged. The results of last winter’s campaign were significant – achieving a social media reach (Facebook and Instagram) of 4.2 million, while engagement with NHS Cheshire and Merseyside’s messaging and channels increased by more than 500%.

7. Creating a compassionate, just and positive culture

Workplace Charter to reduce Gambling Harms

As part of our ongoing commitment to staff wellbeing, we have partnered with Beacon Counselling Trust[5] to enhance awareness and support around gambling-related harms. Training opportunities have been delivered to staff, and a guidance document has been developed to outline how we will meet the national framework. To reinforce this commitment, we will look to sign the Workplace Charter to Reduce Gambling Harms at the September 2025 Board meeting, further strengthening our pledge to support colleagues and reduce gambling-related harm. Signing the Charter means a commitment to adopting a minimum set of standards for supporting employees with gambling-related issues, including providing training, signposting to specialist support, and creating a supportive work environment.

[5] https://beaconcounsellingtrust.co.uk/workplace-charter/

NHS Cheshire and Merseyside recognised with top award for outstanding support to the Armed Forces community

We are incredibly proud to announce that the ICB has been successful in receiving the Gold Award for the Defense Employer Recognition Scheme. The Gold Award is the highest badge of honour for employers recognising their exceptional support to veterans, reservists, Cadet Force Adult Volunteers and military families in the workplace. I would like to express my gratitude to the ICB staff who have worked so diligently to enable the ICB to achieve this award and is a testament to the commitment that the ICB has made to supporting the Armed Forces community and creating a workplace that values the unique skills and experiences of veterans, reservists, Cadet Force Adult Volunteers and military families.

8. Promoting equality and inclusion, and reducing health and workforce inequalities

Living Well bus milestone

Cheshire and Merseyside's mobile health service recently provided its 1,000th cervical screening as part of a programme aiming to reduce health inequalities in our region. The Living Well Service, operated by Cheshire and Wirral Partnership NHS Foundation Trust (CWP), covers the whole of Cheshire and Merseyside. Utilising three specially designed busses, it operates on a fully drop-in basis and has been providing routine UK immunisations, health checks and mental wellbeing support at the heart of our communities since 2022.

All Together Fairer

All Together Fairer, Cheshire and Merseyside's work to reduce health inequalities, has been highlighted by the Local Government Association as a "ground breaking model of collaborative leadership" in a case study on its health inequalities hub. In particular the case study highlights the strong collaboration between the NHS and the nine public health teams in the subregion, thanks in part to the Champs Public Health Collaborative. The full case study can be read here: https://www.local.gov.uk/case-studies/cheshire-and-merseysides-collaborative-model-reduce-health-inequalities-and-improve.

All Together Fairer was also the topic of conversation at a recent All Together Inspired learning event between representatives from the subregion and an academic delegation from the Korea Institute of Child Care and Education (KICCE). Cheshire and Merseyside was one of only three systems selected by KICCE to host a visit, which focused on the programme's work to tackle child and family poverty and included input from public health, Marmot Leads, the combined authority and others.

Asthma campaign – 'Too Much Blue - Get a Review'

A new campaign launched on 8 September 2025 across Cheshire and Merseyside to help children and young people with asthma better manage their condition.

Among children and young people (aged 0-19) across Cheshire and Merseyside, there has been a 16% increase in asthma attendances at A&E in the last two years and a nearly 2% increase in the number of A&E re-attendances due to asthma.

'Too Much Blue - Get a Review' was developed by Beyond, NHS Cheshire and Merseyside's children and young people's transformation programme. It will run throughout autumn 2025 and is aimed at encouraging better self-management of asthma through a mix of education, practical tools and community engagement.

Know Your Numbers Week 8 - 14th September 2025

Cardiovascular disease (CVD) causes 1 in 4 deaths in England; it accounts for around one death every four minutes and is a leading cause of disability. High blood pressure is the largest known single modifiable risk factor for CVD and can lead to heart attacks, strokes and dementia.

It is estimated that up to 300,000 in Cheshire and Merseyside have undiagnosed high blood pressure. The reason it is so important to know your numbers is because the condition usually has no symptoms. Blood Pressure UK leads the annual Know Your Numbers campaign with the aim of reaching those who have high blood pressure, but are unaware.

NHS Cheshire and Merseyside and our partners, including Local Authority Public Health teams, have come together this year to run a collaborative campaign across our system using locally developed resources and a uniform message which can be found at https://happy-hearts.co.uk/professional-hub/happy-hearts-toolkit/

Activities have included:

- Public Health teams in each Place have delivered a series of events in the community, using trained community champions.
- Community Pharmacy have used a 'directed campaign' offer in over 500 pharmacies to promote their blood pressure case finding service using the Know Your Numbers message.
- 60 Optometry practices across the system received resources as an additional opportunity to promote the 'blood pressure case finding pilot'.
- Developing videos using local clinicians as part of the toolkit for promotional materials.

All Together Smiling

A new animation has been launched to support the All Together Smiling supervised toothbrushing programme, which helps children aged 2 to 7 across Cheshire and Merseyside to build better lifelong oral health habits.[6]

The short film introduces children, families and those working in early years to supervised toothbrushing - explaining what it looks like in practice, and why it matters.

With colourful visuals and simple step-by-step guidance, the animation reinforces key oral health messages and encourages twice-daily toothbrushing. The animation has been co-produced and features characters created by local school children from Cheshire and Merseyside.

[6] https://youtu.be/r6xOvcplzJE

Featuring basic sign language, subtitles, and diverse characters, the animation also serves as a practical tool for eligible settings, helping to boost practitioner confidence, supporting set-up and inspiring wider participation in the programme.

Social Value Award

NHS Cheshire and Merseyside has been awarded the prestigious Silver Social Value Quality Mark® for Health, recognising its commitment to embedding social value across health and care services for local people and communities.

The award highlights NHS Cheshire and Merseyside's efforts to create a positive impact beyond healthcare, including tackling health inequalities, supporting local employment and skills, improving community wellbeing, enhancing staff welfare and addressing climate change.

The Social Value Quality Mark® is a nationally recognised accreditation that rigorously evaluates organisations against a wide range of criteria. Achieving Silver status demonstrates that NHS Cheshire and Merseyside is not only measuring and reporting on its social value, but is also delivering innovation and leadership across the system.

9. Decisions taken at the Executive Committee

9.1 At its meetings throughout August and September 2025, the Executive Committee has also considered papers and made decisions on the following areas:

- **Get Britain Working / Work and Health Strategy:** The Executive Committee received a paper on the draft Cheshire and Merseyside Work and Health Strategy and the development of two Get Britain Working Plans covering the devolved regions. The Committee supported the recommendation to endorse these plans/strategy and recommend their approval by Board at its meeting in September 2025.
- **Talking Therapies Funding:** The Executive Committee received a report on and supported the release of national funding allocations for Talking Therapies services across Cheshire and Merseyside.
- **Cunard Building consultation:** The Executive Committee received a paper on and approved the consultation document and start of the consultation with staff around the closure of the ICB offices at the Cunard Building in Liverpool and relocation of affected staff to the Regatta Place in Liverpool.
- **Corporate Estates Plan:** The Committee received a paper on and approved the recommendations within regarding the ICB Estates Plan. This included providing support regarding the downsizing of the ICB office estate for effective use of resources.
- **Mental Health (MH) Text Service:** Received a paper on the development of a MH crisis text service and its delivery plans. The Committee supported option 2 within the paper which confirmed submission of delivery plan for go live of the service in 2026.
- **Mental Health Support Teams in Schools (MHST):** Received a paper on and approved the revised trajectory of the expansion of MHST across Cheshire and Merseyside which was to be submitted to NHS England.

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

- Financial recovery and financial position on a monthly basis
- Resourcing priority programmes across the ICB
- Neighbourhood health proposals
- SALT Contracts
- System Delivery meetings
- Contract arrangements for the Community Cardiology Service provided by Southport & Formby Health
- Winter Planning and responding to Industrial Action
- Cheshire and Wirral SuperMADE event
- Sefton Place Primary Care Estates Update
- S117 Panel Process Options
- Area Prescribing Group recommendations.

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

10. Officer contact details for more information

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Chief Executive

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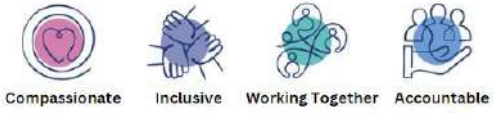
Appendix One

Trust	Oversight		Tiering			CQC
	Segment	Ranking	UEC	Elective	Cancer	Overall rating
Alder Hey Children's Hospital NHS Foundation Trust	1	16/134				Good
Bridgewater Community Healthcare NHS Foundation Trust	3	39/61				RI
Cheshire and Wirral Partnership NHS Foundation Trust	4	49/61				Good
Countess of Chester NHS Foundation Trust	4	133/134	1	1		RI
East Cheshire NHS Trust	3	99/134	1			Good
Liverpool Heart and Chest Hospital NHS Foundation Trust	1	4/134				Outstanding
Liverpool University Hospitals NHS Foundation Trust	4	115/134	2	2	2	Not rated
Liverpool Women's NHS Foundation Trust	3	68/134			1	Good
Mersey and West Lancashire Teaching Hospitals Trust	3	56/134				Outstanding
Mersey Care NHS Foundation Trust	2	25/61				Good
Mid Cheshire Hospitals NHS Foundation Trust	3	96/134	1	1		Good
The Clatterbridge Cancer Centre NHS Foundation Trust	1	8/134				Good
The Walton Centre NHS Foundation Trust	1	7/134				Outstanding
Warrington and Halton Teaching Hospitals NHS Foundation Trust	4	118/134		2		Good
Wirral Community Health and Care NHS Foundation Trust	1	12/61				Good
Wirral University Teaching Hospitals NHS Foundation Trust	4	105/134	1			Good

NHS
Cheshire and Merseyside



Leading integration through collaboration

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 September 2025

Cheshire and Merseyside Integrated Care System Finance Report Month 3 Report and Month 4 Summary Update (2025/26)

Agenda Item No: ICB/09/25/06

Responsible Director: Andrea McGee,
(Interim) Director of Finance and Contracting

Cheshire and Merseyside Integrated Care System Finance Report Month 3 and Month 4 Summary Update (2025/26)

Purpose of the Report

1. Regular financial performance reports are provided to the Finance, Investment and Resources Committee (FIRC) of the ICB who undertake detailed review and challenge on behalf of the Board.

2. This report provides a formal full update to the Board on the financial performance of the Cheshire and Merseyside ICS ("the ICS") at Month 3 2025/26, in terms of relative position against its financial plan, and alongside other measures of financial and operational performance (e.g. efficiency, productivity and workforce).

3. Additionally, Appendix One provides the Board with a summary update on Month 4.

4. The Committee is asked to note the contents of this report in respect of the ICS financial position for both revenue and capital allocations.

Executive Summary

5. On 27th March 2025 the System 'ICS' plan submitted was a combined £255m deficit, consisting of £23.6m surplus on the commissioning side (ICB) partially offsetting an aggregate NHS Provider deficit position of £278.7m. This plan was not approved by NHS England (NHSE), and subsequently a revised plan of £178.3m deficit (£50.4m surplus for the ICB and £228.6m for providers) was agreed and submitted on 30th April 2025. The detailed movements and key planning assumptions had been set out in a separate 2024/25 planning update paper reported to FIRC.

6. As part of submitting a £178.3m deficit plan the ICS has been allocated £178.3m deficit support funding from NHSE to cover the deficit and allow the financial system plan to be adjusted to a balanced breakeven position. The funding has been allocated to providers via an agreed system methodology and in turn collective provider plans have improved. Within the original NHS business rules the revenue deficit support is deemed repayable to NHSE, however an update from NHSE indicates that should the system deliver its 2025/26 plan it will not be repayable. The deficit support funding will only be released to the system quarterly subject to prospective assurance from NHSE covering areas such as progress with delivery of efficiency plans, and review of expenditure and workforce run rates.

7. We have been notified that the Regional Director of Finance has not recommended that the Cheshire and Merseyside system receive Deficit Support Funding in quarter 2. (see Letter received 20th June 2025 in appendix 12) We

have been advised that this funding can be earned back in future months. The national team are to issue advise on how this will be reported in Months 4-6. This equates to £44.5m and accelerates the liquidity challenges some Trusts are managing.

8. As of 30 June 2025 (Month 3), the ICS system is reporting a YTD deficit of £96.3m against a planned YTD deficit of £97.7m resulting in a favourable YTD variance of £1.4m. The system financial position as reported to NHSE at Month 3 is set out in **Table 1** below.

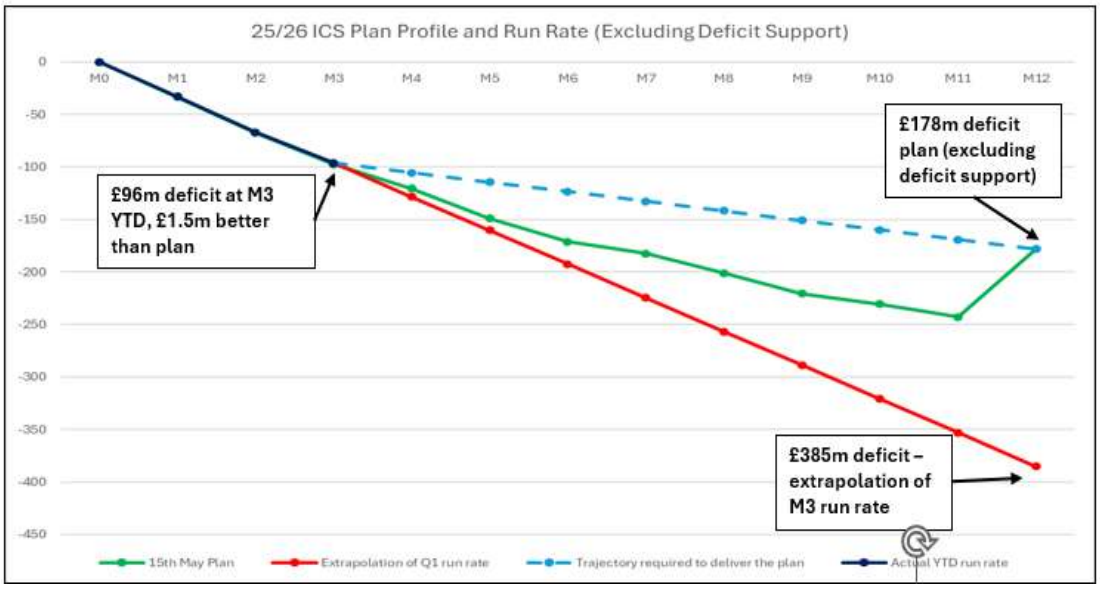
Table 1 – Financial Performance Month 3 - ICS

	Month 3 YTD				FY FOT
	Plan	Actual	Variance		
	£m	£	£	%	£m
ICB	12.6	12.6	(0.0)	(0.0)	50.4
Total Providers	(65.7)	(64.3)	1.4	0.0	(50.3)
Total System	**(53.1)**	**(51.7)**	**1.4**	**0.0**	**0.0**
Total Providers (excluding £178m deficit support)	(110.3)	(108.9)	1.4	0.0	(228.6)
Total System (excluding £178m deficit support)	**(97.7)**	**(96.3)**	**1.4**	**0.0**	**(178.3)**

9. **Chart 1** below shows the profile of the ICS I&E plan submitted to NHSE on 30th April against the actual M3 YTD run rate (excluding deficit support funding). It also shows the monthly run rate trajectory required to support delivery of the plan.

10. It should be noted that at £96.3m YTD deficit, the system has incurred 54% of its £178.3m deficit plan in the first 3 months of the year. This reflects the challenging profile of the plan where CIPs and system recovery plans have been assumed to deliver towards the end of the year. The current run rate will need to improve significantly in order for the system plan to be achieved and so focus and acceleration of CIP and system recovery plans will be critical over the next few weeks.

Chart 1 – ICS Financial Performance – YTD Run Rate vs Plan Profile



11. The summary of the key M3 I&E (excluding deficit support) and CIP metrics against plan by organisation is set out in **Table 2**

Table 2 – Financial Performance Month 3 – by organisation

Org	Month 3 YTD			FY FOT			CIP YTD			
	YTD Plan	YTD Actual	YTD Variance	FY Plan	FOT	Variance	YTD Actual	Variance to YTD Plan	YTD Actual CIP as a % of Op Ex	M3 CIP Recurrent as a % of YTD Plab
	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	%	%
Alder Hey Children's	(1,671)	(1,761)	(90)	7,160	7,160	(0)	3,736	(617)	3.3%	36%
Bridgewater Community	(1,248)	(1,248)	(0)	(1,530)	(1,528)	2	1,156	0	4.3%	100%
Cheshire & Wirral Partnership	(1,813)	(1,756)	57	3,985	3,985	0	2,332	(635)	3.0%	27%
Countess of Chester Hospitals	(13,114)	(13,111)	3	(34,042)	(34,041)	1	1,426	(1,621)	1.4%	47%
East Cheshire Trust	(7,190)	(7,191)	(1)	(17,934)	(17,934)	0	2,533	0	4.1%	45%
Liverpool Heart & Chest	1,865	1,679	(186)	9,552	9,552	0	1,638	(835)	2.5%	30%
Liverpool University Hospitals	(22,659)	(22,621)	38	(56,609)	(56,609)	0	25,075	4,718	6.8%	78%
Liverpool Women's	(8,626)	(8,586)	41	(31,026)	(31,026)	0	2,107	51	4.3%	61%
Mersey Care	237	237	0	14,305	14,305	0	7,542	(891)	3.8%	61%
Mid Cheshire Hospitals	(13,475)	(13,463)	12	(39,380)	(39,380)	0	5,647	(752)	4.7%	44%
Mersey & West Lancs	(23,704)	(22,149)	1,556	(40,950)	(40,950)	(0)	12,545	1,493	4.9%	49%
The Clatterbridge Centre	68	70	2	890	890	(0)	2,411	(661)	2.8%	38%
The Walton Centre	1,366	1,368	2	6,900	6,900	(0)	2,742	0	5.1%	93%
Warrington & Halton Hospitals	(13,517)	(13,517)	0	(28,726)	(28,726)	0	2,538	0	2.4%	60%
Wirral Community	(491)	(489)	2	900	900	0	1,224	173	4.4%	116%
Wirral University Hospitals	(6,305)	(6,315)	(10)	(22,140)	(22,140)	(0)	8,004	(1)	5.8%	53%
TOTAL Providers	**(110,277)**	**(108,852)**	**1,425**	**(228,644)**	**(228,641)**	**2**	**82,657**	**423**	**4.7%**	**58%**
C&M ICB	12,592	12,586	(5)	50,367	50,367	0	15,032	165	3.2%	101%
TOTAL ICS System	**(97,685)**	**(96,266)**	**1,420**	**(178,276)**	**(178,274)**	**2**	**97,689**	**588**	**4.6%**	**65%**

12. Whilst the system is ahead of plan at Month 3 the key issues prevalent in the YTD financial position are:
    - The system has incurred 54% of its £178.3m deficit plan in the first 3 months of the year
    - CIP ahead of plan by £0.6m against the planned YTD efficiencies of £98m, of which only 65% have been delivered recurrently (£34m).

- Initial analysis of the provider M3 run rate indicates that there has been c£20m of non-recurrent items transacted in the YTD M3 position including balance sheet release and other technical items that cannot be repeated again, indicating that without further action taken a potential deterioration to the run rate entering Q2.
- Table 11 sets out the maturity status of collective system CIP plans – as at Month 3 £66m (15%) of efficiencies are at opportunity stage and a further £9m (2%) unidentified) and is a key risk to delivery of plan.
- In additional there is c£155m of full year system recovery schemes of varying levels of development that sit outside of organisational CIP plans that require implementation to support financial plan delivery.
- Providers' pay expenditure is above YTD pay plan (£13.2m, 1.1%), particularly across bank expenditure which is above both plan and the NHSE bank ceiling set as part of planning.
- Provider levels of cash are diminishing, with a minimum of four organisations expecting to apply to NHSE for external cash support from M5 onwards.

Financial Performance Month 3

ICS financial performance – M3

13. As of 30 June 2024 (Month 3), the ICS is reporting a YTD deficit (excluding deficit funding support) of £96.3m against a planned YTD deficit of £97.7m resulting in a favourable YTD variance of £1.4m. The YTD deficit of £96.3m represents 54% of the full year plan of £178.3m deficit.

14. **Table 3** sets out the financial performance surplus / (deficit) at Month 3 at organisation level.

Table 3 – ICS Financial Performance M3 YTD by organisation

Org	Month 3 YTD				Full Year	
	YTD Plan	YTD Actual	YTD Variance	YTD a s % of YTD Income	FOT	Mth 3 YTD as a % of FOT
	£,000	£,000	£,000	%	£,000	%
Alder Hey Children's	(1,671)	(1,761)	(90)	-2%	7,160	-25%
Bridgewater Community	(1,248)	(1,248)	(0)	-5%	(1,528)	82%
Cheshire & Wirral Partnership	(1,813)	(1,756)	57	-2%	3,985	-44%
Countess of Chester Hospitals	(13,114)	(13,111)	3	-14%	(34,041)	39%
East Cheshire Trust	(7,190)	(7,191)	(1)	-13%	(17,934)	40%
Liverpool Heart & Chest	1,865	1,679	(186)	3%	9,552	18%
Liverpool University Hospitals	(22,659)	(22,621)	38	-7%	(56,609)	40%
Liverpool Women's	(8,626)	(8,586)	41	-20%	(31,026)	28%
Mersey Care	237	237	0	0%	14,305	2%
Mid Cheshire Hospitals	(13,475)	(13,463)	12	-13%	(39,380)	34%
Mersey & West Lancs	(23,704)	(22,149)	1,556	-9%	(40,950)	54%
The Clatterbridge Centre	68	70	2	0%	890	8%
The Walton Centre	1,366	1,368	2	3%	6,900	20%
Warrington & Halton Hospitals	(13,517)	(13,517)	0	-14%	(28,726)	47%
Wirral Community	(491)	(489)	2	-2%	900	-54%
Wirral University Hospitals	(6,305)	(6,315)	(10)	-5%	(22,140)	29%
TOTAL Providers	**(110,277)**	**(108,852)**	**1,425**	**-6%**	**(228,641)**	**48%**
C&M ICB	12,592	12,586	(5)		50,367	25%
TOTAL ICS System	**(97,685)**	**(96,266)**	**1,420**		**(178,274)**	**54%**

ICB Financial Performance – M3

15. The ICB reports a surplus of £12.6m for month 3 which is in line with the YTD plan as per **Table 4** below.

Table 4 – ICB Financial Performance M3

Budget Area	M3 YTD Plan £m	M3 YTD Actual £m	M3 YTD Variance £m	M3 YTD Variance %
ICB Net Expenditure				
Acute Services	**960.5**	**962.1**	**(1.6)**	**(0.2%)**
Acute services - NHS	929.5	927.1	2.4	0.3%
Acute services - Independent/commercial sector	32.3	33.7	(1.3)	(4.1%)
Acute services - Other non-NHS	1.8	1.6	0.2	10.2%
Acute Services - Other Net Expenditure	(3.1)	(0.3)	(2.9)	91.1%
Mental Health Services	**196.6**	**199.6**	**(3.0)**	**(1.5%)**
MH Services - NHS	128.4	128.4	0.0	0.0%
MH Services - Independent / Commercial Sector	45.2	44.4	0.8	1.8%
MH Services - Other non-NHS	24.6	26.0	(1.4)	(5.8%)
MH Services - Other net expenditure	(1.7)	0.7	(2.4)	144.2%
Community Health Services	**179.3**	**179.1**	**0.1**	**0.1%**
Continuing Care Services	**122.1**	**120.9**	**1.1**	**0.9%**
Primary Care Services	**166.1**	**168.5**	**(2.4)**	**(1.4%)**
Memo: Prescribing *	138.5	140.8	(2.3)	(2.0%)
Other Commissioned Services	**4.0**	**3.7**	**0.3**	**7.1%**
Other Programme Services	**15.3**	**15.2**	**0.0**	**0.3%**
Reserves / Contingencies	**0.5**	**0.0**	**0.5**	**100.0%**
Delegated Specialised Commissioning	**193.3**	**193.3**	**(0.0)**	**(0.0%)**
Delegated Primary Care Commissioning	**230.6**	**225.7**	**4.9**	**2.1%**
Primary Medical Services	152.0	151.9	0.1	0.1%
Dental Services	52.4	47.7	4.7	8.9%
Ophthalmic Services	7.3	7.2	0.0	0.5%
Pharmacy Services	18.9	18.9	0.0	0.2%
ICB Running Costs	**10.4**	**10.4**	**0.0**	**0.0%**
Total ICB Net Expenditure	**2,078.7**	**2,078.7**	**(0.0)**	**(0.0%)**
TOTAL ICB Surplus/(Deficit)	**12.6**	**12.6**	**(0.0)**	**0.0%**

* classification of prescribing costs differs slightly from the values reported to NHSE through the IFR

16. The YTD position remains in line with plan as at month 3 and the ICB forecasts that it expects to deliver the plan for this financial year.

The key areas of variance from budget for the ICB are as follows:

a) Acute performance – Continued pressure across most places on Independent Sector Ophthalmology activity. Ophthalmology contracts have overperformed by £0.8m during this first quarter. There are further pressures of £0.7m on non-contracted activity and £0.2m on devolved administration activity (payments to Scottish and Welsh NHS bodies for activity delivered under payment by results).

b) Mental Health – mental health budgets include both mental health contracts for commissioned services and individual mental health packages of care. Whilst mental health packages of care are underspending against the budget at month 3, there is a continuation of a significant pressure on ADHD budgets within mental health contracts. ADHD activity is overspending by £3.2m at month 3.

c) All Age Continuing Care – Reporting a year-to-date favourable variance of £1.1m at month 3 following a minor adverse variance at month 2. The favourable movement is in relation to funded nursing care services. **Appendix 1** contains additional information to support the CHC and MH packages of care budgetary performance, including an analysis of patient numbers and the movement in the number of care packages during the month.

d) Primary Care – Local primary Care budgets are reporting a year-to-date deficit of £2.4m. This is almost entirely in relation to the performance of prescribing budgets based on April-25 prescribing data and the estimated costs for May-25 and June-25. Further analysis of the prescribing position is included within **Appendix 3.**

e) Delegated Primary Care budgets are showing an underspend of £4.9m. This is due to the prior year underspends in respect of delegated primary care dental costs.

f) Reserves – A year-to date surplus of £0.5m is reported on reserves. This relates to a small number of place reserves that have been identified as uncommitted and available to support the overall ICB financial position.

g) Running costs – The ICB reports in line with running cost budgets at month 3. The ICB's allocation was reduced by £3.5m in 2025/26 as part of the original target of a 30% reduction in running costs. A further CRES target of £0.4m was required for 2025/26 to offset the impact of pay awards. Pay budgets set at the start of the year assumed a 2.8% uplift for the 2025/26 pay award as per national planning assumptions. A further allocation will be received in month 4 to fund the increase to the confirmed 3.6% agenda for change pay award. There should be no negative impact on the ICB running cost position as a result.

h) Efficiency – The ICB reports delivery of £15m of efficiency savings as at month 3, which is marginally greater than the year to date plan. All age continuing care savings have exceeded the savings plan at this early stage which has offset the shortfall in mental health placements savings. At this relatively early stage in the year, the ICB is forecasting that it will exceed the efficiency savings target of £139m by £8m. This is reliant on a significant acceleration in efficiency savings delivery throughout the later months of the year in line with the phasing of savings plans.

17. Details of ICB financial performance split by place is shown below in table 5.

Table 5 – Place M3 – Financial Performance

	M3 YTD Plan £m	M3 YTD Actual £m	M3 YTD Variance £m
Cheshire - East	(14.0)	(13.6)	0.4
Cheshire - West	(10.4)	(10.3)	0.1
Halton	(2.1)	(3.2)	(1.1)
Knowsley	4.0	3.6	(0.4)
Liverpool	3.5	1.3	(2.2)
Sefton	(2.8)	(3.0)	(0.2)
St Helens	(2.7)	(3.0)	(0.3)
Warrington	(0.9)	(1.1)	(0.2)
Wirral	(6.3)	(7.1)	(0.9)
ICB	44.3	49.1	4.8
Total ICB	**12.6**	**12.6**	**(0.0)**

18. The majority of programme budgets continue to be delegated to place with the exception of Delegated Pharmacy, Optometry, Dental, Specialised Commissioning and Running Costs. Some budgets are retained centrally as they are not managed at place level, with a retained budget surplus held as per financial planning assumptions. This is held centrally due to anticipated allocation reductions over time to return the ICB to its fair share of allocations. Once clarification is provided on the updated fair share allocation and associated pace of change the allocation of budgets between places and central budgets will be reviewed.

Provider Financial Performance – M3

19. **Table 3 above** sets out the ICS Month 3 financial position, split by individual provider alongside ICB position.

20. Whilst providers are on plan at M3 there are several areas covering CIP, expenditure run rates, WTE run rates, variable pay and capital and cash will be subject to review and challenge over the next few weeks. The sections below set out the current position and key indicators across these areas.

21. **Table 6** sets out the provider YTD position by income, pay and non-pay. This indicates that the aggregate YTD pay position is £13.2m (1.1%) adverse to plan. The majority of this relates to unachieved pay efficiencies £4.2m (0.4%) with a reminder a number of operational issues requiring further review with providers. Provider income is £15.4m ahead of plan (0.9%) and the triangulation of any ICB and specialised commissioning contractual income against API contracts will be a key line of enquiry over July. It is expected that pass through drugs and devices will make up a material amount of this variance. The Income variance to plan has

significantly grow since M2 and therefore the reconciliation of the YTD and FOT of income providers have reported against C&M ICB will be a key area of review.

Table 6 – Provider Income and Expenditure vs YTD Plan

	Income - YTD			Total Pay - YTD			Non Pay - YTD			Income YTD Variance	Pay YTD Variance	Non Pay YTD Variance
	YTD Plan £,000	YTD Actual £,000	YTD Variance £,000	YTD Plan £,000	YTD Actual £,000	YTD Variance £,000	YTD Plan £,000	YTD Actual £,000	YTD Variance £,000	%	%	%
Alder Hey Children's	108,172	107,579	(593)	(70,500)	(70,638)	(138)	(37,887)	(37,155)	732	-0.5%	-0.2%	2.0%
Bridgewater Community	24,847	24,705	(142)	(18,384)	(18,529)	(145)	(7,613)	(7,290)	323	-0.6%	-0.8%	4.4%
Cheshire & Wirral Partnership	73,712	73,927	215	(60,321)	(60,417)	(96)	(14,936)	(15,017)	(81)	0.3%	-0.2%	-0.5%
Countess of Chester Hospitals	95,068	96,380	1,313	(73,351)	(73,240)	111	(28,953)	(30,653)	(1,700)	1.4%	0.2%	-5.5%
East Cheshire Trust	54,647	55,021	374	(40,016)	(40,372)	(356)	(18,799)	(18,910)	(111)	0.7%	-0.9%	-0.6%
Liverpool Heart & Chest	64,408	65,147	739	(31,740)	(31,972)	(232)	(30,472)	(31,311)	(839)	1.1%	-0.7%	-2.7%
Liverpool University Hospitals	324,952	333,768	8,816	(223,932)	(230,490)	(6,558)	(107,815)	(110,479)	(2,664)	2.7%	-2.8%	-2.4%
Liverpool Women's	43,050	42,749	(301)	(29,770)	(30,055)	(285)	(17,668)	(17,104)	564	-0.7%	-0.9%	3.3%
Mersey Care	189,955	191,310	1,355	(150,667)	(153,664)	(2,997)	(37,770)	(36,280)	1,490	0.7%	-2.0%	4.1%
Mid Cheshire Hospitals	108,433	107,509	(924)	(78,166)	(79,201)	(1,035)	(36,566)	(34,758)	1,808	-0.9%	-1.3%	5.2%
Mersey & West Lancs	238,505	237,044	(1,461)	(163,549)	(164,966)	(1,417)	(82,291)	(78,032)	4,259	-0.6%	-0.9%	5.5%
The Clatterbridge Centre	77,527	83,942	6,415	(29,544)	(30,579)	(1,035)	(47,251)	(53,268)	(6,017)	8.3%	-3.4%	-11.3%
The Walton Centre	50,304	51,853	1,549	(25,765)	(25,976)	(211)	(23,228)	(24,645)	(1,417)	3.1%	-0.8%	-5.7%
Warrington & Halton Hospitals	95,666	94,151	(1,516)	(74,298)	(73,518)	780	(29,025)	(28,541)	484	-1.6%	1.1%	1.7%
Wirral Community	26,540	26,111	(430)	(20,900)	(20,134)	766	(5,928)	(6,283)	(355)	-1.6%	3.8%	-5.7%
Wirral University Hospitals	128,733	128,751	18	(93,241)	(93,621)	(380)	(36,356)	(36,045)	311	0.0%	-0.4%	0.9%
TOTAL Providers M3 YTD	**1,704,519**	**1,719,947**	**15,429**	**(1,184,144)**	**(1,197,373)**	**(13,229)**	**(562,558)**	**(565,769)**	**(3,211)**	**0.9%**	**-1.1%**	**-0.6%**
Month 2 YTD comparison	**1,132,526**	**1,139,548**	**7,022**	**(788,672)**	**(796,947)**	**(8,275)**	**(374,235)**	**(374,528)**	**(293)**	**0.6%**	**-1.0%**	**-0.1%**

22. **Table 7** sets out spilt of provider pay expenditure across substantive, bank and agency. This indicates that the aggregate YTD pay position is £13.2m (1.1%) adverse to plan, with bank expenditure the material outlier at £7.1m over plan. As part of the planning process providers set bank and agency plans in line with NHSE expectations of a reduction bank expenditure by 10% and agency expenditure by 30% compared to 24/25 run rates. Section 9 of the report sets out the bank and agency position in more detail.

Table 7 – Provider Pay spilt by substantive, bank and agency vs plan

	TOTAL PAY EXPENDITURE (SUB,			TOTAL SUBSTANTIVE			TOTAL BANK			TOTAL AGENCY		
	M3 YTD Actual £,000	M3 YTD Variance £,000	M3 YTD Variance %	M3 YTD Actual £,000	M3 YTD Variance £,000	M3 YTD Variance %	M3 YTD Actual £,000	M3 YTD Variance £,000	M3 YTD Variance %	M3 YTD Actual £,000	M3 YTD Variance £,000	M3 YTD Variance %
Alder Hey Children's	(70,638)	(138)	-0.2%	(69,104)	(484)	-0.7%	(1,298)	127	9%	(179)	57	24%
Bridgewater Community	(18,529)	(145)	-0.8%	(18,115)	(357)	-2.0%	(327)	(28)	-9%	(87)	240	73%
Cheshire & Wirral Partnership	(60,417)	(96)	-0.2%	(56,520)	(509)	-0.9%	(2,424)	(295)	-14%	(1,254)	693	36%
Countess of Chester Hospitals	(73,240)	111	0.2%	(67,217)	626	0.9%	(5,009)	(733)	-17%	(740)	205	22%
East Cheshire Trust	(40,372)	(356)	-0.9%	(35,631)	(1,256)	-3.7%	(3,868)	223	5%	(873)	632	42%
Liverpool Heart & Chest	(31,972)	(232)	-0.7%	(30,920)	(98)	-0.3%	(790)	11	1%	(129)	(12)	-10%
Liverpool University Hospitals	(230,490)	(6,558)	-2.8%	(212,859)	(3,705)	-1.8%	(14,404)	(2,341)	-19%	(2,349)	(720)	-44%
Liverpool Women's	(30,055)	(285)	-0.9%	(28,298)	144	0.5%	(1,313)	(189)	-17%	(340)	(243)	-252%
Mersey Care	(153,664)	(2,997)	-2.0%	(139,182)	(384)	-0.3%	(11,422)	(2,253)	-25%	(3,060)	(360)	-13%
Mid Cheshire Hospitals	(79,201)	(1,035)	-1.3%	(72,617)	(974)	-1.4%	(4,366)	(155)	-4%	(1,927)	37	2%
Mersey & West Lancs	(164,966)	(1,417)	-0.9%	(100,490)	(1,025)	-0.7%	(11,593)	(616)	-6%	(3,942)	(1,160)	-42%
The Clatterbridge Centre	(30,579)	(1,035)	-3.4%	(29,962)	(982)	-3.4%	(254)	(5)	-2%	(294)	21	7%
The Walton Centre	(25,976)	(211)	-0.8%	(25,013)	(370)	-1.5%	(905)	217	19%	(58)	(58)	-100%
Warrington & Halton Hospitals	(73,518)	780	1.1%	(65,706)	953	1.4%	(7,205)	(292)	-4%	(607)	119	16%
Wirral Community	(20,134)	766	3.8%	(19,034)	959	4.8%	(974)	(217)	-29%	(126)	23	15%
Wirral University Hospitals	(93,621)	(380)	-0.4%	(85,217)	(30)	0.0%	(6,535)	(572)	-10%	(1,525)	239	14%
TOTAL	**(1,197,373)**	**(13,229)**	**-1.1%**	**(1,055,884)**	**(7,491)**		**(72,687)**	**(7,118)**		**(17,491)**	**(289)**	

NHS Provider Agency and Bank Expenditure

23. As part of the 2025/26 plan C&M ICS NHS Providers set a plan for agency spend of £66.7m, compared to the ICS agency ceiling set by NHSE for 2025/26 of £76.9m. Similarly, providers set a 2025/26 plan for bank spend of £259.9m, compared to the ICS bank ceiling set by NHSE for 2025/26 of £273.9m. This reflects the planning requirements to achieve a 30% reduction in agency expenditure and 10% reduction in bank expenditure compared to 2024/25 but also the additional efficiency requirements required to support overall plan delivery.

24. Agency spend is being closely monitored with approval required from NHS England for all non-clinical agency.

25. At Month 3, agency spend is £17.5m (£0.3m above plan), with six providers reporting a YTD adverse variance to plan. Bank spend is £72.7m (£7.1m above plan, with 12 providers reporting a YTD variance to plan. Trust level information on agency and bank spend can be found in **Appendices 3 and 4**.

26. **Table 8** below sets out the aggregate agency and bank spend performance as a system. This indicates that bank expenditure is an area of concern, £7.1m over plan YTD and an extrapolation of the YTD position for the year could result in a significant overspend against plan and ceiling. Bank usage and reducing the rate price per shift has been a significant focus of the C&M financial control oversight group over June and progress is expected to the made in this area.

Table 8 – Provider Agency and Bank Expenditure

Agency Position	YTD Plan £m	YTD Actual £m	YTD Variance £m	FY Plan £m
All Providers Agency Spend	17.3	17.5	-0.2	66.7
C&M Annual Agency Ceiling				76.0
Forecast Variance to Ceiling				9.3
Extrapolation of M3 YTD				**70.0**

Bank Position	YTD Plan £m	YTD Actual £m	YTD Variance £m	FY Plan £m
All Providers Bank Spend	65.6	72.7	-7.1	259.0
C&M Annual Bank Ceiling				273.9
Forecast Variance to Ceiling				14.9
Extrapolation of M3 YTD				**290.7**

27. **Charts 3 and 4** below sets out the agency and bank expenditure monthly run rate from 24/25 Month 10 to 25/26 Month vs the position against plan and ceiling.

Chart 3 – Agency Expenditure Run Rate vs Plan and Ceiling

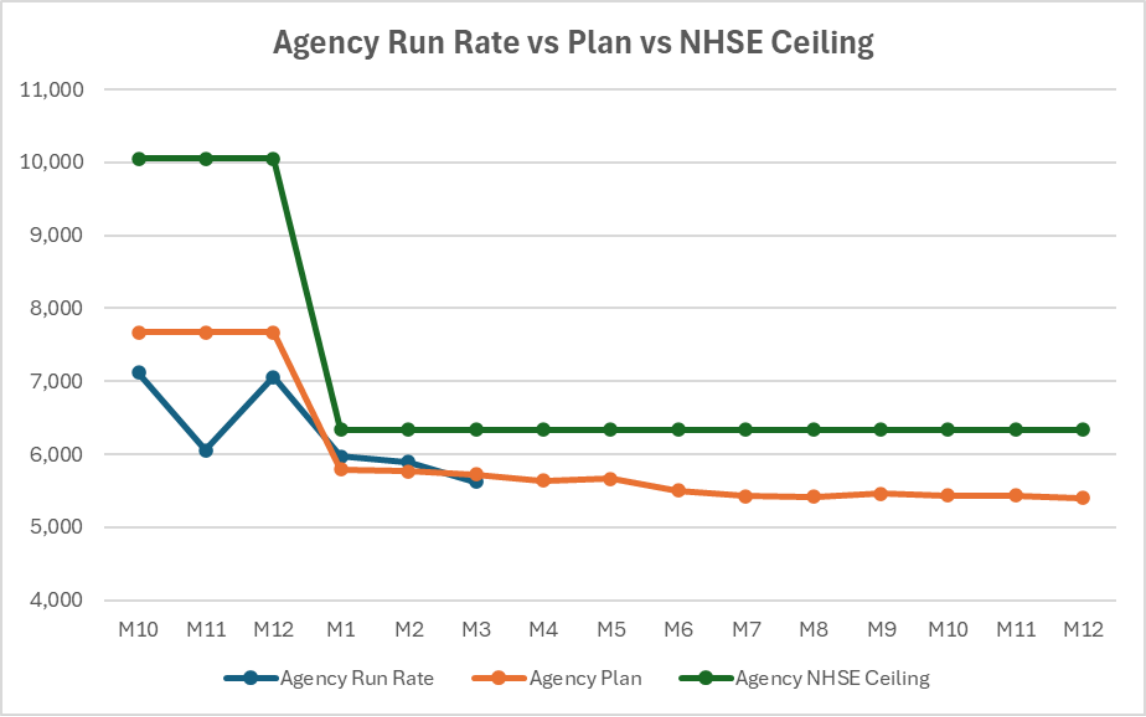
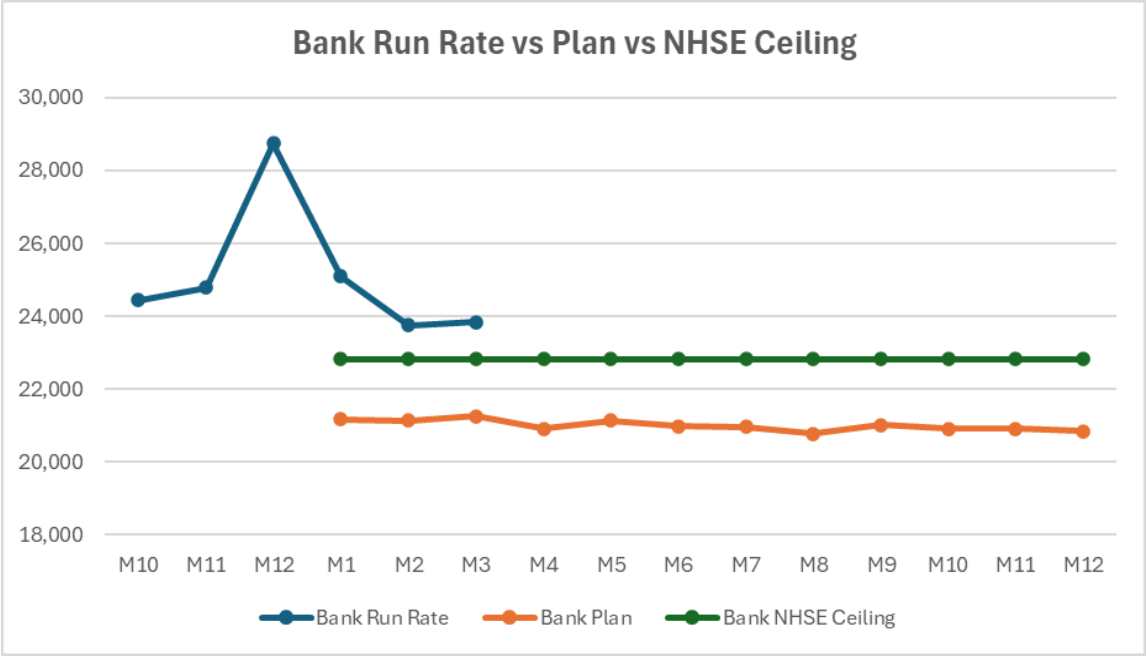


Chart 4 –Bank Expenditure Run Rate vs Plan and Ceiling

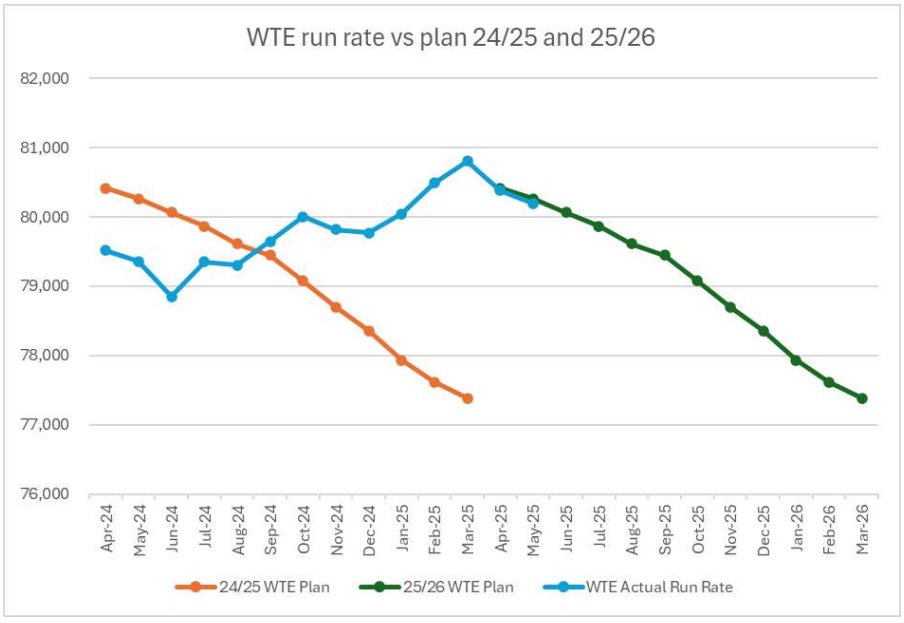


Workforce

28. **At the time of writing this report the Month 3 WTE data is unavailable and therefore the below sections report the Month 2 position.**

29. Workforce and its triangulation with finance, performance and productivity will continue to be key focus across the system. **Chart 5** sets out the provider WTEs run rate across 24/25 to Month 2 25/26 and the planned aggregate planned reductions forecast to the end of the year. **Appendix 6** sets out in more detail the movements at provider level.

Chart 5 – Workforce (WTE) Run Rate 24/25 and 25/26



30. **Table 9** below sets out the workforce run rate per month and the actuals against M2 plan by sector:

Table 9 – M2 Workforce movements vs 24/25 run rate and M2 25/26 Plan

Workforce (WTEs) - source PWRs / mitigation plan submission	M10 Actuals	M11 Actuals	M12 Actuals	M1 Actuals	M2 Actuals	M10 to M2 Trend	M2 Plan	M2 Variance to Plan	% var to plan
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	%
C&M Providers Total	**80,046**	**80,492**	**80,808**	**80,381**	**80,194**		**80,265**	**70**	**0.1%**
by Sector									
Acute	49,731	49,918	50,108	49,814	49,756		50,055	299	0.6%
Specialist	11,645	11,768	11,821	11,641	11,626		11,778	152	1.3%
Community / MH	18,669	18,806	18,879	18,926	18,812		18,432	(380)	-2.1%
TOTAL Providers	**80,046**	**80,492**	**80,808**	**80,381**	**80,194**		**80,265**	**70**	**0.1%**

31. The Month 2 provider workforce data indicate there is a 70 WTE favourable position against the YTD plan (0.1%), however the WTE position is relatively static vs the run rate and higher than that of 6 months ago and 24/25 average. Triangulation of WTE run rates and pay expenditure run rates will be a key area of review and challenge with providers. At Month 2, whilst WTE is broadly in line with plan (0.1%), the pay expenditure is adverse to YTD. Triangulation of the workforce plans with finance and performance has been a critical key component of the 2025/26 planning process, and extended provider and system vacancy controls have been further strengthened in April 2025 including a recruitment freeze on non-clinical posts.

System Efficiencies

32. For 2025/26 providers and ICB are forecasting delivery of £433m and £139m efficiencies respectively. In addition to the aggregate system efficiency plan of £583m (7.2% of ICB Allocations), there is also £155m of ICB and provider system recovery schemes within providers' plans but reported separately from the main CIP plans. These stretch system recovery schemes largely represent schemes across the urgent care pathway, non-criteria to reside, service changes that require system partner support to be developed and delivered

CIP position

33. **Table 10** shows at Month 3 the aggregate CIP YTD plan has been achieved with a small overachievement of £0.6m. The £97.7m efficiencies delivered YTD represent 4.6% of provider and ICS expenditure/allocation against the annual plan of 7.1%, indicating a larger proportion of the savings required in the remaining months.

34. Furthermore only 65% of the system efficiencies YTD plan has been delivered recurrently as at Month 3. This increases the risk in the underlying financial position of the ICS and is subject to ongoing work by providers to both recover

the YTD shortfall and address the recurrent position. Work has commenced, with the support of Simon Worthington, to review and triangulate this position with the actual and forecast expenditure run rates.

35. More detail on System efficiencies, by organisation, is included in **Appendix 7**.

Table 10 – ICS M3 YTD Efficiency Delivery

Org	CIP delivery (Month 3 YTD)					CIP Recurrent / Non Recurent YTD			Full year CIP		CIP Metrics	
	M3 YTD Plan £,000	M3 YTD Actual £,000	M3 YTD Variance £,000	M3 YTD % Variance %	M3 YTD CIP as a % of CIP FOT %	M3 YTD Actual Recurrent £,000	M3 YTD Actual Non Recurrent £,000	M3 Actual Recurrent as a % of YTD plan %	Full year CIP £,000	FOT £,000	M3 CIP delivery as a % of Op Ex %	CIP FOT as % of Op Ex %
TOTAL Providers	**82,234**	**82,657**	**423**	**0.5%**	**19%**	**47,961**	**34,696**	**58%**	**433,118**	**435,659**	**4.7%**	**6.3%**
C&M ICB	14,867	15,032	165	1.1%	10%	15,032	-	101%	139,352	147,383	3.2%	7.5%
TOTAL ICS System	**97,101**	**97,689**	**588**	**0.6%**	**17%**	**62,993**	**34,696**	**65%**	**572,470**	**583,042**	**4.6%**	**7.2%**

36. **Table 11** sets out the current risk and development status of efficiency schemes. As at the end of June 2025 16% of the CIP schemes are currently deemed to be at opportunity and unidentified stage. The maturity of CIP development is currently being reported to NHSE weekly and is a key metric in providing assurance on delivery of the overall plan. A Financial Control Oversight Group has been established since April, chaired by the System Turnaround Director, which brings both ICB Place teams and Providers Operational SROs together to progress schemes whilst along holding organisations to account. Further detail at organisational level on CIP maturity is included in **Appendix 8.**

Table 11 – Efficiency Development and Risk status (as at 30 June 2025)

	Fully Developed £,000	Plans in Progress £,000	Opportunity £,000	Unidentified £,000	Total Efficiencies £,000
Providers	278,326	83,488	65,749	8,095	**435,659**
ICB	100,625	25,693	21,065	-	**147,383**
C&M ICS	**378,951**	**109,181**	**86,814**	**8,095**	**583,042**
% of development status	**65%**	**19%**	**15%**	**1%**	

37. The £8.1m unidentified largely relates to one organisation, Countess of Chester, who have a different approach to CIP development and reporting with all schemes only being developed and implemented on a recurrent basis. The trust does have a level of compensating underspends on pay and non-pay budgets and is working to recover the unidentified CIP reported to date on a recurrent basis to support the exit run rate into 2026/27.

Additional System Recovery schemes position

38. As part of finalising the 2025/26 plans £235m of further system recovery and stretch opportunities were included in both ICB and provider plans. Due to nature of the opportunities a proportion of schemes (£79.5m) were included directly into organisation CIP plans, with the remaining £159.5m included within ICB and provider plans as cost reduction schemes but to be developed further and monitored outside of the CIP plans.

39. The table below sets out the latest position, showing by Provider how much of the £235m has been identified in Provider positions.

	Place holders in 25/26 plans £000s	Placeholders identified £000s	
Alder Hey Children's	7.3	3.5	48%
Liverpool Heart & Chest	6.1	4.9	80%
Liverpool University Hospitals	43.6	40.3	92%
Liverpool Women's	5	4.3	86%
Mersey Care	10.3	3.9	38%
The Clatterbridge Centre	7.2	6.4	89%
The Walton Centre	4.8	4.8	100%
Liverpool Cluster	**84.3**	**68.1**	**81%**
Cheshire & Wirral Partnership	5.4	1.0	19%
Countess of Chester Hospitals	10.7	5.3	49%
East Cheshire Trust	5.6	1.3	23%
Mid Cheshire Hospitals	13.2	10.0	76%
Cheshire Cluster	**34.9**	**17.6**	**50%**
Bridgewater Community	3	0.5	17%
Mersey & West Lancs	34.9	11.7	34%
Warrington & Halton Hospitals	13.1	2.3	17%
Mid Mersey Cluster	**51**	**14.5**	**28%**
Wirral Community	2.7	2.7	100%
Wirral University Hospitals	16.5	6.0	36%
Wirral Cluster	**19.2**	**8.7**	**45%**
TOTAL Providers	**189.4**	**108.8**	**57%**
C&M ICB	46	32.0	70%
Total ICS	**235.4**	**140.8**	**60%**

40. The £140.8m identified relates to a number of different themes; £8.5m on service changes within Providers, £58.1m through expansion of CIP schemes, £32.2m revenue to capital scheme and £15.4m from the Urgent and Emergency Care review (see below).

41. The workstreams set up to identify areas of consistency potential opportunities for improvement will continue to work on the remaining £94.5m gap. They cover the following areas:
    - Pay arrangements for nursing and allied health professionals covering overtime / bank rates, agreements for 1:1s and enhanced Care, and e-rostering arrangements.
    - Similar reviews for Medical staff, looking at Pay Enhancements, Waiting List initiatives, Standardised Rate cards ad Agency/locum spend.
    - Urgent and emergency care, reviewing performance and further opportunities for efficiency saving and removing premium system costs for escalation areas.

Financial Recovery Approach and Turnaround

42. For 2025/26 a Financial Control and Oversight Group (FCOG) has been established to build on and follow on the work of Recovery undertaken during 2024/25 with a much tighter focus on financial efficiency.

43. The FCOG is responsible for the oversight and assurance of ICB and Provider efficiency programmes, through which the system will deliver its short and long-term financial plans. An update from FCOG is included as a separate agenda item.

44. Simon Worthington has been asked by the region to continue his work with the system and is undertaking further work on reporting (in particular cost improvement approaches) & forecasting arrangements alongside the ICB and C&M Providers based on Month 3 performance

45. PwC have reported on their findings and will be continuing their work covering:
    - Development of a System Oversight Framework and specific oversight of 6 high risk providers
    - Assessment of grip and control measures
    - Balance Sheet review and assessment

46. Further detail is covered in a separate agenda item

System Risks & Mitigations

47. Several risks have been reported through the recent planning progress and are subject to ongoing to monitoring and management by the respective organisations:

    a. **Identification and delivery of recurrent CIPs** – this is subject to focussed System wide review to identify areas for acceleration and improvement.

    b. **Provider contract performance against API contracts** – in 2025/26 the C&M ICB has a fixed level of resource for Elective Recovery and activity delivery whilst planning to deliver 65% on RTT – this is subject to close monitoring through contract meetings.

    c. **Inflation** – specifically; non-pay inflation for providers and prescribing and continuing care/packages of care for the ICB above national planning assumptions.

d. **Cost of out of area placements** arising from delayed transfers of care.

e. **Industrial action disruption** – the original plan assumes no further industrial action throughout 25/26. The impact of the proposed Junior Doctor industrial action will manifest in July's figures and is currently being assessed.

f. **Deficit support funding** – plan assumes that providers receive funding quarterly but is dependent on plan delivery and NHSE assurance. Q2 is currently being withheld.

g. **ADHD** – growing cost due to expansion of IS providers in the market and higher prices.

h. **ICB Management Cost Reductions** – the plan included an assumption that additional savings as a result of further reductions to management costs on the basis that redundancy costs in line with guidance. The funding for redundancy costs remains unconfirmed.

Cash

48. **At the time of writing the report the information on provider cash balances at M3 was unavailable, therefore the below section sets out the Month 2 position**. Since Month 2 the ICS has been notified that one quarter (Q2) of the Deficit Support Funding has been put on hold by NHSE until further assurances on plan delivery are evidenced by the system and all organisations. This equates to c£45m across eight organisations. The ICB is currently working with those impacted organisations to review all potential mitigating actions which will be covered by a system wide cash management MoU (Memorandum of Understanding). Any provider with immediate cash shortfalls to meet payroll and contractual obligations have been requested to notify NHS England for further consideration.

49. The Providers' cash position at Month 2 was £414.5m, with the detail set out in **Appendix 9** by organisation. Year-end cash balances are £61.7m lower than at the end of 2024/25. The reduction is a combination of the YTD M2 deficit but also payment of 24/25 capital creditors in the first two months. The average operating days cash in the system at Month 2 is 23 days but this ranges from 1 operating days cash in one provider to 99 days operating days cash in another. A cash working group has been established to share best practice on cash management strategies but also review all available options to providers and the ICB but to mitigate the need for further external cash support.

50. Acute organisations with a planned deficit have included in their cash forecasts receipt £178m deficit support funding. Release of this cash support is contingent on delivery of plans YTD and prospective quarterly assurance undertaken by NHSE on delivery of full year plans. There are five organisations that have included in their plans a requirement for external cash support from NHSE during 2025/26 to support their I&E deficit plans – Mersey and West Lancs Teaching NHS Trust, Warrington & Halton Teaching Hospitals FT, Liverpool Women's NHS

FT, Countess of Chester Hospital NHS FT and Wirral Teaching Hospitals NHS FT.

51. **Table 13** below set out the aggregate provider cash balance at Month 2, the level of distress cash requests received from NHSE to date and forecast for the year, and the Month 2 average Better Payment Practice Code (BPPC) position across providers. The aggregate provider BPPC performance is currently at an average of 92.3% of number of bills paid within the 95%. Further detail of BPPC performance by provider is set put in **Appendix 10.**

Table 13 – Provider Cash and BPPC Performance – Month 2

Org	Cash Balance			Operating Days Cash	DHSC External Cash Support - Revenue		BPPC % of bills paid in target	
	2024/25 M12 Closing Cash Balance	2025/26 M2 Closing Cash Balance	Movement	25/26 M2 Actual	M2 YTD	FOT	2024/25 M2 By number	2024/25 M2 By Value
	£m	£m	£m	Days	£m	£m	%	%
Alder Hey Children's	53.7	38.1	(15.6)	35	0.0	0.0	92.4%	88.8%
Bridgewater Community	8.2	5.7	(2.5)	22	0.0	0.0	98.4%	98.9%
Cheshire & Wirral Partnership	28.5	24.0	(4.5)	31	0.0	0.0	98.3%	97.7%
Countess of Chester Hospitals	28.2	15.8	(12.4)	14	0.0	8.0	94.6%	94.3%
East Cheshire Trust	14.0	10.9	(3.1)	18	0.0	0.0	96.9%	97.0%
Liverpool Heart & Chest	49.4	48.1	(1.2)	76	0.0	0.0	98.0%	99.3%
Liverpool University Hospitals	30.4	30.2	(0.3)	8	0.0	0.0	74.4%	90.3%
Liverpool Women's	3.8	5.3	1.4	11	0.0	15.0	95.2%	97.1%
Mersey Care	53.8	49.4	(4.4)	24	0.0	0.0	95.4%	96.9%
Mid Cheshire Hospitals	36.3	35.0	(1.3)	30	0.0	0.0	95.4%	94.8%
Mersey & West Lancs	10.2	3.7	(6.5)	1	0.0	19.0	93.5%	95.5%
The Clatterbridge Centre	73.2	69.5	(3.6)	79	0.0	0.0	97.3%	99.1%
The Walton Centre	62.4	51.3	(11.2)	99	0.0	0.0	90.0%	96.1%
Warrington & Halton Hospitals	16.3	12.9	(3.4)	12	0.0	15.3	48.5%	48.8%
Wirral Community	7.8	10.5	2.7	39	0.0	0.0	90.4%	94.6%
Wirral University Hospitals	0.1	4.2	4.1	3	8.0	19.5	81.6%	91.0%
TOTAL Providers	**476.2**	**414.5**	**(61.7)**	**23**	**8.0**	**76.8**	**90.0%**	**92.5%**

52. The BPPC of WUTH and Warrington & Halton is of particular system concern. WUTH have been in conversations with the national team regarding their cash requirements and received £8m external cash support in Month 1.

53. The review of the cash position by national team has focussed on cash requests above planned deficit levels, workforce and financial recovery trajectories being on track and working capital balances i.e. high levels of receivables.

Provider and Primary Care Capital

54. The 'Charge against Capital Allocation' represents the System's performance against its operational core capital allocation, which is wholly managed at the System's discretion. For 2024/25 the System's Secondary Care Core allocation in 2023/24 is £200.0m, a Primary Care allocation of £6.0m, and an assumed

allocation of £41.5m Capital Freedoms from prior year higher performing provider I&E surpluses and £2m UEC capital incentive allocation for high performing UEC performance in Q4 of 24/25. The Capital Freedoms and UEC Incentive capital remain subject to NHSE approval but have been included in the plan as per NHSE guidance. Within the overall £249m capital system plan £21.7m remains unallocated with the intention to allocate to providers once NHSE approvals have been confirmed on the capital freedoms and UEC incentive elements.

55. **Tables 14 & 15** sets out the Month 3 position capital expenditure against plan at a system level but also the ICB's primary care capital position. At Month 3 there is a YTD underspend of £31.5m which is across the provider sector. The £5.7m forecast variance relates to two known issues:

- Additional £5m allocation from NHSE for UEC Incentive capital linked to improved UEC performance in Q4 of 24/25. This allocation is CDEL cover (non-cash) only as is spilt across the following three organisations: £2m Alder Hey, £2m Warrington & Halton and £1m Countess of Chester
- Additional £0.7m allocation to C&M ICB for GPIT (GP Information Technology) equipment.

Table 14 - System (Provider & ICB) - Charge against Capital Allocation M3

	Plan YTD	Actual YTD	Variance YTD	Plan Year Ending	Forecast Year Ending	Variance Year Ending	
	£'000	£'000	£'000	£'000	£'000	£'000	%
System charge against allocation	65,702	34,200	31,502	249,501	255,201	(5,699)	(2.3%)
Capital allocation					255,201		
Variance to allocation					0		
Allocation met					Yes		

Table 15 – ICB - Charge against allocation M3

ICB Charge against CDEL allocation	Plan YTD	Actual YTD	Variance YTD	Plan Year Ending	Forecast Year Ending	Variance Year Ending	
	£'000	£'000	£'000	£'000	£'000	£'000	%
Cheshire And Merseyside ICB	-	-	-	27,712	28,410	(698)	(2.5%)
Capital allocation					28,410		
Variance to allocation					-		
Allocation met					Yes		

56. **Appendix 11** sets out the detailed M3 capital position by provider.

57. In addition to the core capital plans, the ICS has been allocated a further £64m of national funding across three main programme areas: Estates Safety, Constitutional Standards Recovery (covering Diagnostics, Elective and Urgent Care), Mental Health Out of Area Placements. The initial allocation of this was covered in the 25/26 planning paper but this spend remains subject to providers

developing and submitting formal detailed business cases that require ICB letters of support and NHSE regional and national approval.

Ask of the Board and Recommendations

58. The Committee is asked to note the financial position and metrics reported at Month 3 and the risks to delivery of the financial plan which are described in the paper.

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Appendices

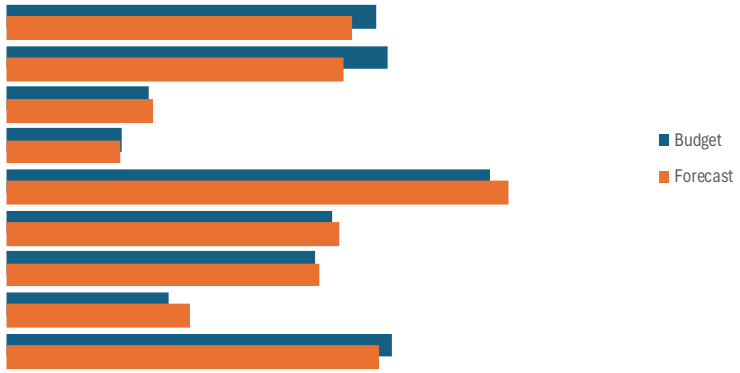
Appendix 1:	**Continuing Care and Complex Care Additional information M3**
Appendix 3:	**Prescribing budgetary performance M3**
Appendix 4:	**Agency Expenditure Run Rate – and position vs plan M3 YTD**
Appendix 5:	**Bank Expenditure Run Rate – and position vs plan M3 YTD**
Appendix 6:	**Workforce Analysis vs trend and Plan by Provider at M2**
Appendix 7:	**System Efficiencies: Current Performance M3**
Appendix 8:	**System Efficiencies – Maturity / Development Status as at M3**
Appendix 9:	**Provider Cash at Month 2**
Appendix 10:	**Provider BPPC at Month 2**
Appendix 11:	**Provider Capital Expenditure vs ICS Allocation at Month 3**
Appendix 12 :	**DSF Q2 Letter**
Appendix 13	**Month 4 Summary Update position for the Cheshire and Merseyside ICS**

Appendix 1

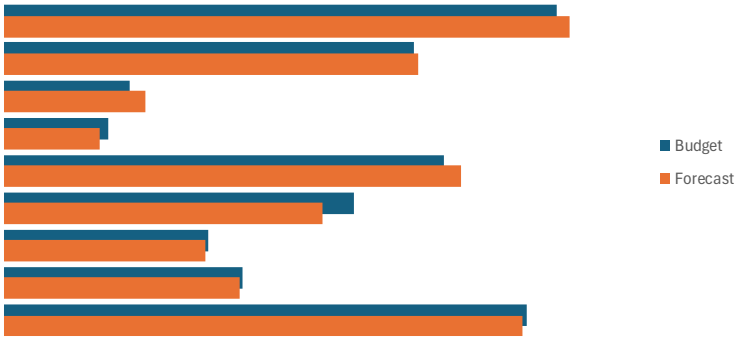
Continuing Care and Complex Care Additional information M3

CHC and MH packages - Financial performance by place

Mental Health Packages of Care	Year to Date			FOT		
	Budget (£000's)	Actual (£000's)	Variance (£000's)	Budget (£000's)	Forecast (£000's)	Variance (£000's)
Cheshire East	7,558	7,276	282	29,728	27,759	1,969
Cheshire West	7,786	7,127	659	30,625	27,080	3,545
Halton	2,914	3,090	(176)	11,441	11,790	(349)
Knowsley	2,359	2,029	330	9,272	9,136	136
Liverpool	9,894	10,291	(397)	38,810	40,241	(1,430)
Sefton	6,641	6,931	(290)	26,111	26,722	(611)
St Helens	6,314	6,239	75	24,796	25,119	(324)
Warrington	3,321	3,755	(435)	13,032	14,781	(1,749)
Wirral	7,874	7,719	156	30,896	29,931	965
Total	**54,661**	**54,457**	**204**	**214,711**	**212,559**	**2,152**



All Age Continuing Care	Year to Date			FOT		
	Budget (£000's)	Actual (£000's)	Variance (£000's)	Budget (£000's)	Forecast (£000's)	Variance (£000's)
Cheshire East	23,067	22,889	178	88,237	90,359	(2,122)
Cheshire West	16,655	16,890	(235)	65,571	66,194	(623)
Halton	5,120	5,665	(545)	20,229	22,705	(2,476)
Knowsley	4,290	3,879	411	16,616	15,358	1,258
Liverpool	17,842	18,916	(1,074)	70,399	73,023	(2,624)
Sefton	15,014	14,117	897	56,009	50,898	5,111
St Helens	8,526	8,383	143	32,568	32,136	431
Warrington	9,681	9,012	670	38,185	37,652	533
Wirral	21,889	21,136	754	83,533	82,798	735
ICB	0	61	(61)	0	0	0
Total	**122,084**	**120,947**	**1,137**	**471,348**	**471,124**	**224**

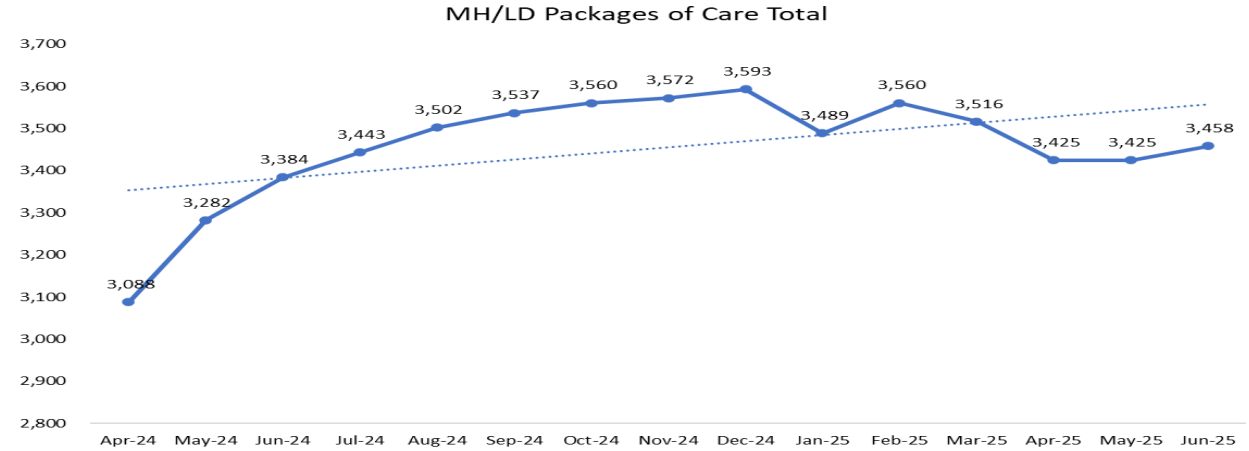


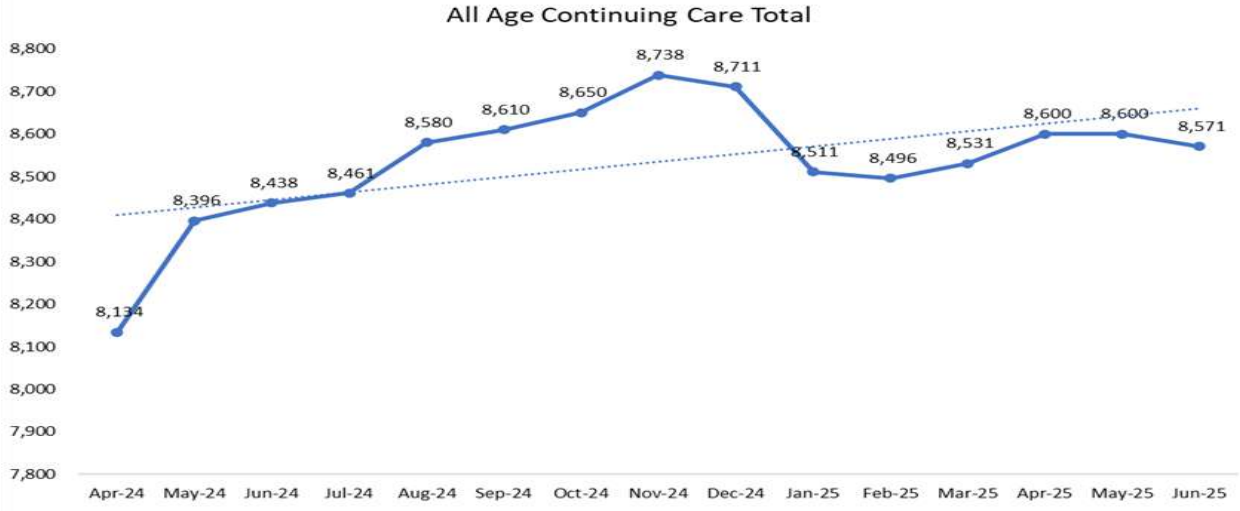
CHC and MH packages - Financial Performance by budget area

Mental Health Packages of Care	Year to Date			FOT			Prior Month FOT		
	Budget (£000's)	Actual (£000's)	Variance (£000's)	Budget (£000's)	Forecast (£000's)	Variance (£000's)	Budget (£000's)	Forecast (£000's)	Variance (£000's)
COMPLEX LEARNING DISABILITIES	11,323	11,654	(331)	44,534	44,289	246	43,325	43,325	0
COMMUNITY B SUPPORTED HOUSING SERVICES	1,480	1,015	465	5,936	4,299	1,637	5,579	5,579	0
MENTAL HEALTH PLACEMENTS IN HOSPITALS	8,612	8,261	351	33,807	32,082	1,725	31,900	31,900	0
MENTAL HEALTH ACT	26,375	27,303	(927)	102,871	106,644	(3,774)	106,397	106,397	0
ACUTE MH OOA PLACEMENTS ADULT	2,467	2,373	94	9,894	9,178	716	8,561	8,561	0
ACQUIRED BRIAN INJURY	4,405	3,852	553	17,669	16,067	1,602	16,303	16,303	0
COMPLEX CARE TOTAL	54,661	54,457	204	214,711	212,559	2,152	212,065	212,065	0

All Age Continuing Care	Year to Date			FOT			Prior Month FOT		
	Budget (£000's)	Actual (£000's)	Variance (£000's)	Budget (£000's)	Forecast (£000's)	Variance (£000's)	Budget (£000's)	Forecast (£000's)	Variance (£000's)
CHC ADULT FULLY FUNDED	51,660	52,872	(1,211)	196,035	197,609	(1,575)	194,393	194,393	0
CHC AD FULL FUND PERS HLTH BUD	19,039	18,360	679	75,424	77,665	(2,241)	75,664	75,664	0
CHC ADULT - FULLY FUNDED - FAST TRACK	15,177	14,621	556	55,048	54,383	666	56,162	56,162	0
CHC AD FULL FUND PERS HLTH BUD - FAST TRACK	811	505	306	3,252	1,706	1,546	3,252	3,252	0
ADULT JOINT FUNDED CONTINUING CARE	5,860	6,067	(207)	23,172	23,382	(210)	26,006	26,006	0
ADULT JOINT FUNDED CONTINUING CARE PERSONAL HEALTH BUDGETS	1,949	1,786	162	7,816	7,478	338	7,816	7,816	0
CONTINUING HEALTHCARE ASSESSMENT & SUPPORT	5,210	5,003	207	20,899	20,345	553	21,051	21,051	0
FUNDED NURSING CARE	17,625	16,781	844	70,663	68,718	1,945	70,763	70,763	0
CHILDRENS CONTINUING CARE	3,636	3,943	(307)	14,556	16,620	(2,064)	14,556	14,556	0
CHILDRENS CONTINUING CARE PERSONAL HEALTH BUDGETS	1,118	1,009	108	4,484	3,218	1,266	4,484	4,484	0
AACC TOTAL	122,084	120,947	1,137	471,348	471,124	224	474,146	474,146	0

CHC and MH packages – Trend of Patient Numbers





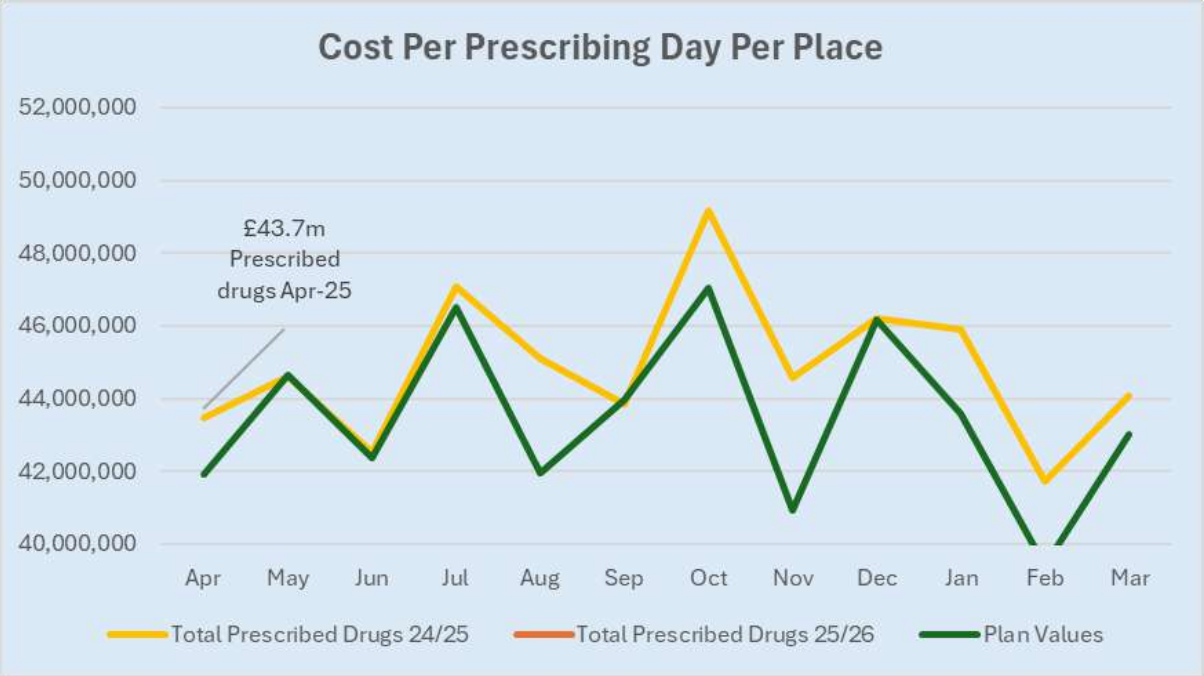
CHC and MH packages – Swing in Packages in-month

Mental Health Packages of Care	Number of Patients - Opening Position	No. New Patient in Month	No. Ended in Month	Change in Patient Numbers	Number of Patients - Closing Position	Cost New Patients (£)	Increased Patient Costs (£)	Decrease in Cost (£)	Overall Change in Cost (£)
COMPLEX LEARNING DISABILITIES	419	191	(173)	18	437	19,526,316	3,271,643	(23,654,597)	(856,637)
COMMUNITY B SUPPORTED HOUSING SERVICES	112	51	(53)	(2)	110	2,240,830	140,109	(2,360,866)	20,073
MENTAL HEALTH PLACEMENTS IN HOSPITALS	144	15	(17)	(2)	142	4,262,206	315,339	(6,101,122)	(1,523,577)
MENTAL HEALTH ACT	2,637	873	(841)	32	2,669	38,975,454	11,682,055	(46,505,144)	4,152,365
ACUTE MH OOA PLACEMENTS ADULT	49	2	(6)	(4)	45	169,616	1,384,061	(1,852,963)	(299,285)
ACQUIRED BRIAN INJURY	64	11	(20)	(9)	55	1,000,529	2,663,454	(2,250,462)	1,413,520
MENTAL HEALTH PACKAGES OF CARE TOTAL	**3,425**	**1,143**	**(1,110)**	**33**	**3,458**	**66,174,952**	**19,456,661**	**(82,725,155)**	**2,906,459**

All Age Continuing Care	Number of Patients - Opening Position	No. New Patient in Month	No. Ended in Month	Change in Patient Numbers	Number of Patients - Closing Position	Cost New Patients (£)	Increased Patient Costs (£)	Decrease in Cost (£)	Decrease in Cost (£)
CHC ADULT FULLY FUNDED	1,656	179	(220)	(41)	1,615	17,652,101	3,154,654	(21,875,552)	(1,068,797)
CHC AD FULL FUND PERS HLTH BUD	526	38	(33)	5	531	3,840,791	1,817,591	(9,794,286)	(4,135,905)
CHC ADULT - FULLY FUNDED - FAST TRACK	925	520	(523)	(3)	922	14,920,230	2,228,219	(19,073,953)	(1,925,504)
CHC AD FULL FUND PERS HLTH BUD - FAST TRACK	30	8	(12)	(4)	26	139,879	167	(788,757)	(648,711)
ADULT JOINT FUNDED CONTINUING CARE	311	105	(114)	(9)	302	9,992,458	1,694,029	(13,118,814)	(1,432,327)
ADULT JOINT FUNDED CONTINUING CARE PERSONAL HEALTH BUDGETS	106	44	(46)	(2)	104	3,267,445	206,531	(3,550,340)	(76,364)
CONTINUING HEALTHCARE ASSESSMENT & SUPPORT	-	3	(3)	-	-	8,944,772	399,077	(653,794)	8,690,056
FUNDED NURSING CARE	4,861	669	(646)	23	4,884	7,159,001	490,103	(8,962,634)	(1,313,530)
CHILDRENS CONTINUING CARE	120	12	(7)	5	125	517,359	1,580,644	(1,214,574)	883,429
CHILDRENS CONTINUING CARE PERSONAL HEALTH BUDGETS	65	5	(8)	(3)	62	52,471	265,468	(502,401)	(184,462)
ALL AGE CONTINUING CARE TOTAL	**8,600**	**1,583**	**(1,612)**	**(29)**	**8,571**	**66,486,505**	**11,836,483**	**(79,535,104)**	**(1,212,116)**

- **Some itemised patient data was unavailable at M2, therefore the number of new and ended patients in month is high, this can be disregarded this month.**

Appendix 3 – Prescribing



Key Messages Below:

Financial Planning Overview – Tirzepatide Forecasts

Within the financial plans, a projected spend of £3.366 million was assumed for the current year. From a horizon scanning perspective, Tirzepatide growth was excluded from the 2025/26 planning cycle, as we were awaiting further guidance from NICE.

For the first quarter (April to June, Months 1–3), Tirzepatide costs are estimated at £2.7 million. This reflects a significant rise in cost per prescribing day, which has increased to £36.5K per day, compared to £4.5K for the first quarter of 2024/25 in the previous period. **NB This relates to the Diabetes prescribing of Tirzepatide.**

Dapagliflozin Usage Update – April Activity

The use of Dapagliflozin has demonstrated a substantial cost increase, with expenditure rising by £377K in April alone. While horizon scanning projections anticipated a 50% growth, the actual data for April indicates an 80% increase, significantly exceeding expectations.

This increase corresponds to an additional £15.7k increase in prescribing day.

Items Dispensed

April 2025 has seen an increase of 8,030 items prescribed per dispensing day. This is increase of 3.7%

Appendix 4 – Agency Expenditure Run Rate – and position vs plan M3 YTD by provider

	2024/25			2025/26			2025/26			2025/26			2025/26	
	M10	M11	M12	M1 in month	M1 in month	M1 in month	M2 in month	M2 in month	M2 in month	M3 in month	M3 in month	M3 in month	M3 YTD as a % of paybill	Actual Run Rate Trendline M10-M3
	Actual £,000	Actual £,000	Actual £,000	Plan £,000	Actual £,000	Variance £,000	Plan £,000	Actual £,000	Variance £,000	Plan £,000	Actual £,000	Variance £,000	%	
Alder Hey Children's	67	68	18	79	62	17	79	51	28	79	66	13	0.2%	
Bridgewater Community	91	69	62	112	42	70	109	30	79	106	15	91	0.4%	
Cheshire & Wirral Partnership	515	(317)	560	676	408	268	650	487	163	621	359	262	1.5%	
Countess of Chester Hospitals	219	280	206	315	247	68	315	254	61	315	239	76	0.7%	
East Cheshire Trust	509	453	421	508	339	169	508	270	238	489	264	225	1.5%	
Liverpool Heart & Chest	4	26	39	39	27	12	39	23	16	39	79	(40)	0.2%	
Liverpool University Hospitals	874	787	924	543	694	(151)	543	853	(310)	543	802	(259)	0.7%	
Liverpool Women's	95	61	87	32	136	(104)	32	119	(87)	32	85	(53)	0.8%	
Mersey Care	1,038	980	1,019	900	1,032	(132)	900	921	(21)	900	1,107	(207)	1.3%	
Mid Cheshire Hospitals	1,034	1,059	1,176	651	760	(109)	655	628	27	658	539	119	1.8%	
Mersey & West Lancs	1,513	1,223	1,628	927	1,105	(178)	927	1,372	(445)	927	1,465	(538)	1.5%	
The Clatterbridge Centre	119	130	148	105	110	(5)	105	98	7	105	86	19	0.7%	
The Walton Centre	58	49	(40)	0	1	(1)	0	33	(33)	0	24	(24)	0.1%	
Warrington & Halton Hospitals	275	436	394	242	319	(77)	242	119	123	242	169	73	0.6%	
Wirral Community	(26)	46	63	50	42	8	50	39	11	50	45	5	0.4%	
Wirral University Hospitals	732	705	358	588	649	(61)	588	598	(10)	588	278	310	1.3%	
Agency Expenditure	**7,116**	**6,056**	**7,062**	**5,767**	**5,974**	**(207)**	**5,742**	**5,896**	**(154)**	**5,694**	**5,622**	**72**	**1.0%**	

Appendix 5 – Bank Expenditure Run Rate – and position vs plan M3 YTD by provider

	2024/25			2025/26			2025/26			2025/26			2025/26	
	M10	M11	M12	M1 in month	M1 in month	M1 in month	M2 in month	M2 in month	M2 in month	M3 in month	M3 in month	M3 in month	M3 YTD as a % of paybill	Actual Run Rate Trendline M10-M2
	Actual £,000	Actual £,000	Actual £,000	Plan £,000	Actual £,000	Variance £,000	Plan £,000	Actual £,000	Variance £,000	Plan £,000	Actual £,000	Variance £,000	%	
Alder Hey Children's	684	757	638	475	455	20	475	445	30	475	398	77	1.8%	
Bridgewater Community	65	79	117	100	113	(13)	100	110	(10)	100	104	(5)	1.8%	
Cheshire & Wirral Partnership	667	685	1,022	722	825	(103)	709	809	(100)	698	790	(92)	4.0%	
Countess of Chester Hospitals	1,514	1,565	1,840	1,425	1,742	(317)	1,425	1,447	(22)	1,425	1,820	(395)	6.8%	
East Cheshire Trust	1,275	1,207	1,484	1,308	1,302	6	1,280	1,209	71	1,503	1,357	146	9.6%	
Liverpool Heart & Chest	326	367	320	267	188	79	267	329	(62)	267	273	(6)	2.5%	
Liverpool University Hospitals	4,763	5,214	5,180	4,021	4,818	(797)	4,021	4,830	(809)	4,021	4,756	(735)	6.2%	
Liverpool Women's	435	486	299	375	457	(82)	375	471	(96)	375	385	(10)	4.4%	
Mersey Care	4,064	4,033	5,144	3,051	4,456	(1,405)	3,059	3,537	(478)	3,059	3,429	(370)	7.4%	
Mid Cheshire Hospitals	2,074	1,823	1,978	1,402	1,590	(188)	1,404	1,412	(8)	1,405	1,364	41	5.5%	
Mersey & West Lancs	2,811	3,724	4,629	3,659	3,791	(132)	3,659	3,801	(142)	3,659	4,001	(342)	7.0%	
The Clatterbridge Centre	120	(30)	159	83	93	(10)	83	138	(55)	83	23	60	0.8%	
The Walton Centre	399	853	475	372	297	75	391	362	29	359	246	113	3.5%	
Warrington & Halton Hospitals	2,587	1,516	2,908	2,342	2,401	(59)	2,322	2,427	(105)	2,249	2,377	(128)	9.8%	
Wirral Community	342	309	182	252	322	(70)	252	301	(49)	252	351	(98)	4.8%	
Wirral University Hospitals	2,317	2,204	2,377	1,321	2,239	(918)	2,534	2,134	400	2,108	2,162	(54)	7.0%	
Bank Expenditure	**24,443**	**24,792**	**28,751**	**21,175**	**25,089**	**(3,915)**	**22,356**	**23,762**	**(1,406)**	**22,038**	**23,836**	**(1,798)**	6.1%	

Appendix 6 – Workforce Analysis vs trend and Plan by Provider at Month 2

	2024/25			2025/26					
Workforce (WTEs) - source PWRs / mitigation plan submission	M10 Actuals	M11 Actuals	M12 Actuals	M1 Actuals	M2 Actuals	M10 to M2 Trend	M2 Plan	M2 Variance to Plan	% var to plan
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	%
Alder Hey Children's	4,426	4,480	4,464	4,346	4,322		4,491	169	3.8%
Bridgewater Community	1,444	1,436	1,422	1,407	1,403		1,444	41	2.9%
Cheshire & Wirral Partnership	4,050	4,095	4,152	4,147	4,080		3,976	(103)	-2.6%
Countess of Chester Hospitals	4,864	4,870	4,920	4,892	4,827		4,792	(34)	-0.7%
East Cheshire Trust	2,672	2,663	2,707	2,652	2,650		2,668	18	0.7%
Liverpool Heart & Chest	1,912	1,934	1,939	1,970	1,982		2,013	30	1.5%
Liverpool University Hospitals	15,104	15,249	15,232	15,114	15,204		15,234	30	0.2%
Liverpool Women's	1,772	1,803	1,842	1,823	1,817		1,791	(26)	-1.4%
Mersey Care	11,616	11,714	11,758	11,836	11,814		11,461	(353)	-3.1%
Mid Cheshire Hospitals	5,529	5,538	5,577	5,502	5,517		5,569	52	0.9%
Mersey & West Lancs	10,575	10,632	10,638	10,631	10,623		10,715	92	0.9%
The Clatterbridge Centre	1,931	1,942	1,957	1,927	1,926		1,919	(7)	-0.4%
The Walton Centre	1,604	1,608	1,619	1,575	1,579		1,564	(15)	-0.9%
Warrington & Halton Hospitals	4,653	4,658	4,692	4,730	4,666		4,762	96	2.0%
Wirral Community	1,560	1,561	1,547	1,535	1,516		1,550	34	2.2%
Wirral University Hospitals	6,336	6,308	6,343	6,293	6,269		6,314	45	0.7%
C&M Providers Total	**80,046**	**80,492**	**80,808**	**80,381**	**80,194**		**80,265**	**70**	**0.1%**
by Sector									
Acute	49,731	49,918	50,108	49,814	49,756		50,055	299	0.6%
Specialist	11,645	11,768	11,821	11,641	11,626		11,778	152	1.3%
Community / MH	18,669	18,806	18,879	18,926	18,812		18,432	(380)	-2.1%
TOTAL Providers	**80,046**	**80,492**	**80,808**	**80,381**	**80,194**		**80,265**	**70**	**0.1%**

NHS
Cheshire and Merseyside

Appendix 7 - System Efficiencies: Current Performance M3

Org	CIP delivery (Month 3 YTD)					CIP Recurrent / Non Recurent YTD			Full year CIP		CIP Metrics	
	M3 YTD Plan	M3 YTD Actual	M3 YTD Variance	M3 YTD % Variance	M3 YTD CIP as a % of CIP FOT	M3 YTD Actual Recurrent	M3 YTD Actual Non Recurrent	M3 Actual Recurrent as a % of YTD plan	Full year CIP	FOT	M3 CIP delivery as a % of Op Ex	CIP FOT as % of Op Ex
	£,000	£,000	£,000	%	%	£,000	£,000	%	£,000	£,000	%	%
Alder Hey Children's	4,353	3,736	(617)	-14%	16%	1,560	2,176	36%	22,746	22,746	3.3%	5.1%
Bridgewater Commur	1,156	1,156	0	0%	21%	1,156	-	100%	5,475	5,475	4.3%	5.2%
Cheshire & Wirral Par	2,967	2,332	(635)	-21%	16%	810	1,522	27%	14,856	14,856	3.0%	4.8%
Countess of Chester	3,047	1,426	(1,621)	-53%	5%	1,426	-	47%	27,703	27,705	1.4%	5.9%
East Cheshire Trust	2,533	2,533	0	0%	21%	1,141	1,392	45%	12,175	12,175	4.1%	5.1%
Liverpool Heart & Che	2,473	1,638	(835)	-34%	12%	747	891	30%	13,499	13,505	2.5%	5.2%
Liverpool University H	20,357	25,075	4,718	23%	21%	15,840	9,235	78%	117,185	117,185	6.8%	8.2%
Liverpool Women's	2,056	2,107	51	2%	17%	1,255	853	61%	12,680	12,680	4.3%	6.3%
Mersey Care	8,433	7,542	(891)	-11%	19%	5,172	2,370	61%	40,696	40,696	3.8%	5.0%
Mid Cheshire Hospita	6,399	5,647	(752)	-12%	18%	2,814	2,833	44%	31,668	31,668	4.7%	6.6%
Mersey & West Lancs	11,052	12,545	1,493	14%	25%	5,382	7,163	49%	48,200	49,700	4.9%	5.0%
The Clatterbridge Ce	3,073	2,411	(661)	-22%	16%	1,156	1,256	38%	14,790	14,790	2.8%	4.6%
The Walton Centre	2,742	2,742	0	0%	22%	2,547	196	93%	12,247	12,247	5.1%	5.7%
Warrington & Halton	2,538	2,538	0	0%	12%	1,514	1,025	60%	21,477	21,477	2.4%	5.1%
Wirral Community	1,050	1,224	173	16%	18%	1,224	-	116%	5,702	6,733	4.4%	6.1%
Wirral University Hos	8,005	8,004	(1)	0%	25%	4,218	3,786	53%	32,020	32,021	5.8%	5.8%
TOTAL Providers	**82,234**	**82,657**	**423**	**0.5%**	**19%**	**47,961**	**34,696**	**58%**	**433,118**	**435,659**	**4.7%**	**6.3%**
C&M ICB	14,867	15,032	165	1.1%	10%	15,032	-	101%	139,352	147,383	3.2%	7.5%
TOTAL ICS System	**97,101**	**97,689**	**588**	**0.6%**	**17%**	**62,993**	**34,696**	**65%**	**572,470**	**583,042**	**4.6%**	**7.2%**

Appendix 8 – System Efficiencies – Full Year Maturity / Development Status as at M3

	In Year CIP maturity - Month 3 reporting									
	Fully Developed £,000	Plans in Progress £,000	Opportunity £,000	Unidentified £,000	Total Efficiencies £,000	Fully Developed £,000	Plans in Progress £,000	Opportunity £,000	Unidentified £,000
Cheshire & Mersey ICB	100,625	25,693	21,065	0	**147,383**	68%	17%	14%	0%
Alder Hey Children's	12,310	3,114	7,322	-	**22,746**	54%	14%	32%	0%
Bridgewater Community	3,965	1,510	-	-	**5,475**	72%	28%	0%	0%
Cheshire & Wirral Partnership	14,856	-	-	-	**14,856**	100%	0%	0%	0%
Countess of Chester Hospitals	7,220	6,756	5,643	8,086	**27,705**	26%	24%	20%	29%
East Cheshire Trust	11,312	629	234	0	**12,175**	93%	5%	2%	0%
Liverpool Heart & Chest	8,867	1,366	3,266	6	**13,505**	66%	10%	24%	0%
Liverpool University Hospitals	63,923	24,295	28,967	-	**117,185**	55%	21%	25%	0%
Liverpool Women's	7,110	2,308	3,262	-	**12,680**	56%	18%	26%	0%
Mersey Care	31,763	8,603	330	-	**40,696**	78%	21%	1%	0%
Mid Cheshire Hospitals	21,385	8,503	1,779	1	**31,668**	68%	27%	6%	0%
Mersey & West Lancs	29,639	14,057	6,004	0	**49,700**	60%	28%	12%	0%
The Clatterbridge Centre	9,233	1,311	4,247	-	**14,790**	62%	9%	29%	0%
The Walton Centre	10,791	1,053	403	0	**12,247**	88%	9%	3%	0%
Warrington & Halton Hospitals	12,955	6,123	2,400	- 0	**21,477**	60%	29%	11%	0%
Wirral Community	4,980	411	1,340	2	**6,733**	74%	6%	20%	0%
Wirral University Hospitals	28,019	3,449	553	0	**32,021**	88%	11%	2%	0%
TOTAL C&M ICS	**378,951**	**109,181**	**86,814**	**8,095**	**583,042**	**65%**	**19%**	**15%**	**1%**

Appendix 9: Provider Cash at Month 2

Org	Cash Balance			Operating Days Cash Actual and Forecast*								Trend	DHSC External Cash Support - Revenue		BPPC % of bills paid in target	
	2024/25 M12 Closing Cash Balance	2025/26 M2 Closing Cash Balance	Movement	24/25 M10 Actual	24/25 M11 Actual	24/25 M12 Actual	25/26 M2 Actual	25/26 M3 Forecast	25/26 M4 Forecast	25/26 M5 Forecast	25/26 M6 Forecast		M2 YTD	FOT	2024/25 M2 By number	2024/25 M2 By Value
	£m	£m	£m	Days	Days	Days	Days	Days	Days	Days	Days		£m	£m	%	%
Alder Hey Children's	53.7	38.1	(15.6)	53	46	34	35	28	23	21	20		0.0	0.0	92.4%	88.8%
Bridgewater Community	8.2	5.7	(2.5)	29	33	20	22	26	22	16	10		0.0	0.0	98.4%	98.9%
Cheshire & Wirral Partnership	28.5	24.0	(4.5)	44	41	28	31	31	31	31	27		0.0	0.0	98.3%	97.7%
Countess of Chester Hospitals	28.2	15.8	(12.4)	4	29	17	14	9	9	(1)	(9)		0.0	8.0	94.6%	94.3%
East Cheshire Trust	14.0	10.9	(3.1)	20	32	15	18	17	13	7	7		0.0	0.0	96.9%	97.0%
Liverpool Heart & Chest	49.4	48.1	(1.2)	62	66	58	76	75	80	80	79		0.0	0.0	98.0%	99.3%
Liverpool University Hospitals	30.4	30.2	(0.3)	2	8	6	8	5	4	4	1		0.0	0.0	74.4%	90.3%
Liverpool Women's	3.8	5.3	1.4	15	13	6	11	6	2	(2)	(5)		0.0	15.0	95.2%	97.1%
Mersey Care	53.8	49.4	(4.4)	29	27	17	24	22	21	20	7		0.0	0.0	95.4%	96.9%
Mid Cheshire Hospitals	36.3	35.0	(1.3)	34	41	21	30	27	25	27	23		0.0	0.0	95.4%	94.8%
Mersey & West Lancs	10.2	3.7	(6.5)	1	3	3	1	1	0	(0)	(1)		0.0	19.0	93.5%	95.5%
The Clatterbridge Centre	73.2	69.5	(3.6)	85	82	63	79	87	93	95	91		0.0	0.0	97.3%	99.1%
The Walton Centre	62.4	51.3	(11.2)	111	103	83	99	100	107	110	108		0.0	0.0	90.0%	96.1%
Warrington & Halton Hospitals	16.3	12.9	(3.4)	14	11	11	12	16	14	12	5		0.0	15.3	48.5%	48.8%
Wirral Community	7.8	10.5	2.7	37	37	19	39	36	38	37	34		0.0	0.0	90.4%	94.6%
Wirral University Hospitals	0.1	4.2	4.1	3	3	0	3	1	5	4	0		8.0	19.5	81.6%	91.0%
TOTAL Providers	**476.2**	**414.5**	**(61.7)**			**18**	**23**	**21**	**21**	**20**	**18**		**8.0**	**76.8**	**90.0%**	**92.5%**

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

** the Forecast does include revenue Deficit Support Funding via ICB

**NOTE THAT THIS NOT INCLUDE THE IMPACT OF Q2 Deficit Support Funding (DSF) withdrawn – which will further impact the cash position and requirement for further mitigation / NHSE external cash support*

Appendix 10: **Provider BPPC at Month 2**

Better Payment Pratice Code (BPPC)	BPPC % of bills paid within 95% target By Number					BPPC % of bills paid within 95% target By Value				
	24/25 M10 %	24/25 M11 %	24/25 M12 %	25/26 M2 %	Trend	24/25 M10 %	24/25 M11 %	24/25 M12 %	25/26 M2 %	Trend
Alder Hey Children's	93.3%	93.3%	93.2%	92.4%		91.8%	91.8%	91.5%	88.8%	
Bridgewater Community	98.2%	98.3%	98.4%	98.4%		98.2%	98.5%	98.4%	98.9%	
Cheshire & Wirral Partnership	95.8%	95.9%	96.2%	98.3%		93.0%	93.3%	93.9%	97.7%	
Countess of Chester Hospitals	95.2%	95.1%	95.0%	94.6%		95.2%	95.2%	95.4%	94.3%	
East Cheshire Trust	93.3%	93.6%	93.8%	96.9%		91.3%	91.8%	92.4%	97.0%	
Liverpool Heart & Chest	97.2%	97.3%	97.4%	98.0%		98.1%	98.1%	98.2%	99.3%	
Liverpool University Hospitals	76.8%	76.9%	76.6%	74.4%		91.3%	91.2%	90.9%	90.3%	
Liverpool Women's	93.5%	93.1%	93.4%	95.2%		95.2%	94.9%	94.7%	97.1%	
Mersey Care	95.4%	95.5%	95.5%	95.4%		96.1%	96.0%	96.0%	96.9%	
Mid Cheshire Hospitals	94.5%	94.6%	94.7%	95.4%		94.4%	94.5%	94.4%	94.8%	
Mersey & West Lancs	84.3%	85.0%	85.7%	93.5%		92.0%	92.3%	92.6%	95.5%	
The Clatterbridge Centre	97.9%	97.9%	97.7%	97.3%		98.9%	98.9%	98.9%	99.1%	
The Walton Centre	93.1%	93.0%	88.8%	90.0%		93.4%	92.9%	90.7%	96.1%	
Warrington & Halton Hospitals	87.0%	87.0%	87.3%	48.5%		92.9%	93.3%	92.9%	48.8%	
Wirral Community	91.9%	91.9%	92.3%	90.4%		95.2%	95.5%	95.8%	94.6%	
Wirral University Hospitals	57.8%	61.3%	60.2%	81.6%		74.6%	76.0%	76.0%	91.0%	
Average C&M Providers	**90.3%**	**90.6%**	**90.4%**	**90.0%**		**93.2%**	**93.4%**	**93.3%**	**92.5%**	

Appendix 11: Provider Capital Expenditure vs ICS Allocation at Month 3

	Plan YTD	Actual YTD	Variance YTD	Plan Year Ending	Forecast Year Ending	Variance Year Ending	
	£'000	£'000	£'000	£'000	£'000	£'000	%
Alder Hey Children'S NHS Foundation	8,473	9,093	(620)	13,377	15,377	(2,000)	(15.0%)
Bridgewater Community Healthcare NH	1,597	1,108	489	4,542	4,542	-	0.0%
Cheshire And Wirral Partnership NHS	2,671	2,024	647	8,522	8,522	-	0.0%
Countess Of Chester Hospital NHS Fo	3,399	967	2,432	10,289	11,289	(1,000)	(9.7%)
East Cheshire NHS Trust	3,992	2,832	1,160	10,362	10,362	-	0.0%
Liverpool Heart And Chest Hospital NH	2,815	872	1,943	7,935	7,935	-	0.0%
Liverpool University Hospitals NHS Fo	7,483	2,522	4,961	47,587	47,587	-	0.0%
Liverpool Women'S NHS Foundation T	1,007	838	169	6,888	6,888	-	0.0%
Mersey and West Lancashire Teaching	9,496	462	9,034	30,962	30,962	-	0.0%
Mersey Care NHS Foundation Trust	13,206	9,054	4,152	21,879	21,879	-	0.0%
Mid Cheshire Hospitals NHS Foundati	2,680	981	1,699	10,962	10,963	(1)	(0.0%)
The Clatterbridge Cancer Centre NHS	100	543	(443)	9,809	9,809	-	0.0%
The Walton Centre NHS Foundation T	2,400	638	1,762	9,520	9,520	-	0.0%
Warrington And Halton Teaching Hosp	1,712	600	1,112	11,932	13,932	(2,000)	(16.8%)
Wirral Community Health And Care NH	1,059	464	595	3,772	3,772	(0)	(0.0%)
Wirral University Teaching Hospital NH	3,612	1,202	2,410	13,451	13,451	-	0.0%
-	-	-	-	-	-	-	0.0%
Total Provider charge against alloca	65,702	34,200	31,502	221,789	226,791	(5,001)	(2.3%)
Capital allocation					226,791		
Variance to allocation					0		
Allocation met					Yes		

Appendix 12: DSF Q2 Letter

NHS England

Cathy Elliott
Chief Executive Officer
NHS Cheshire and Merseyside ICB

NHS England
North West Region
3 Piccadilly Place
Manchester
M1 3BN

Via email

20 June 2025

Dear Cathy

As you will be aware, NHS England has introduced a requirement that Regional Directors provide assurance to the NHS England CEO and CFO in relation to the delivery of system financial plans as a condition of issuing deficit support funding for each quarter.

On Tuesday 24 June, we will be making a recommendation regarding access to Quarter 2 deficit support funding for each North West system. In making this assessment we will take into account, relevant information, including but not limited to:

- Month 2 financial data.
- The progress with development of savings plans and associated workforce changes.
- The risk associated with contracts not yet agreed between commissioners and providers.
- Observable trends in actual expenditure and whole-time equivalents.
- Relevant external reports.
- Intelligence from oversight meetings.

I am writing to inform you of our current assessment and to invite you to respond ahead of our final submission on 24 June.

I can confirm that our current assessment is that we are unable to recommend that the Cheshire and Merseyside system should receive Deficit Support Funding for Q2.

Whilst the system is on plan at Month 2, there are a number of non-recurrent mitigations which drive this position. There remains significant risk in the remainder of the year to deliver a very 'back-loaded' plan. This risk is highlighted in the report from Simon Worthington on his review of CIPs, which identified concerns about the deliverability of savings plans and the robustness of CIP processes. As such we are not currently assured that sufficient progress will be made with developing savings to ensure delivery of the plan.

Having reviewed month 2 financial and workforce data, we cannot see any robust evidence to contradict our assessment, although we are keen to understand any

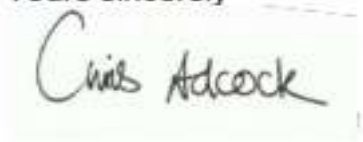
NHS England

information you have which would warrant further consideration or potentially impact on this assessment.

If deficit support funding is withheld in Q2, it will be withheld from the system as a whole. The system will be able to earn back the Q2 deficit support funding by providing sufficient assurance at Q3 about the deliverability of the plan. In the meantime, non-receipt of deficit support funding is likely to present cash challenges to a number of providers in the system and urgent action to assess and mitigate the associated risks will be required. Obviously, provider organisations have been briefed previously on the delivery and performance requirements to support the recovery of DSF income and will have been considering their response to this risk. My team will work with all parties across the system to fully understand the current status of this and the level of risk non-recovery of this income would create and the extent to which mitigations have been put in place.

I appreciate that this presents an immediate additional challenge for the system and therefore our immediate focus must be on how best to recover the position at the earliest opportunity. As a regional team we are committed to supporting you to deliver the necessary improvements so that the system can return to financial balance.

Yours sincerely



Chris Adcock
Regional Director of Finance – North West

Cc. Alex Kirkpatrick, Director of Operational Finance – North West
Mark Bakewell, Interim Chief Finance Officer – C&M ICB

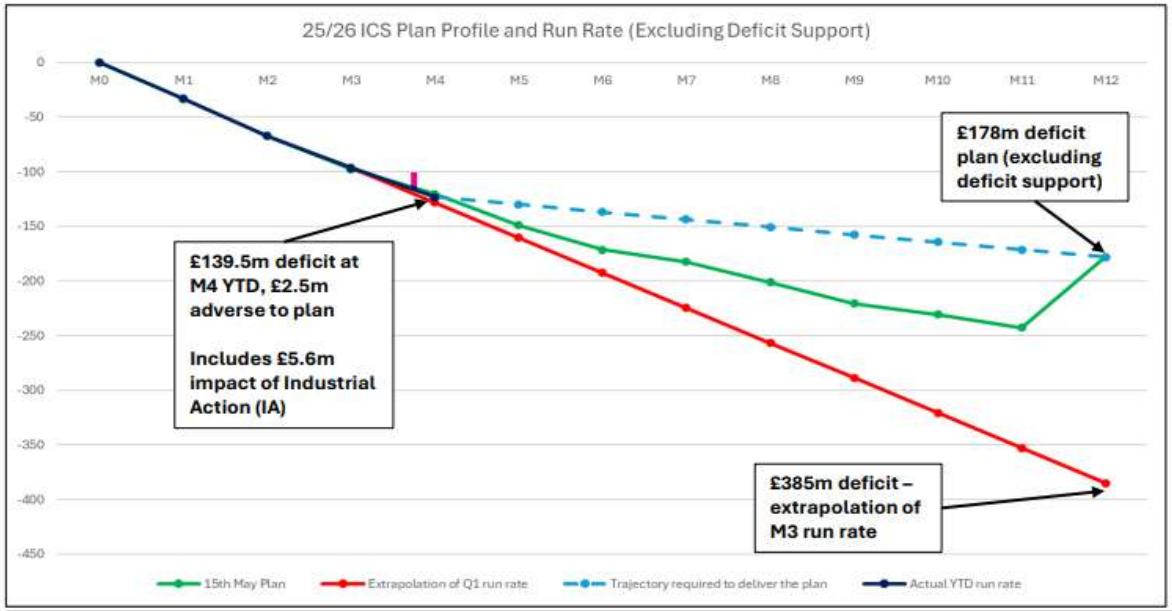
Appendix 13

NHS
Cheshire and Merseyside

Cheshire & Merseyside ICS
Financial position
M4 25/26

C&M ICB FIRC – 19th August 2025

Month 4 – C&M ICS Financial Position - Headlines



- £139.5m deficit at M4 YTD (excluding deficit support), £2.5m adverse to plan.
- The YTD position includes £5.6m from the impact of industrial action (IA) in July.
- Months 4 required a stepped improvement of £9m in month to achieve plan. Without the impact of IA then YTD position would have been £2.6m favourable to YTD plan
- The final settlement on the pay award has been accounted for in M4, and the incremental 0.97% uplift has created a c£2m pressure in month due to underlying provider deficits.
- A further £10m on non recurrent measures in the month have been reported. Reduced reliance on non-recurrent measures vital to maintain/improve underlying position
- c£75m of 'placeholder' schemes profiled in M12

- **C&M Providers behind Plan by £2.1m** – due to industrial action impact (£5.6m), pay award impact (£2m) – offset by £5.4m of providers improvements
- **Pay run rates (providers):**
  - Agency £5.8m in month – £0.2m above M4 plan, £0.5m above plan YTF but below NHS Ceiling
  - Bank £26.1m in month – increase of £2.2m vs M2&M3 due to industrial action – excluding this would have been a decrease. Bank remains above plan and NHS Ceiling YTD.
  - Overall Pay £22.7m (0.7%) higher than plan – includes pay award of £2m which needs validating.
- £148m CIP delivered £49.6m is non recurrent (29% of plan) – impact on underlying position
- £8m of CIP left unidentified (Countess of Chester) and £52m in Opportunity.
- Of the £235m stretch, £155m recognised by Providers, with £80.1m remaining.
- With Q2 Deficit Support Funding on hold - £23.3m DSF has not been distributed in M4 adding to cash pressure
- In August – the following orgs have requested distressed cash via NHSE – COCH (£12m), LWH (£4m), MWL (£11m), W&H (£5m), WUFT (£17m)

Month 4 – C&M ICS YTD I&E

Org	Month 4 YTD (including DSF)			DSF YTD			Month 4 YTD (excluding DSF)			FY FOT (excluding DSF)		
	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance	FY Plan	FOT	Variance
	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	%	£,000	£,000	£,000
Alder Hey Children's	(1,193)	(1,464)	(271)	0	0	0	(1,193)	(1,464)	(271)	7,160	7,160	0
Bridgewater Community	(1,620)	(1,620)	0	0	0	0	(1,620)	(1,620)	0	(1,530)	(1,530)	0
Cheshire & Wirral Partnership	(2,263)	(2,168)	95	0	0	0	(2,263)	(2,168)	95	3,985	3,985	0
Countess of Chester Hospitals	(9,558)	(11,380)	(1,822)	(6,542)	(4,907)	(1,636)	(16,100)	(16,287)	(187)	(34,042)	(34,040)	2
East Cheshire Trust	(5,994)	(7,168)	(1,174)	(3,444)	(2,583)	(861)	(9,438)	(9,751)	(313)	(17,934)	(17,934)	0
Liverpool Heart & Chest	2,952	2,770	(182)	0	0	0	2,952	2,770	(182)	9,552	9,552	0
Liverpool University Hospitals	(14,761)	(18,463)	(3,702)	(14,830)	(11,122)	(3,708)	(29,591)	(29,585)	6	(56,609)	(56,609)	0
Liverpool Women's	(6,066)	(7,339)	(1,273)	(5,101)	(3,826)	(1,275)	(11,167)	(11,165)	2	(31,026)	(31,020)	6
Mersey Care	314	695	381	0	0	0	314	695	381	14,305	14,305	0
Mid Cheshire Hospitals	(11,002)	(14,187)	(3,185)	(7,681)	(5,761)	(1,920)	(18,683)	(19,948)	(1,265)	(39,380)	(39,380)	0
Mersey & West Lancs	(18,025)	(19,462)	(1,437)	(10,075)	(7,556)	(2,519)	(28,100)	(27,018)	1,082	(40,950)	(40,950)	0
The Clatterbridge Centre	91	94	3	0	0	0	91	94	3	890	890	(0)
The Walton Centre	1,952	1,963	11	0	0	0	1,952	1,963	11	6,900	6,900	0
Warrington & Halton Hospitals	(9,908)	(11,434)	(1,526)	(6,108)	(4,582)	(1,526)	(16,016)	(16,016)	0	(28,726)	(28,726)	0
Wirral Community	(460)	441	901	0	0	0	(460)	441	901	900	900	0
Wirral University Hospitals	(2,381)	(6,219)	(3,838)	(5,636)	(4,229)	(1,407)	(8,017)	(10,448)	(2,431)	(22,140)	(22,140)	0
TOTAL Providers	**(77,922)**	**(94,941)**	**(17,019)**	**(59,418)**	**(44,565)**	**(14,852)**	**(137,340)**	**(139,507)**	**(2,167)**	**(228,645)**	**(228,637)**	**8**
C&M ICB	16,789	16,479	(310)	0	0	0	16,789	16,479	(310)	50,367	50,367	0
TOTAL ICS System	**(61,133)**	**(78,462)**	**(17,329)**	**(59,418)**	**(44,565)**	**(14,852)**	**(120,551)**	**(123,028)**	**(2,477)**	**(178,278)**	**(178,270)**	**8**

- Aggregate ICS Position £78.9m deficit YTD (including Q1 deficit support) – £17.3m adverse from plan, of which £14.9m relates to withhold of M4 deficit support
- Aggregate ICS position £123.0m deficit YTD (excluding deficit support) – £2.5m adverse from plan
- The first four months of the financial year consumes 54% of the annual deficit ICS plan

Month 4 YTD – C&M ICS Position – including ICB Expenditure Position

	Plan YTD £m	Actual YTD £m	Variance YTD £m	Variance %
System Revenue Resource Limit	**(2,778.2)**			
ICB Net Expenditure				
Acute Services	1,260.4	1,259.2	1.2	0.1%
Mental Health Services	261.7	268.3	(6.6)	(2.5%)
Community Health Services	239.9	238.6	1.4	0.6%
Continuing Care Services	161.7	162.5	(0.8)	(0.5%)
Primary Care Services	226.2	232.4	(6.2)	(2.8%)
Other Commissioned Services	5.3	5.0	0.3	4.8%
Other Programme Services	20.3	20.0	0.4	1.8%
Reserves / Contingencies	(0.2)	0.0	(0.2)	100.0%
Delegated Specialised Commissioning	257.2	255.1	2.1	0.8%
Delegated Primary Care Commissioning	314.7	306.5	8.2	2.6%
ICB Running Costs	14.0	14.0	0.0	0.0%
Total ICB Net Expenditure	**2,761.4**	**2,761.7**	**(0.3)**	**(0.0%)**
ICB Surplus/(Deficit) excluding Deficit Support Funding	**16.8**	**16.5**	**(0.3)**	**(0.0%)**
ICS Providers I&E - Adjusted Financial Performance				
Income	(2,291.5)	(2,306.8)	15.3	(0.7%)
Pay	1,589.9	1,612.5	(22.7)	(1.4%)
Non-Pay	748.3	760.5	(12.2)	(1.6%)
Non Operating Items	31.3	28.8	2.5	8.0%
TOTAL Provider Surplus/(Deficit)	**(77.9)**	**(94.9)**	**(17.0)**	**0.7%**
Less Non-Recurrent Deficit Support Funding	(59.4)	(44.6)	14.9	
Provider Surplus/(Deficit) excluding Deficit Support Funding	**(137.3)**	**(139.5)**	**(2.2)**	**0.1%**
ICS Surplus/(Deficit)	**(61.1)**	**(78.5)**	**(17.3)**	**(0.6%)**
ICS Surplus/(Deficit) excluding Deficit Support Funding	**(120.6)**	**(123.0)**	**(2.5)**	**(0.1%)**

ICB month 4 YTD position reported in line with plan overall. Key issues in YTD are as follows:

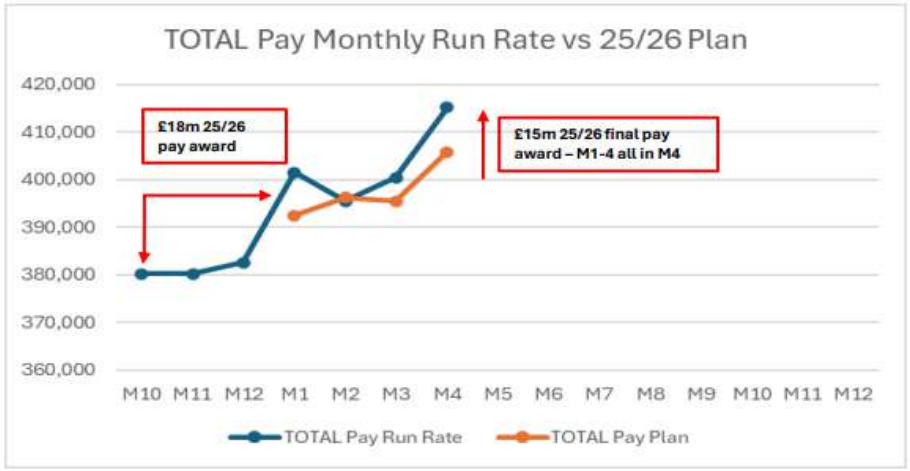
- Mental Health Contracts – Continued overperformance on ADHD activity and revised prices leading to pressures
- Primary Care - Pressure on prescribing budgets based on May-25 prescribing data, prescribing cost per day higher than anticipated.
- Surplus on Delegated Primary Care in relation to Primary Care Dental
- CHC – adult fully funded packages in excess of plan
-

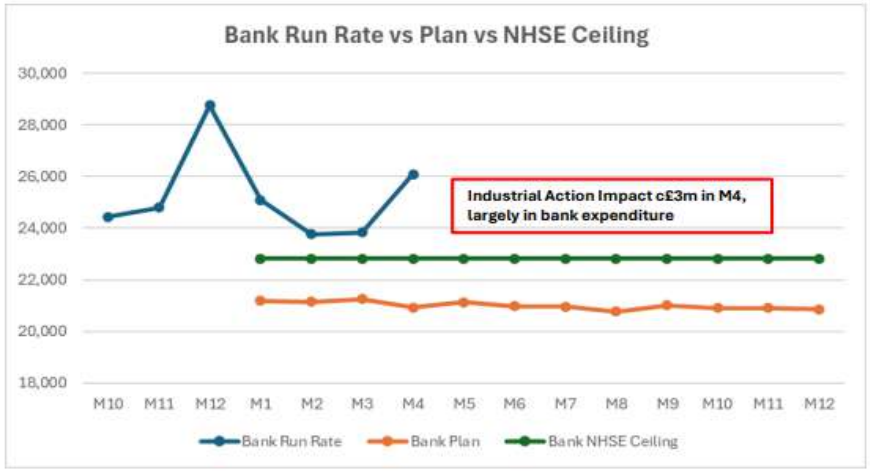
2025/26 Month 4 CIP delivery and recurrent YTD position

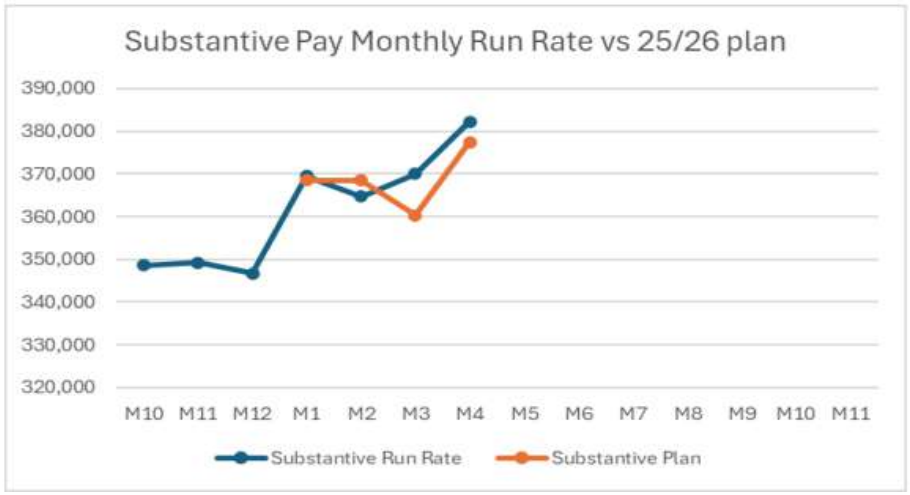
Org	CIP delivery (Month 4 YTD)					CIP Recurrent / Non Recurent YTD			Full year CIP				CIP Metrics	
	M4 YTD Plan	M4 YTD Actual	M4 YTD Variance	M4 YTD % Variance	M4 YTD CIP as a % of CIP FOT	M4 YTD Actual Recurrent	M4 YTD Actual Non Recurrent	M4 Actual Recurrent as a % of YTD plan	Full year CIP	FOT	Variance to plan	M4 YTD CIP as a % of CIP FOT	M4 CIP delivery as a % of Op Ex	CIP FOT as % of Op Ex
	£,0	£,0	£,0			£,0	£,0		£,0	£,0	£,0		%	%
Alder Hey Children's	6,169	6,169	0	0%	27%	3,160	3,009	51%	22,746	22,746	0	27%	4.1%	5.1%
Bridgewater Community	1,581	1,595	14	1%	29%	1,489	106	94%	5,475	5,475	(0)	29%	4.4%	5.2%
Cheshire & Wirral Partnership	3,959	3,606	(353)	-9%	24%	1,254	2,352	32%	14,856	14,856	(0)	24%	3.4%	4.8%
Countess of Chester Hospitals	5,448	2,151	(3,297)	-61%	8%	2,151	-	39%	27,703	27,703	0	8%	1.5%	6.6%
East Cheshire Trust	3,536	3,538	2	0%	29%	1,624	1,913	46%	12,175	12,175	(0)	29%	4.2%	5.0%
Liverpool Heart & Chest	3,445	2,438	(1,007)	-29%	18%	1,301	1,137	38%	13,499	13,499	0	18%	2.8%	5.0%
Liverpool University Hospitals	27,896	34,243	6,347	23%	29%	17,321	16,922	62%	117,185	117,185	0	29%	6.9%	8.1%
Liverpool Women's	3,021	3,150	129	4%	25%	1,817	1,332	60%	12,680	12,680	1	25%	4.8%	6.3%
Mersey Care	11,244	10,983	(261)	-2%	27%	7,823	3,160	70%	40,696	40,697	1	27%	4.1%	4.9%
Mid Cheshire Hospitals	9,055	8,709	(346)	-4%	28%	5,907	2,802	65%	31,668	31,668	0	28%	5.4%	6.6%
Mersey & West Lancs	14,825	16,550	1,725	12%	33%	8,752	7,798	59%	48,200	49,700	1,500	33%	4.8%	5.0%
The Clatterbridge Centre	4,097	3,806	(291)	-7%	26%	2,298	1,508	56%	14,790	14,790	0	26%	3.2%	4.6%
The Walton Centre	3,768	3,768	0	0%	31%	3,453	315	92%	12,247	12,247	0	31%	5.2%	5.6%
Warrington & Halton Hospitals	4,586	4,586	0	0%	21%	2,010	2,576	44%	21,477	21,477	(0)	21%	3.2%	5.1%
Wirral Community	1,567	1,646	78	5%	25%	1,646	-	105%	5,702	6,677	975	25%	4.5%	6.0%
Wirral University Hospitals	10,673	10,672	(2)	0%	33%	5,920	4,751	55%	32,020	32,016	(3)	33%	5.7%	5.9%
TOTAL Providers	**114,869**	**117,608**	**2,739**	**2.4%**	**27%**	**67,926**	**49,682**	**59%**	**433,118**	**435,591**	**2,473**	**27%**	**5.0%**	**6.2%**
C&M ICB	23,677	30,206	6,530	27.6%	22%	30,206	-	128%	139,352	137,505	(1,847)	22%	6.5%	7.5%
TOTAL ICS System	**138,546**	**147,814**	**9,269**	**6.7%**	**26%**	**98,132**	**49,682**	**71%**	**572,470**	**573,096**	**626**	**26%**	**5.0%**	**7.0%**

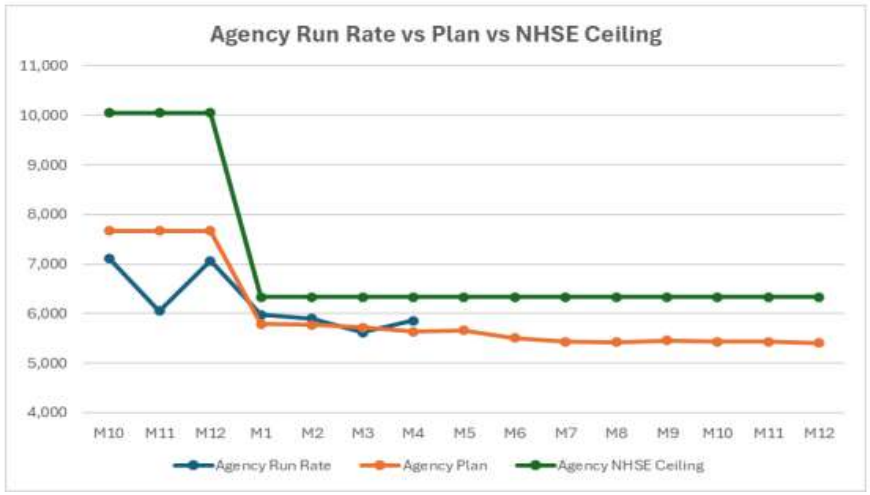
- £9.2m favourable CIP to plan, largely driven by ICB and Liverpool University Hospitals over delivery
- x6 organisations with material YTD CIP shortfall
- Of £148m delivered £49.6m is non recurrent (29% of plan) – impact on underlying position – to understand in SW work
- Of £148m delivered £59m is pay related, of which c42% is non recurrent

2025/26 Month 4 – pay run rates at system level









2025/26 Month 4 – Provider Capital (core capital against C&M ICS Allocation)

Org	Total Charge against Capital Allocation (including impact of IFRS 16)						
	YTD Plan	YTD Actual	YTD Variance	FY Plan	FOT	FOT Variance	YTD as a % of FOT
	£,000	£,000	£,000	£,000	£,000	£,000	%
Alder Hey Children's	9,324	9,798	(474)	13,377	17,477	(4,100)	56%
Bridgewater Community	1,824	1,210	614	4,542	4,542	0	27%
Cheshire & Wirral Partnership	3,470	3,235	235	8,522	8,522	0	38%
Countess of Chester Hospitals	3,649	3,922	(273)	10,289	11,289	(1,000)	35%
East Cheshire Trust	4,768	3,135	1,633	10,362	10,362	0	30%
Liverpool Heart & Chest	3,275	573	2,702	7,935	7,935	0	7%
Liverpool University Hospitals	8,438	3,619	4,819	47,587	47,587	0	8%
Liverpool Women's	1,511	952	559	6,888	6,888	0	14%
Mersey Care	15,668	9,532	6,136	21,879	19,879	2,000	48%
Mid Cheshire Hospitals	3,175	1,393	1,782	10,962	10,964	(2)	13%
Mersey & West Lancs	11,882	1,042	10,840	30,962	30,962	0	3%
The Clatterbridge Centre	100	972	(872)	9,809	9,809	0	10%
The Walton Centre	2,983	1,500	1,483	9,520	9,520	0	16%
Warrington & Halton Hospitals	2,930	853	2,077	11,932	13,932	(2,000)	6%
Wirral Community	1,277	639	638	3,772	3,772	0	17%
Wirral University Hospitals	4,735	1,978	2,757	13,451	13,451	0	15%
TOTAL Providers	**79,009**	**44,353**	**34,656**	**221,789**	**226,891**	**(5,102)**	**20%**

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 September 2025

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

Agenda Item No: ICB/09/25/07

Committee Chair: Mike Burrows,
ICB Non-Executive Member

NHS
Cheshire and Merseyside

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

Committee Chair	Mike Burrows
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Meeting date	July and August 2025

Key escalation and discussion points from the Committee meeting

Alert

At its July 2025 meeting:

- **Month 3 position**
  Excluding Deficit Support (£44.5m) the system has reported at YTD deficit of £96.3m, against a planned YTD deficit of £97.m resulting in a positive YTD variance of £1.4m.

  Key Risks within the position include:
  - Notification of DSF to be withheld in Q2 due to ongoing concern about credibility of delivery of forecast plan.
  - CIP delivery dependent on non-recurrent - £34m of £97.7m
  - 3 organisations with less than 10 operating days of cash: MWL, WUTH and LUHFT.
  - Pressure on ICB position stems from Acute overperformance in IS, Mental Health packages of care, All age continuing care and prescribing.

At its August 2025 meeting:

- **Month 4 position**
  For Month 4 the system has reported at YTD deficit of £78.5m, against a planned YTD deficit of £61.1m resulting in an adverse YTD variance of £17.3m. **Key drivers include:**
  - Deficit Support Funding withheld in M4 - £14.8m
  - Industrial Action impact of £5m
  - Pay Award impact of £2.1m.

  Key Risks within the position include:
  - CIP ahead of plan by £9.3m (MWL, LUHFT and ICB main drivers)
  - Reliance on non-recurrent CIP - £49m out of £147m
  - Total Pay costs are above plan by £15m
  - 5 Trusts requested operating cash support in September (LWH, COCH, MWL, WHH and WUTH)
  - Risks specific to the ICB position are:
    - Prescribing budget – will require significant oversight and management
    - Increasing ADHD costs, related to both price and volume
    - Increasing Continuing Healthcare costs.

- **Staffing** – emerging risk with regard to staffing resource alongside the background of increased levels of oversight and significant organisational change.

Advise

At its July 2025 meeting:

- **Turnaround update**
  - PWC rapid diagnostic concluded
  - Simon Worthington working on standardisation and assessment of in-year and forecast position

- **Cash update**
  - Cash MOU developed across all C&M Providers to maximise cash for as long as possible. Recognise that the national cash regime is not yet published.

- **FCOG update**
  - ICB forecast savings identified of £147m, above the target of £139m.
  - Providers forecast savings total £435m, above planned target of £433m, but reliant on non-recurrent CIPs.

At its August 2025 meeting:

- **Turnaround update**
  - PWC Risk Assessment to be completed for next meeting
  - Simon Worthington monthly assessment for forecast to continue
  - Additional support in Month 5 on reporting underlying position.

- **Contracting update**
  - Disputes outstanding in relation to MWL, MWAS and Bridgewater.

- **FCOG update**
  - ICB forecast savings total £137m, below planned target of £139m.
  - Providers forecast savings total £435m, above planned target of £433m, but reliant on non-recurrent CIPs.
  - CHC remains a challenge.

Assure

At its July 2025 meeting:

- **Update to ICB and System Finance Business Rules** published June 2025
- Estates Programme Workstream update provided

At its August 2025 meeting:

- **Associations**
  Report on work carried out alongside other ICBs to review allocations methodology produced by ACRA.

Committee risk management

Overall review of Risk assessment processes and reporting is underway and will report more fully to FIRC later in the year.

Achievement of the ICB Annual Delivery Plan

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

Service Programme / Focus Area	Key actions/discussion undertaken
Deliver of financial savings through productivity and reducing Waste	FCOG update
Delivery of the financial position	Month 4 report
Development and delivery of the Capital Plans.	Month 4 report
Development of System Estates Plans to deliver a programme to review and rationalise our corporate estates.	Estates update due in September

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 September 2025

Integrated Performance Report

Agenda Item No: ICB/09/25/08

Responsible Director: Anthony Middleton
Director of Performance and Planning

NHS
Cheshire and Merseyside

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 2025, see appendix one, provides an overview of key metrics drawn from the 2025/26 Operational plans, specifically covering Urgent Care, Planned Care, Diagnostics, Cancer, Mental Health, Learning Disabilities, Primary and Community Care, Health Inequalities and Improvement, Quality & Safety, Workforce and Finance.

2.2 For metrics that are not performing to plan, the integrated performance report provides further analysis of the issues, actions and risks to delivery in section 5 of the integrated performance report.

3. Ask of the Board and Recommendations

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

4. Reasons for Recommendations

4.1 The report is sent for assurance.

5. Background

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

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

Objective One: Tackling Health Inequalities in access, outcomes and experience
Reviewing the quality and performance of services, providers and place enables the ICB to set system plans that support improvement against health inequalities.

Objective Two: Improving Population Health and Healthcare
Monitoring and management of quality and performance allows the ICB to identify where improvements have been made and address areas where further improvement is required.

Objective Three: Enhancing Productivity and Value for Money
The report supports the ICB to triangulate key aspects of service delivery, finance and workforce to improve productivity and ensure value for money.

Objective Four: Helping to support broader social and economic development
The report does not directly address this objective.

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

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

8. Link to meeting CQC ICS Themes and Quality Statements

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

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

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

9. Risks

9.1 The report provides a broad selection of key metrics and identifies areas where delivery is at risk. Exception reporting identifies the issues, mitigating actions and delivery against those metrics.

9.2 There is a risk that the system will not meet elective care recovery targets set out in the 2025/26 Operational Planning Guidance, including referral to treatment times, time to first appointment and 52-week RTT waiting time standards, due to constrained elective capacity, rising demand, workforce shortages and financial constraints. This may result in prolonged patient waits,

increased clinical risk, poor patient experience, financial impact, and reputational harm. This corresponds to Board Assurance Framework Risk P14.

9.3 Additionally, there is a risk that the system will be unable to deliver timely and effective urgent and emergency care services due to rising demand, workforce pressures, capacity constraints, and delayed patient discharges. This may result in non-compliance with key NHS 2025/26 planning guidance standards, including the 4-hour ED target, 12-hour decision-to-admit (DTA) breaches, and ambulance handover delays. These risks may contribute to patient harm, regulatory scrutiny, and reputational damage. This maps to Board Assurance Framework Risk P15.

10. Finance

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

11. Communication and Engagement

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

12. Equality, Diversity and Inclusion

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

13. Climate Change / Sustainability

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

14. Next Steps and Responsible Person to take forward

14.1 Actions and feedback will be taken by Anthony Middleton, Director of Performance and Planning. Actions will be shared with, and followed up by, relevant teams. Feedback will support future reporting to the Q&P committee.

15. Officer contact details for more information

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

16. Appendices

Appendix One: Integrated Quality and Performance report

NHS
Cheshire and Merseyside

Integrated Performance Report

25th September 2025

Index

Integrated Quality & Performance Report – Guidance:

NHS Cheshire and Merseyside

Provider Acronyms:

ACUTE TRUSTS		SPECIALIST TRUSTS		COMMUNITY AND MENTAL HEALTH TRUSTS		KEY SYSTEM PARTNERS	
COCH	COUNTESS OF CHESTER HOSPITAL NHS FT	AHCH	ALDER HEY CHILDREN'S HOSPITAL NHS FT	BCHC	BRIDGEWATER COMMUNITY HEALTHCARE NHS FT	NWAS	NORTH WEST AMBULANCE SERVICE NHS TRUST
ECT	EAST CHESHIRE NHS TRUST	LHCH	LIVERPOOL HEART AND CHEST HOSPITAL NHS FT	WCHC	WIRRAL COMMUNITY HEALTH AND CARE NHS FT	CMCA	CHESHIRE AND MERSEYSIDE CANCER ALLIANCE
MCHT	MID CHESHIRE HOSPITALS NHS FT	LWH	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	MCFT	MERSEY CARE NHS FT	**OTHER**	
LUFT	LIVERPOOL UNIVERSITY HOSPITALS NHS FT	TCCC	THE CLATTERBRIDGE CANCER CENTRE NHS FT	CWP	CHESHIRE AND WIRRAL PARTNERSHIP NHS FT	OOA	OUT OF AREA AND OTHER PROVIDERS
MWL	MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	TWC	THE WALTON CENTRE NHS FT				
WHH	WARRINGTON AND HALTON TEACHING HOSPITALS NHS FT						
WUTH	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT						

Key:

Data formatting

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

C&M National Ranking against the 42 ICBs

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

C&M National Ranking against the 22 Cancer Alliances

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

Notes on interpreting the data

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

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

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

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

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

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

Integrated Quality & Performance Report – Interpreting SPC Charts:

NHS Cheshire and Merseyside

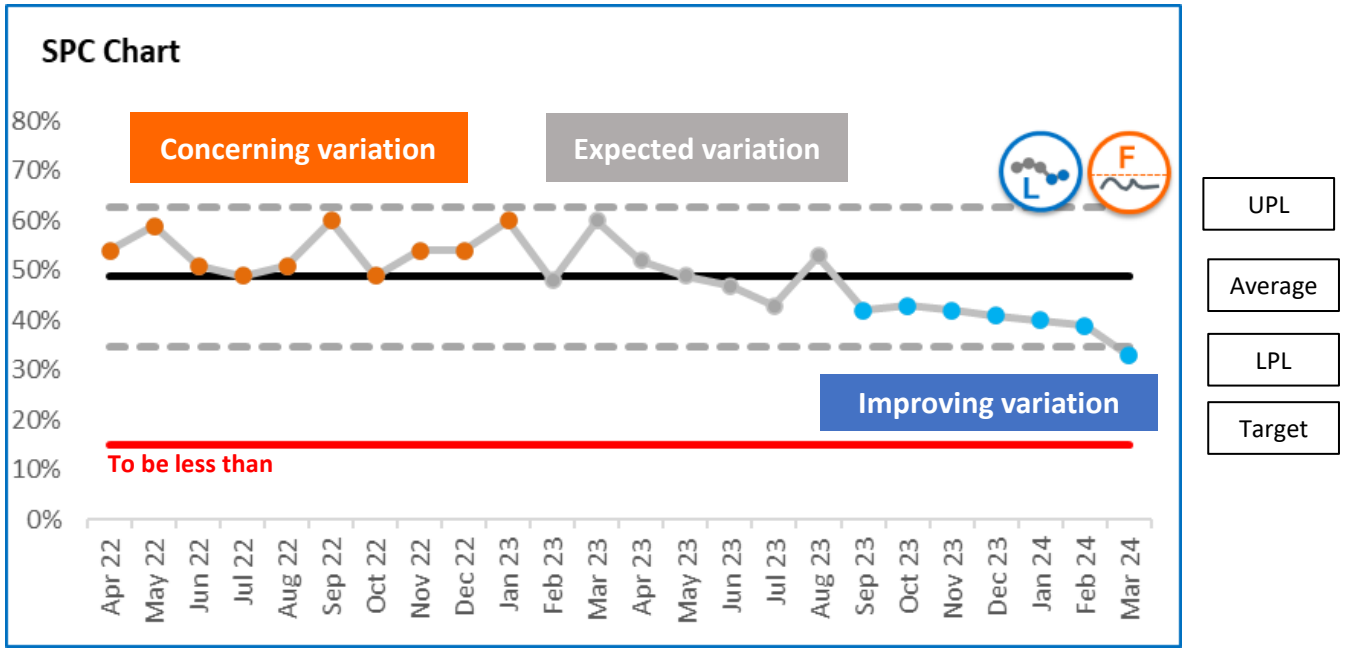
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

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

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

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

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



UPL

Average

LPL

Target

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

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

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

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

Integrated Quality & Performance Report – Interpreting summary icons:

NHS Cheshire and Merseyside

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

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

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

1. ICB Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Local Trajectory	National Target	Region value	National value	Latest Rank
Urgent care	4-hour A&E waiting time (% waiting less than 4 hours)	Aug-25	74.3%	72.9%	72.3%	72.4%	71.4%	72.9%	73.1%	72.6%	72.7%	73.7%	73.0%	71.9%	72.8%	74.6%	78% by Year end	73.1%	75.9%	33/42
	Ambulance category 2 mean response time	Aug-25	00:24:58	00:38:08	00:56:23	00:52:34	01:06:45	00:52:51	00:38:28	00:32:43	00:27:58	00:26:44	00:30:22	00:32:05	00:27:24	-	00:30:00	00:23:13	00:27:15	21/42
	Mean Ambulance Handover time (ED and Non ED)	Aug-25	00:32:05	00:44:08	00:52:35	00:50:58	00:55:51	00:47:53	00:39:09	00:34:32	00:34:23	00:31:57	00:32:58	00:31:04	00:25:02	00:35:08	00:15:00	00:21:48	00:25:34	24/42
	A&E 12 hour waits from arrival	Aug-25	15.5%	16.6%	17.0%	15.7%	18.3%	18.3%	17.4%	16.2%	15.9%	16.6%	16.8%	17.0%	16.3%	16.0%	-	12.6%	8.9%	40/42
	Adult G&A bed occupancy	Aug-25	94.9%	95.6%	96.3%	96.5%	96.0%	97.4%	97.2%	95.9%	96.4%	96.5%	95.8%	95.6%	94.9%		92.0%	94.0%	93.6%	27/42
	Percentage of beds occupied by patients no longer meeting the criteria to reside*	Jul-25	19.9%	19.6%	20.4%	21.7%	19.5%	22.7%	21.6%	22.9%	21.3%	20.6%	20.1%	20.6%			-	n/a	n/a	-
	Discharges - Average delay (exclude zero delay)	Jul-25		10.5	9.2	9.0	8.8	9.5	9.0	10.1	9.8	8.8	8.6	8.4		9.0		6.9	6.1	35/42
	Percentage of patients discharged on discharge ready date	Jul-25		88.1%	89.0%	87.8%	89.1%	88.2%	89.0%	89.0%	88.3%	88.3%	88.4%	88.5%		86.8%		87.2%	85.9%	10/42
Planned care	Total incomplete Referral to Treatment (RTT) pathways	Jul-25	372,357	369,065	367,350	366,053	361,746	358,637	356,570	360,184	354,386	350,979	355,722	362,412		359,134	-	1,038,192	7,402,796	-
	The % of people waiting less than 18 weeks on the waiting list (RTT)	Jul-25	56.3%	56.2%	56.9%	57.4%	56.7%	56.5%	57.3%	58.0%	58.0%	59.1%	59.0%	58.7%		58.9%	92.0%	58.3%	61.3%	31/42
	The % of people waiting more than 52 weeks on the waiting list (RTT)	Jul-25	4.1%	3.7%	3.5%	3.4%	3.3%	3.4%	3.3%	3.0%	3.5%	3.7%	3.9%	3.9%		2.8%		3.4%	2.6%	40/42
	Number of 52+ week RTT waits, of which children under 18 years.	Jul-25	1,295	1,029	1,063	886	902	922	919	750	972	983	1,031	1,098		823	-	n/a	n/a	-
	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Jul-25	1,972	985	1,091	1,093	1,282	1,167	1,091	659	990	1,443	1,325	1,242		-	0 by Sept 2024	1,853	11,950	
	Patients waiting more than 6 weeks for a diagnostic test	Jul-25	10.1%	8.8%	7.2%	6.9%	10.3%	11.2%	5.9%	6.7%	10.1%	12.0%	11.4%	11.2%		5.0%	5.0%	15.3%	21.9%	3/42
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Jun-25	74.6%	73.0%	73.8%	75.9%	74.9%	71.6%	74.7%	76.4%	76.1%	75.0%	73.8%			73.2%	85.0%	69.3%	67.1%	9/42
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Jun-25	94.3%	93.3%	94.6%	94.2%	95.5%	92.8%	95.8%	95.3%	94.7%	95.5%	95.5%			96.0%	96.0%	95.3%	91.7%	14/42
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Jun-25	73.2%	71.4%	73.3%	75.4%	75.5%	66.8%	76.6%	76.3%	75.4%	71.8%	73.6%			77.8%	77% by Year end	76.2%	76.8%	38/42
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028. (rolling 12 months)	May-25	58.1%	58.5%	58.5%	58.6%	58.9%	58.8%	59.0%	59.2%	59.3%	59.4%				70.0%	75% by 2028	58.5%	59.3%	25/42
Mental Health	Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Mar-25	20,945	21,055	21,255	21,315	21,490	21,650	21,770	21,825								55730	620772	-
	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Jun-25	75%	73%	75%	76%	78%	79%	79%	83%	77%	76%	69%			60.0%	60.0%	73.0%	71.3%	30/42
	People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months	To Jun 2025	52.0%			52.0%			62.0%			56.0%				-	60.0%	58.0%	60.0%	32/42
	Dementia Diagnosis Rate	Jul-25	67.6%	67.4%	67.6%	67.4%	67.3%	67.2%	67.4%	67.6%	67.6%	67.6%	67.8%	68.0%		66.7%	66.7%	70.5%	66.1%	14/42
	CYP Eating Disorders Routine	Jun-25	77.0%	79.0%	84.0%	87.0%	89.0%	88.0%	87.0%	86.0%	92.0%	93.0%	93.0%			95.0%	95.0%	83.0%	72.2%	7/42
	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact	Jun-25	34,655	34,660	34,730	35,000	34,550	34,710	34,550	34,625	35,450	35,185	35,485			37246	-	123325	848057	-
	Number of people accessing specialist Community PMH and MMHS services	Jun-25	3,370	3,420	3,480	3,505	3,555	3,530	3,555	3,625	3,620	3,600	3,645			3420	-	9020	65463	1/42
	Talking Therapies completing a course of treatment - % of plan achieved	Jun-25	93.0%	93.1%	95.0%	94.0%	92.0%	92.0%	92.0%	91.0%	102.0%	97.0%	104.0%			100.0%	100.0%	103.0%	99.0%	16/42
	Talking Therapies Reliable Recovery	Jun-25	46.0%	46.0%	48.0%	48.0%	45.0%	47.0%	47.0%	49.0%	48.0%	48.0%	48.0%			48.0%	48.0%	46.0%	47.1%	18/42
	Talking Therapies Reliable Improvement	Jun-25	65.0%	65.0%	66.0%	66.0%	65.0%	66.0%	68.0%	68.0%	67.0%	68.0%	68.0%			67.0%	67.0%	67.0%	67.8%	26/42
Note/s	* No local plan for 2025/26, Data no longer reported nationally																			

1. ICB Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Local Trajectory	National Target	Region value	National value	Latest Rank
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Jul-25	95	90	85	85	85	80	80	80	80	75	75	75		48	-	240	1,785	23/42
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Jun 25 YTD	23.8%	29.8%	37.6%	45.7%	52.7%	63.0%	73.3%	85.5%	3.1%	7.5%	12.7%			9.8%	**75%** by Year end	13.7%	13.3%	21/42
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Jun-25	86%	85%	86%	83%	85%	84%	83%	85%	86%	86%	86%			70.0%	**70.0%**	86.0%	85.0%	25/42
	Virtual Wards Utilisation	Jul-25	62%	74.6%	93.2%	75.2%	69.2%	94.7%	73.5%	83.1%	75.3%	74.7%	63.7%	78.9%		80.0%	**80.0%**	69.5%	71.6%	19/42
	Community Services Waiting List (Adults)	May-25	54,021	54,830	48,815	48,663	50,574	50,937	41,919	43,198	42,897	41,462						86,622	784,716	-
	Community services Waiting List (CYP)	May-25	24,426	23,542	21,747	22,890	22,834	23,164	20,184	20,110	20,519	21,794						45,692	318,867	-
	Community Services – Adults waiting over 52 weeks	May-25	382	433	435	411	234	164	94	118	95	71				0		802	12,350	-
Primary Care	Units of dental activity delivered as a proportion of all units of dental activity contracted	Jul-25	77.0%	82.0%	86.0%	88.0%	78.0%	82.0%	94.0%	95.0%	82.0%	81.0%	75.0%	73.0%		80.0%	**100.0%**	81.0%	80.0%	33/42
	Number of unique patients seen by an NHS Dentist – Adults (24 month)	Jul-25	928,716	929,925	932,009	932,314	933,534	934,964	936,873	937,773	940,716	940,830	940,593	942,639		943,484		2,653,622	18,136,220	-
	Number of unique patients seen by an NHS Dentist – Children (12 month)	Jul-25	325,733	327,329	329,456	330,255	331,503	332,275	332,480	333,475	333,796	333,660	333,876	334,352		334,384		1,024,446	7,172,644	-
	Appointments in General Practice & Primary Care networks	Jun-25	1,171,799	1,253,935	1,649,116	1,319,968	1,191,861	1,401,109	1,258,627	1,342,136	1,237,198	1,220,981	1,272,114			1,198,474		-	-	-
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care. (rolling 12 months)	May-25	7.07%	7.06%	6.94%	6.94%	6.94%	6.98%	7.02%	7.09%	7.14%	7.18%				10.0%	**10.0%**	-	7.62% (Dec 24)	-
	Total volume of antibiotic prescribing in primary care	May-25	1.03	1.02	1.02	1.01	1.01	0.99	0.98	0.97	0.95	0.94				0.871	**0.871**	-	1.00	-
Integrated care - BCF metrics	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (average of place rates)***	Q4 24/25	231.5		228.6			163.1								-	-	159.3	151.4	-
	Percentage of people who are discharged from acute hospital to their usual place of residence	Mar-25	93.3%	93.3%	93.2%	93.2%	93.4%	92.8%	93.4%	93.3%						-	-	92.4%	93.0%	-
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 (average of place rates)***	Q3 24/25	526.1		542.5											-	-	346.4	351.0	-
Specialised Commissioning	Cardiac Treatment waiting list (LH&CH) #	Jul-25	407	410	414	390	401	389	386	376	363	383	403	402		450				-
	Neurosurgery waiting list (TWC) #	Jul-25	853	885	876	929	914	927	921	967	974	950	993	1,006		858				-
	Specialised Paediatrics waiting list (AHCH) #	Jul-25	356	287	312	265	261	256	269	248	238	221	203	180		350				-
	Vascular waiting list (LUFT) #	Jul-25	160	145	145	163	153	166	167	180	160	183	182	213		176				-
Note/s	*** Awaiting clarification from NHSE re: metric criteria. Plans are no longer comparable to actuals largely due to implementation of SDEC (Type 5) in year but also revisions to National crtieria which systems need time to adopt and validate. # RAG rating based on 12 month comparison (Red = Higher, Green = Lower)																			

1. ICB Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Local Trajectory	National Target	Region value	National value	Latest Rank
Health Inequalities & Improvement	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q4 24/25	65.6%		65.50%			69.07%								77.0%	80.0%	70.12%	70.3%	30/42
	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with lipid lowering therapies	Q4 24/25	62.3%		62.6%			63.2%									65.0%	62.7%	63.62%	19/42
	Smoking at Time of Delivery V2	Q4 24/25	6.8%		6.1%			5.9%									<6%	5.7%	5.10%	31/42
	Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems.(Aged 15+) ~	Aug-25	13.7%	13.7%	13.6%	13.6%	13.5%	13.5%	13.4%				14.0%	14.0%	14.0%	12.0%	12.0%	-	12.7%^	-
Continuing Healthcare	Standard Referrals completed within 28 days	Q1 25/26	64.70%		73.10%			76%			71.70%					>80%	>80%	80.9%	75.6%	26/42
	Number eligible for Fast Track CHC per 50,000 population (snapshot at end of quarter)	Q1 25/26	29.15		27.18			27.04			23.78					<18		20.53	16.54	35/42
	Number eligible for standard CHC per 50,000 population (snapshot at end of quarter)	Q1 25/26	53.36		53.85			54.67			54.27					<34		46.42	32.47	40/42
Maternity	HIE (Hypoxic ischemic encephalopathy) grade 2 or 3 per 1,000 live births (>=37 weeks)	Q1 25/26	1.1		0.9			0.5			0.7					2.5	2.5	1.3		
	Still birth per 1,000 (rolling 12 months)	Apr-25	2.45	2.48	2.64	2.53	2.72	3.02	3.11	2.95	3.05					-	2.6*	-	3.8	-
Quality & Safety	Healthcare Acquired Infections: Clostridium Difficile - Place aggregation (All cases)	12 months to Jul 25	1097	1118	1156	1176	1205	1198	1210	1191	1155	1143	1133	1134		843		3201	18317	
	Healthcare Acquired Infections: E.Coli Place aggregation (All cases)	12 months to Jun 25	2307	2318	2359	2357	2367	2352	2333	2330	2330	2326	2330			2001		5928	43850	
	Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation #	Mar-25	0.992	0.988	0.989	0.984	0.986	0.997	0.988	0.986						0.887 to 1.127 *		-	1.000	-
	Never Events	Aug-25	1	1	0	3	0	6	1	2	0	5	3	2	0	0	0	-	-	-
Workforce / HR (ICS total)	Staff in post	Jun-25	73,039	73,548	73,910	74,068	74,101	74,208	74,450	74,600	74,524	74,473	74,462			74,446	-			
	Bank	Jun-25	5,255	5,122	5,084	4,868	4,848	5,000	5,289	5,459	5,213	4,850	4,548			4,764	-			
	Agency	Jun-25	1,009	932	1,009	886	824	838	775	749	644	638	606			856.2	-			
	Turnover	May-25	11.0%	10.9%	10.9%	10.8%	10.7%			10.4%	10.1%	10.0%				11.4%	-		13.3%	20/42
	Sickness##	May-25	5.6%	5.6%	5.6%	5.6%	5.6%	6.2%	5.7%	6.1%	6.1%	6.1%				6.1%	-	5.7%	4.9%	38/42
Note/s	# Banding changed Aug 23 to reflect SOF bandings for providers. Green = no providers higher than expected, Amber = 1-2 providers higher than expected, Red = more than 2 providers higher than expected ~ New methodology from June, data now reported in line with CIPHA ## latest rank, region and national values are one month behind latest data * Original NHS target was to halve the 2010 stillbirth rate of 5.1 per 1,000 by 2025. replaced with a reduction to 2.3 per 1,000 by 2030																			

2. ICB Aggregate Financial Position

NHS Cheshire and Merseyside

ICB Overall Financial Position:

Category	Metric	Latest period	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Plan (£m)	Dir. Of Travel	FOT (£m) Plan	FOT (£m) Current	FOT (£m) Variance
Finance	Financial position £m (ICS) ACTUAL	May-25	-138.0	-166.9	-108.5	-112.9	-129.5	-129.7	-109.7	-89.7	-45.9	-	-37.4	-51.7	-78.4	-61.1	↘	0.0	0.0	0.0
	Financial position £ms (ICS) VARIANCE	May-25	-38.5	-48.5	-48.8	-51.4	-67.4	-61.2	-47.3	-33.2	-45.9	-	0.2	1.4	-17.3		↘			
	Efficiencies £ms (ICS) ACTUAL	May-25	92.3	119.9	156.4	192.9	235.3	276.6	321.3	362.7	417.1	-	61.0	98.1	147.8	138.5	↗	572.4	573.0	0.6
	Efficiencies £ms (ICS) VARIANCE	May-25	-20.2	-26.6	-25.0	-26.7	-22.5	-20.7	-23.4	-29.4	-22.8	-	-1.9	1.0	9.3		↗			
	Capital £ms (ICS) ACTUAL	May-25	65.6	81.8	97.1	121.7	145.0	170.0	204.1	241.0	327.0	-	-	-		-	-	255.2	255.2	0.0
	Capital £ms (ICS) VARIANCE	May-25	11.3	13.6	26.8	28.3	28.2	32.1	24.6	10.9	-16.7	-	-	-		-	-			

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

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

3. Provider / Trust Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Providers																	
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts				Net OOA/ Other/ ICB	ICB *
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP		
NHS SOF	Segment (NEW)@	25/26 Q1	④	③	③	④	④	④	③	①	①	③	①	①	③	①	②	④		
Urgent care	4-hour A&E waiting time % waiting less than 4 hours	Aug-25	64.4%	48.0%	56.0%	73.4%	67.4%	74.4%	78.0%	94.5%	-	91.3%	-	-	-	-	-	-	-	72.8%
	Mean Ambulance Handover time (ED and Non ED)	Aug-25	00:20:58	00:33:38	00:23:54	00:22:32	00:20:43	00:26:25	00:27:11	00:20:06										00:25:02
	A&E 12 hour waits from arrival	Aug-25	13.2%	18.8%	20.0%	20.4%	23.0%	11.9%	19.0%	#	-	**	-	-	-	-	-	-	-	16.3%
	Adult G&A bed occupancy	Aug-25	97.8%	99.2%	95.1%	94.6%	96.6%	94.2%	98.6%	-	77.0%	57.8%	81.5%	84.3%					-	94.9%
	Percentage of beds occupied by patients no longer meeting the criteria to reside	Jun-25	22.4%	16.3%	21.9%	13.4%	24.7%	21.8%	19.4%										-	20.6%
	Discharges - Average delay (exclude zero delay)	Jul-25	11.4	**	**	**	9.2	7.7	8.8	0.0	5.5	1.8	14.3	0.0						8.4
	Percentage of patients discharged on discharge ready date	Jul-25	92.7%	**	**	**	81.0%	83.7%	92.5%	100.0%	97.6%	88.3%	96.1%	100.0%						88.5%
Planned care	Total incomplete Referral to Treatment (RTT) pathways	Jul-25	34,989	16,968	42,114	47,312	33,311	65,798	75,581	18,022	5,079	16,410	1,154	14,233			29	-	-	362,412
	The % of people waiting less than 18 weeks on the waiting list (RTT)	Jul-25	50.2%	59.7%	54.2%	61.8%	57.2%	55.9%	63.6%	58.3%	73.5%	46.3%	96.6%	63.0%			100.0%			58.7%
	The % of people waiting more than 52 weeks on the waiting list (RTT)	Jul-25	8.5%	2.3%	4.9%	2.7%	4.9%	3.8%	2.6%	2.2%	0.9%	6.0%	0.0%	0.8%			0.0%			3.9%
	Number of 52+ week RTT waits, of which children under 18 years.	Jul-25	113	36	211	129	111	27	102	368	0	1	0	0						1,098
	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Jul-25	205	9	452	16	56	266	232	1	1	10	0	3			0	-		1,242
	Patients waiting more than 6 weeks for a diagnostic test	Jul-25	19.9%	16.2%	19.5%	9.3%	3.9%	5.4%	11.2%	4.0%	0.4%	13.2%	0.0%	0.3%	34.6%	0.0%	-	-	-	11.2%
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Jun-25	71.1%	77.1%	68.3%	78.4%	78.4%	71.6%	75.5%	100.0%	79.6%	42.9%	80.1%	100.0%	41.7%				-	73.8%
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Jun-25	96.8%	94.7%	84.7%	92.7%	98.0%	89.8%	94.7%	100.0%	100.0%	78.4%	99.6%	100.0%	-				-	95.5%
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Jun-25	83.3%	77.5%	75.6%	73.4%	74.0%	74.1%	68.3%	100.0%	78.3%	55.3%	83.3%	100.0%	-				-	73.6%
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028 (calendar YTD)	May-25	61.7%	65.9%	63.8%	61.3%	49.7%	58.2%	55.4%	50.0%	54.3%	75.6%	67.9%	-	100.0%	-				59.4%
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6, 7 and 8 for the ICB's latest position on the above metrics ** Indicates that provider did not meet to DQ criteria and is excluded from the analysis # Value supressed due to small numbers ~ No targets set for 2025/26 @ NHS SOF Segments - Highest = 1 (Consistently high performing) , 2 (Requires some improvement or support), 3 (Experiencing significant challenges and requires more intensive support), 4 (Mandated intensive support due to serious problems or risks to care quality)																			

3. Provider / Trust Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Providers																	
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts				Net OOA/ Other/ ICB	ICB *
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP		
Learing Disabilities	Inpatients with a learning disability and/or autism (rounded to nearest 5)	Jul-25	#							#							55	25		75
Mental Health	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Jun-25			Mental Health service providers only												64.0%	84.0%	-	69.0%
	CYP Eating Disorders Routine	Jun-25								95%							84.0%	100.0%		93.0%
	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact	Jun-25				1650				4985					1805		8790	8180	10075	35485
	Number of people accessing specialist Community PMH and MMHS services	Jun-25															2385	1315		3645
	Talking Therapies completing a course of treatment - % of LTP trajectory	Jun-25	Just number available/ no target																	104.0%
	Talking Therapies Reliable Recovery	Jun-25															47.0%			48.0%
	Talking Therapies Reliable Improvement	Jun-25															65.0%			68.0%
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Jun-25	80.0%	91.0%	88%	Community Service Providers only									90.0%	87.0%	78.0%	79%	84%	86.0%
	Virtual Wards Utilisation ~	Jul-25	100.0%	56.0%	78.3%	85.0%	64.0%	62.9%	73.7%	100.0%										78.9%
	Community Services Waiting List (Adults)	May-25	0	4,608	6,532	446	-	-	348	0	139	-	-	-	3,581	5,514	20,294	5,514	-5514	41,462
	Community services Waiting List (CYP)	May-25	1,315	797	2,779	5,447	-	-	879	5,075	0	-	-	-	4,349	327	826	327	-327	21,794
	Community Services – Adults waiting over 52 weeks	May-25	0	1	3	0	-	-	0	0	0	-	-	-	65	0	2	0	0	71
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6, 7 and 8 for the ICB's latest position on the above metrics ** Indicates that provider did not meet to DQ criteria and is excluded from the analysis # Value supressed due to small numbers ~ NHSE published and MWL local BIP data are different, NHSE published MWL data includes 20 paediatric hospital at home beds which is not included in local BIP published data																			

3. Provider / Trust Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Providers																	
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts				Net OOA/ Other/ ICB	ICB *
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP		
Health Inequalities & Improvement	Smoking at Time of Delivery (NEW) data only available at ICB/Place level																			5.9%
Maternity	HIE (Hypoxic ischemic encephalopathy) grade 2 or 3 per 1,000 live births (>=37 weeks)	25/26 Q1	0.0	0.0	1.5	1.4	3.5		0.0			0.0								0.7
	Still birth per 1,000 (rolling 12 months)	Apr-25	2.62	1.63	4.72	1.77	2.45	-	2.58	-	-	3.84	-	-						3.05
Quality & Safety	Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation (Healthcare Associated)	12 months to Jul 25	79	26	39	154	80	190	128	20	4	2	14	12						748
	Healthcare Acquired Infections: E.Coli (Healthcare associated)	12 months to Jun 25	68	31	56	99	84	240	158	16	7	4	28	9						800
	Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation** #	Mar-25	0.9089	1.2072	0.9368	0.9731	1.0483	0.9673	1.0020											0.986
	Never Events (rolling 12 month total)	12 Months to Aug 25	3	0	1	4	1	2	5	2	1	1	0	2	0	0	0	1	0	23
Workforce / HR (Trust Figures)	Staff in post	Jun-25	4,517	2,399	5,086	5,883	4,268	14,056	9,770	4,222	1,914	1,721	1,898	1,497	1,370	1,464	10,535	3,861	-	74,472
	Bank	Jun-25	324	197	372	347	357	874	652	91	60	73	11	66	20	48	859	196	-	5,098
	Agency	Jun-25	22	47	82	26	31	105	116	6	4	6	13	4	1	6	97	42	-	624
	Turnover	May-25	11.9%	10.4%	9.2%	10.0%	9.3%	10.2%	8.7%	10.8%	9.7%	9.6%	8.8%	12.6%	10.2%	11.0%	10.1%	10.0%	-	10.4%
	Sickness (via Ops Plan Monitoring Dashboard)	May-25	5.7%	5.5%	5.2%	6.0%	5.8%	6.1%	6.1%	5.7%	5.0%	5.9%	4.9%	5.6%	6.6%	6.4%	7.6%	6.1%	-	6.1%
Finance	Overall Financial position **Variance** (£m)	Jul-25	-0.19	-0.31	-1.27	-2.43	0.00	0.01	1.08	-0.27	-0.18	0.00	0.00	0.01	0.00	0.90	0.38	0.10	-0.31	-2.48
	Efficiencies (Variance)	Jul-25	-3.30	0.00	-0.35	-0.00	0.00	6.35	1.73	0.00	-1.01	0.13	-0.29	0.00	0.01	0.08	-0.26	-0.35	6.53	9.27
	Capital (Variance)	Jul-25	-0.27	1.63	1.78	2.76	2.08	4.82	10.84	-0.47	2.70	0.56	-0.87	1.48	0.61	0.64	6.14	0.24	0.00	34.66
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6, 7 and 8 for the ICB's latest position on the above metrics ** The SHMI banding gives an indication for each non-specialist trust on whether the observed number of deaths in hospital, or within 30 days of discharge from hospital, was as expected when compared to the national baseline, as the UCL and LCL vary from trusts to trust. This "banding" is different to the "rate" used for the ICB on slide 5, therefore a comparison cannot be drawn between the two. # Banding changed Aug 23 to reflect SOF rating by NHSE. 'As expected' rating is RAG rated Green, 'Higher than expected' is RAG rated Red.																			

4. Place Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Sub ICB Place										ICB *	Local Trajectory	National Target
			Cheshire & Wirral				Merseyside								
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton				
			East **	West **							South Sefton	S/port & Formby			
Urgent Care	4-hour A&E waiting time % waiting less than 4 hours	Aug-25	53.0%	61.2%	27.8%	58.5%	75.0%	72.1%	76.0%	74.2%	64.2%		72.8%	74.6%	78% by Year end
	Ambulance category 2 mean response time	Aug-25	00:31:55		00:33:35	00:31:58	00:32:06	00:34:33	00:34:19	00:33:05	00:33:54		00:27:24		00:30:00
	A&E 12 hour waits from arrival	Aug-25	17.1%		18.7%	21.7%	10.5%	22.8%	16.3%	23.4%	13.5%		16.3%	16.0%	-
	Discharges - Average delay (exclude zero delay)	Jul-25	7.8	8.7	8.2	8.8	8.5	11.9	5.9	12.1	7.0		8.4	9.0	
	Percentage of patients discharged on discharge ready date	Jul-25	90.7%	92.7%	96.4%	81.5%	84.5%	96.9%	94.1%	92.4%	82.7%		88.5%	87%	
Planned Care	Total incomplete Referral to Treatment (RTT) pathways	Jul-25	115,058		52,003	27,689	57,267	28,910	22,707	20,791	37,987		362,412	359,134	-
	The % of people waiting less than 18 weeks on the waiting list (RTT)	Jul-25	55.7%		62.1%	59.5%	56.6%	63.0%	60.5%	59.5%	56.5%	66.5%	58.7%	58.9%	
	The % of people waiting more than 52 weeks on the waiting list (RTT)	Jul-25	4.9%		3.0%	4.2%	3.7%	2.6%	3.4%	4.2%	3.0%		3.9%	2.8%	
	Patients waiting more than 6 weeks for a diagnostic test	Jul-25	17.5%		9.1%	5.0%	5.8%	13.1%	9.8%	12.1%	7.2%		11.2%	5.0%	5%
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Jun-25	71.6%	70.2%	75.9%	74.3%	73.6%	80.0%	70.0%	88.6%	67.3%		73.8%	73.2%	85.0%
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Jun-25	89.2%	93.5%	95.9%	97.3%	95.4%	96.1%	96.6%	97.9%	94.5%		95.5%	96.0%	96.0%
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Jun-25	76.3%	75.6%	73.5%	72.8%	70.9%	80.8%	78.7%	77.3%	65.0%		73.6%	77.8%	77% by Year end
Mental Health	Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Mar-25	4,055		2,460	1,445	6,565	1,095	1,890	1,030	3,550		21825		
	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Jun-25	87.0%		64.0%	82.0%	61.0%	-	69.0%	100.0%	68.0%	67.0%	69.0%	60.0%	60.0%
	People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months	To Jun 2025	54.0%		56.0%	62.0%	55.0%	49.0%	59.0%	67.0%	47.0%	63.0%	56.0%	-	60.0%
	Dementia Diagnosis Rate	Jul-25	67.4%		66.4%	73.4%	69.1%	66.5%	65.9%	66.8%	68.70%		68.0%	66.7%	66.7%
	CYP Eating Disorders Routine	Jun-25	100.0%		100.0%	100.0%	85.0%	94.0%	100.0%	87.0%	88.0%	94.0%	93.0%	95.0%	95.0%
	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact	Jun-25	5880		4690	4000	8695	4085	2630	1705	2360	1575	35485	37246	-
	Number of people accessing specialist Community PMH and MMHS services	Jun-25	1035		385	300	730	300	285	190	255	165	3645	3420	-
	Talking Therapies completing a course of treatment	Jun-25	785		420	185	600	245	145	70	140	100	104.0%	100.0%	100.0%
	Talking Therapies Reliable Recovery	Jun-25	49.0%		47.0%	51.0%	46.0%	49.0%	50.0%	43.0%	45.0%	56.0%	48.0%	48.0%	48.0%
	Talking Therapies Reliable Improvement	Jun-25	70.0%		67.0%	68.0%	65.0%	66.0%	64.0%	59.0%	71.0%	69.0%	68.0%	67.0%	67.0%
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6, 7 and 8 for the ICB's latest position on the above metrics ** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT. # Potential data issue at Wirral Communityy Health which recorded no patients seen within 4-hours														

4. Place Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Sub ICB Place									ICB *	Local Trajectory	National Target
			Cheshire & Wirral				Merseyside							
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton			
			East **	West **							South Sefton	S/port & Formby		
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Jul-25	15		10	5	10	5	10	10	5		75	48	-
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Jun 25 YTD	12.5%		10.7%	10.9%	12.7%	10.1%	12.5%	17.2%	17.3%		12.7%	9.8%	**75%** by Year end
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Jun-25	88.0%	81.0%	88.0%	84.0%	78.0%	83.0%	87.0%	95.0%	78.0%		86.0%	70.0%	**70.0%**
	Virtual Wards Utilisation Number only	Jul-25	67	97	41	29	50	41	11	14	16		364		
	Community Services Waiting List (Adults) - data only available at ICB/Provider level												41,462		
	Community services Waiting List (CYP) - data only available at ICB/Provider level												21,794		
	Community Services – Adults waiting over 52 weeks - data only available at ICB/Provider level												71		
Primary Care	Appointments in General Practice & Primary Care networks @	Jun-25	190,418	173,169	205,447	106,517	246,909	87,344	81,030	57,306	123,974		1,272,114	1198474	
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care. (rolling 12 months)	May-25	6.02%	7.28%	9.28%	6.20%	7.39%	6.11%	6.62%	6.36%	7.74%		7.18%	10.0%	**10.0%**
	Total volume of antibiotic prescribing in primary care	May-25	0.79	0.88	1.03	0.85	0.94	1.13	1.11	0.98	0.97		0.94	0.871	**0.871**
Integrated care - BCF metrics ***	Unplanned hospitalisation for chronic ambulatory care sensitive conditions ***	Q4 24/25	134.8	186.7	104.4	100.1	227.9	187.5	220.7	156.7	149.0		228.6	-	-
	Percentage of people who are discharged from acute hospital to their usual place of residence	Mar-25	88.9%	90.6%	94.4%	95.1%	95.5%	94.6%	94.5%	95.5%	92.6%		93.3%	-	-
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 ***	Q3 24/25	552.8	547.7	329.8	383.4	751.0	550.2	772.2	494.1	501.4		542.5	-	-
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6,7 and 8 for the ICB's latest position on the above metrics ** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT. *** Awaiting clarification from NHSE re: metric criteria. Plans are no longer comparable to actuals largely due to implementation of SDEC (Type 5) in year but also revisions to National crtieria which systems need time to adopt and validate. ~ Wirral and Warrington have reported figures less than half the previous quarter @ RAG based on last year postion, Green for greater than last year														

4. Place Aggregate Position

NHS Cheshire and Merseyside

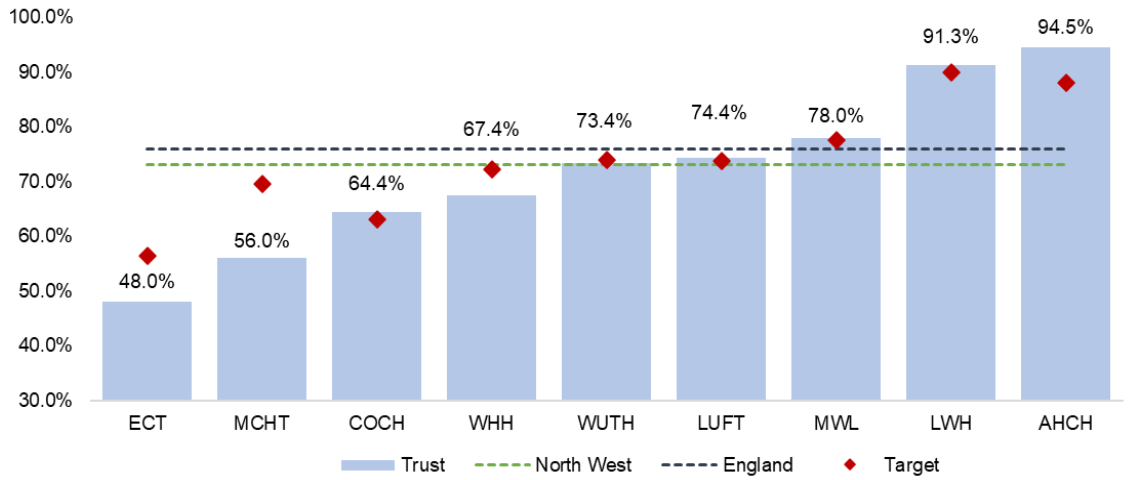
Category	Metric	Latest period	Sub ICB Place										ICB *	Local Trajectory	National Target
			Cheshire & Wirral				Merseyside								
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton				
			East **	West **							South Sefton	S/port & Formby			
Health Inequalities & Improvement	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q4 24/25	69.4%		67.9%	68.6%	69.8%	69.4%	69.9%	71.3%	67.0%		69.1%	77.0%	80.0%
	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with lipid lowering therapies	Q4 24/25	62.4%		65.7%	61.7%	65.6%	62.3%	64.2%	62.4%	60.8%		63.2%		65%
	Smoking at Time of Delivery	Q4 24/25	4.3%		6.8%	4.9%	5.3%	8.9%	7.3%	8.8%	6.7%		5.9%		<6%
	Smoking prevalence (aged 15+) - As reported on CIPHA from GP Systems	Aug-25	11.60%		13.50%	12.60%	16.90%	14.20%	16.90%	15.30%	15.20%	11.90%	14.0%	12%	12%
Continuing Healthcare	Standard Referrals completed within 28 days	Q1 25/26	70.0%		68.5%	89.7%	56.0%	100.0%	92.3%	81.8%	60.5%	65.0%	71.70%	>80%	>80%
	Number eligible for Fast Track CHC per 50,000 population (snapshot at end of quarter)	Q1 25/26	20.95		33.25	22.38	20.83	5.77	6.94	22.86	45.03	56.98	23.78	<18	
	Number eligible for standard CHC per 50,000 population (snapshot at end of quarter)	Q1 25/26	64.4		72.8	40.2	47.3	25.2	30.3	44.4	55.0	83.6	54.27	<34	
Quality & Safety	Still birth per 1,000 - data only available at ICB/Provider level														
	Healthcare Acquired Infections: Clostridium Difficile - (All cases)	12 months to Jul 25	258		225	99	221	61	88	67	115		1134	843	-
	Healthcare Acquired Infections: E.Coli - (All cases)	12 months to Jun 25	657		280	195	450	196	201	110	241		2330	2001	
Finance	Overall Financial position Variance (£m)	Jul-25	-1.2	-0.4	-2.1	0.2	-3.2	-0.2	-0.7	-1.5	0.0		8.8	0.0	0.0
	Efficiencies (Variance)	Jul-25	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	0.0	0.0
	Mental Health Investment Standard met/not met (MHIS)	Jul-25	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Yes	Yes
	BCF achievement (Places achieving expenditure target)	Jul-25	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	9/9	9/9
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 6,7 and 8 for the ICB's latest position on the above metrics ** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT. *** Local trajectories set by Place as part of their BCF submissions to NHSE, therefore RAG rating will vary for Places with lower/higher trajectories **** In order to report performance at Place the indicator "% of CYP accessing services following a referral" has been used - this is different to the NHS Oversight Framework indicator used in the ICB table														

5. Exception Report – Urgent Care

NHS Cheshire and Merseyside

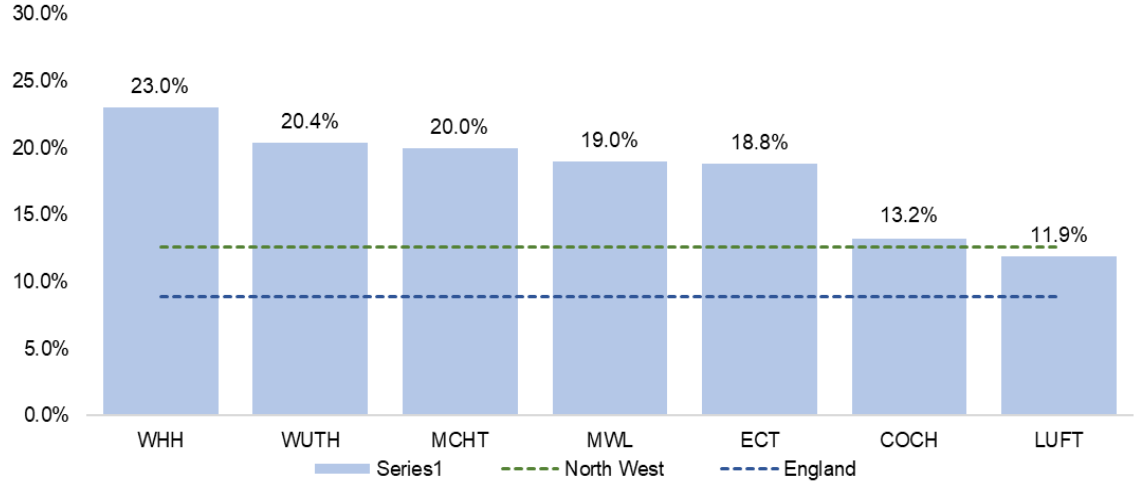
A&E 4 hour waits from arrival

Latest ICB Performance (Aug-25)	72.8%	National Ranking	33/42
Provider Breakdown (Aug-25)			Improved



A&E 12 hour waits from arrival

Latest ICB Performance (Aug-25)	16.3%	National Ranking	40/42
Provider Breakdown (Aug-25)			Improved



Issue

- Cheshire and Merseyside's latest A&E 4-hour performance in August is **72.8%**, ranking **33rd out of 42 ICBs** and below the national ambition of 78%. This represents an improvement compared to July. A&E 12-hour waits from arrival remain a significant challenge, with **16.3% of patients delayed over 12 hours**, placing the ICB **40th out of 42 nationally**. This is a slight improvement on the previous month. Ambulance handover times are improving across C&M with implementation of Handover 45 (HO 45) initiative in August.

Action:

- **Mid Mersey (MWL):** Monitoring application of ECIST Criteria to admit tool, discharge & NC2R tracker and long-stay (12+ hr) guardian role. While achieving **78.% 4-hour standard**, 12-hour waits at **19.0%**.
- **East Cheshire (ECT):** Front door GP & Fit to Sit maximised (ECIST) 4-hour performance has improved to 48%. ED rotas remain under review to strengthen SIFT at triage & earlier mental health escalation.
- **Mid Cheshire (MCHT):** 4-hour performance **improved to 56%**; 12-hour waits **improved to 20%**. Focused on triage improvements and reducing prolonged ED stays by early escalation internally & to SCC.
- **Countess of Chester (COCH):** 4-hour performance **improved 64.4%**, 12-hour waits **improved to 13.2%**. Reviewing rotas and maximising front-door streaming to UTC to strengthen performance.
- **Wirral (WUTH):** 4-hour performance **improved 73.4%**, 12-hour waits **improved 20.4%**. Call-before-convey activity remains below plan; frailty SDEC embedding maximising home-first service continues as priority.
- **Liverpool (LUFT):** 4-hour performance **improved 74.4%**, & 12-hour waits **improved 11.9%**. Focused on reducing prolonged ED stays with specialty in-reach & maximising sub-acute community options.
- **Warrington (WHH):** 4-hour performance improved **67.4%**, but 12-hour waits **23%**. ECIST review identified significant staffing shortfall; tests of change in palliative & frailty pathways underway.
- **Women's (LWH):** 4-hour performance strong and improved at **91.3%**, no material 12-hour wait issue.
- **Alder Hey (AHCH):** Best performer in system improved at **94.5%** for 4-hour performance.

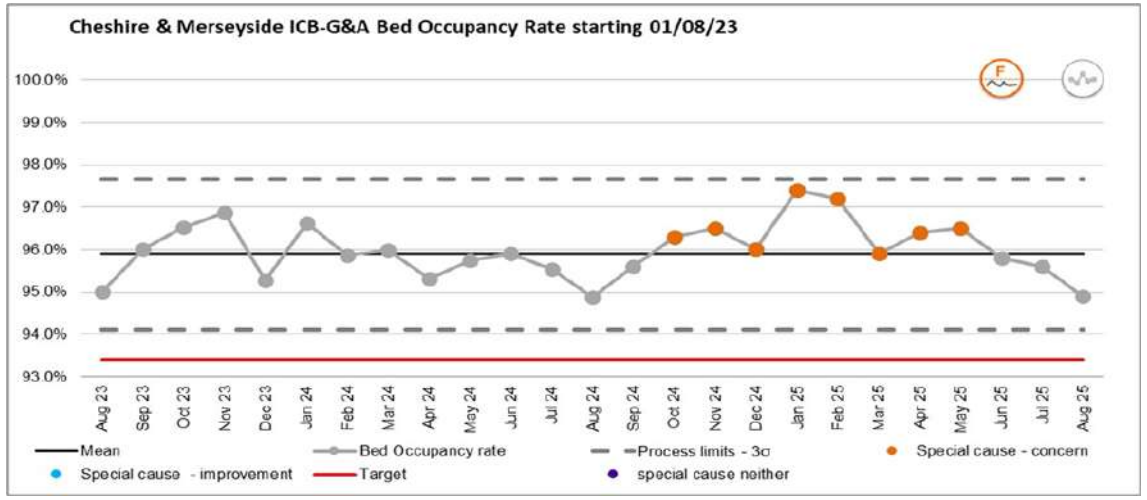
Delivery:

- Cheshire and Merseyside remains committed to the national recovery trajectory, with a focus on delivering **78% 4-hour performance by Quarter 3** and achieving a **sustained reduction in 12-hour ED breaches**.
- Improvement plans are being progressed through local tests of change, workforce reviews, frailty pathways, and enhanced use of urgent community response and specialty in-reach.
- System-wide recovery efforts will continue to be tracked through SCC governance, aligned with the 2025/26 UEC Improvement Plan.

5. Exception Report – Urgent Care

NHS Cheshire and Merseyside

Adult G&A bed occupancy			
Latest ICB Performance (Aug-25)	94.9%	National Ranking	27/42
ICB Trend (Aug-25)			Improved



Issue

- Adult G&A bed occupancy across Cheshire and Merseyside remains **high at 94.9 but improved from 95.6%**, ranking the ICB **27 out of 42 nationally**. Whilst this is an **improvement on recent months**, it remains above the ideal operational threshold (92–93%) and continues to constrain patient flow and discharge processes.

Action:

- **Warrington:** Older People's Short Stay Unit (OPSSU) open, with board round audits underway. Early data shows reduced LOS for 65+ NEL patients. Findings will inform wider roll-out & regular NC2R scrutiny. Embedding handover 45 initiative
- **Wirral:** Therapy pathway review to address NCTR delays; early engagement of Care Transfer Hubs for housing-related discharge needs. Actions overseen by the weekly executive NC2R discharge cell.
- **LUFT:** Maximising Implementation of Expected Discharge Date (EDD) and discharge tracker supporting Pathway 0 management. Progress made in reducing corridor care at Royal Liverpool, though challenges remain with escalation capacity at Aintree but improving discharge numbers to sub-acute services.
- **East Cheshire:** 7-day multidisciplinary "sprint" model embedded to accelerate discharge planning across medical and surgical specialties & maximizing GP at front door model. Embedding handover 45.
- **MWL:** Discharge tracker and EDD processes embedded, improving monitoring of Pathway 0 patients, latest reporting does not yet reflect recent de-escalation of surge beds. Embedding Handover 45.

Delivery

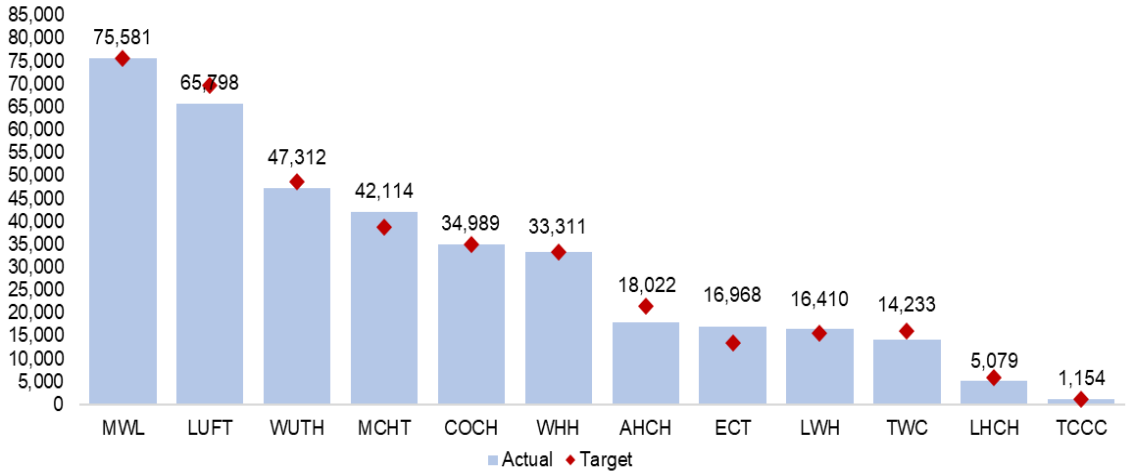
- C&M remain focused on driving down G&A bed occupancy as part of its **2025/26 UEC recovery programme**, recognising this as a critical enabler of flow and reduced ED delays.
- Sustained reductions will be tracked through SCC governance, with particular focus on Pathway 0 patients, escalation bed use, and impact of newly implemented short stay and therapy models.

5. Exception Report – Planned Care & Diagnostics

NHS Cheshire and Merseyside

Total incomplete Referral to Treatment (RTT) pathways

Latest ICB Performance (July-25)	362,412	National Ranking	n/a
Provider Breakdown (July-25)			Deteriorated



Issue

- The current total wait list size reported in July was 362,412. Early indications are showing that this decreased In August to 359,124.
- At present, COCH, Mid Cheshire, Liverpool Women's, East Cheshire and MWL all have slightly increased position.

Action

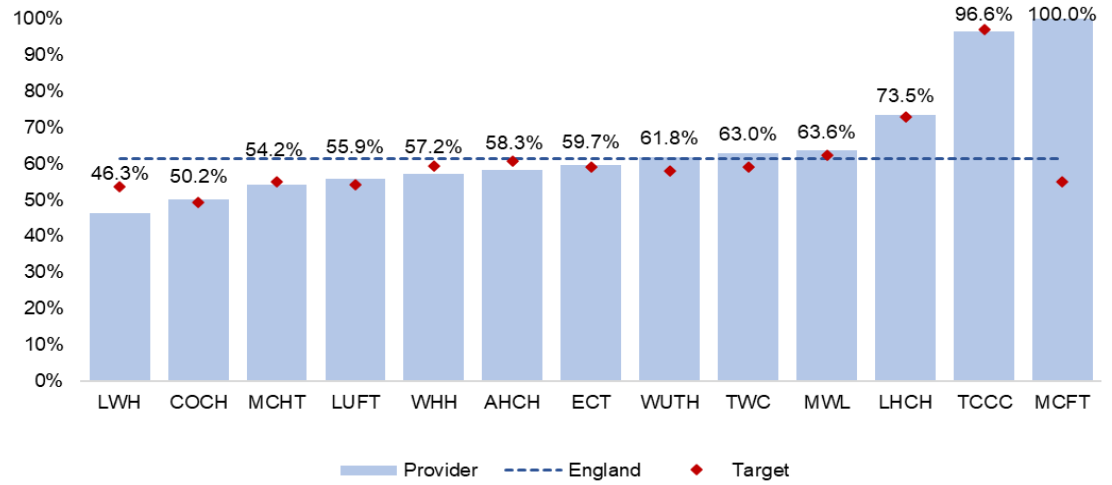
- The trusts continue to work through demand management at the point of referral to reduce total wait list size.
- Continued mobilisation of the new EPR system across both East and Mid Cheshire having impact on total wait list size.
- Post referral A&G programmes are in place at speciality level including A&G ICB project steering group which is in place.
- Referral Management Service .
- MSK triaging continues to be optimised.

Delivery

- Continue to monitor total wait list position by Trust and check and challenge in place at Trust Performance and Delivery calls

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

Latest ICB Performance (July-25)	58.7%	National Ranking	31/42
Provider Breakdown (July-25)			Deteriorated



Issue

- C&M August trajectory is reporting at 58.9%. As of 31st August C&M are reporting at 57.8%
- Several trusts are behind plan in relation to the % of people waiting less than 18-week on the waiting list
- 2 trusts are deploying new trust-wide EPR systems, both providers are experiencing challenges due to DCS implementation. The robustness of recovery plans is variable between providers.

Action

- The elective reform team has fortnightly calls with all providers to review challenges, actions are underway to improve their position and when providers anticipate they will achieve targets. Specific recovery actions are managed and overseen with system support in place when required.
- Improvement and transformation programmes covering T&O, ENT and Gynaecology have been initiated.
- Increasing the use of A&G, PIFU and going further with validation will improve the Trusts ability to manage the demand and decrease waits.
- Targeted delivery of the 65 and 52ww target will support improvement in 18ww position.

Delivery

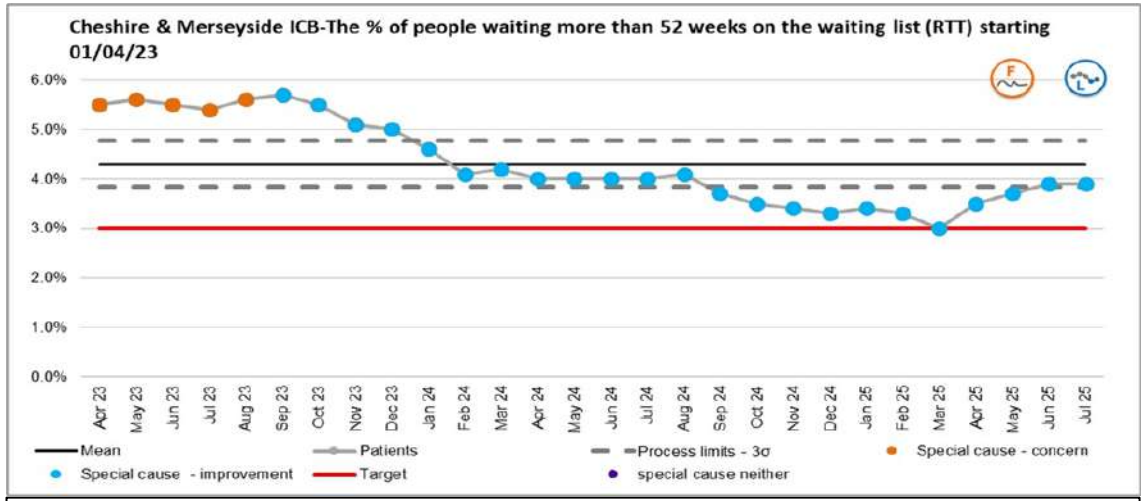
- There is a continued focus on working towards the 18ww and this remains a key critical priority to meet our target for March 2026.

5. Exception Report – Planned Care

NHS Cheshire and Merseyside

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

Latest ICB Performance (July-25)	3.9%	National Ranking	40/42
ICB Trend (July-25)			No change



Issue

- Several trusts are behind plan in relation to reducing their 52 week waits position, although overall special cause improvement can be seen over time. There are currently 14,934 patients waiting over 52 weeks.
- 2 trusts are deploying new trust-wide EPR systems, both providers are experiencing challenges due to DCS implementation. The robustness of recovery plans is variable between providers.

Action

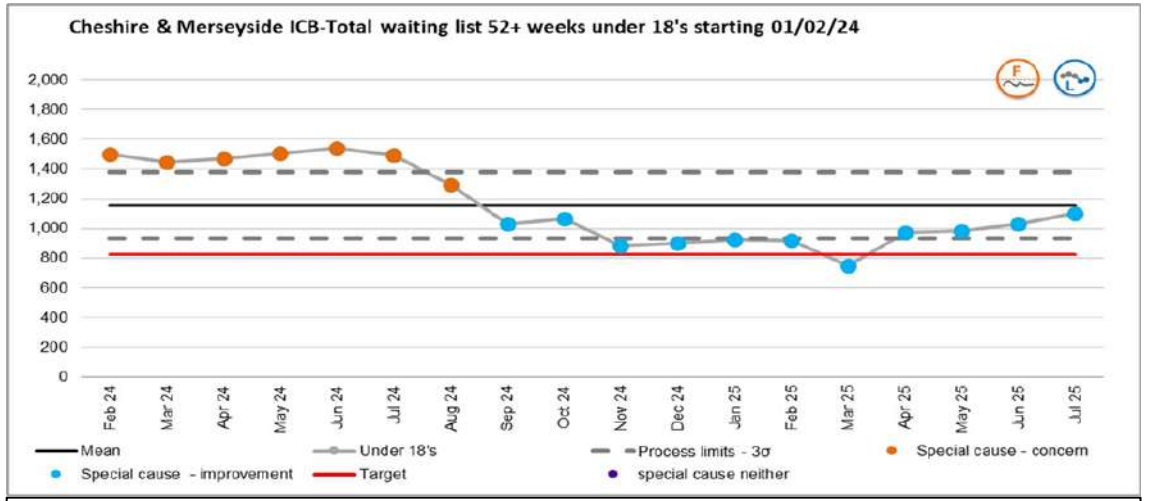
- The elective reform team has fortnightly calls with all providers to review their plan vs actual position. Specific recovery actions are managed and overseen with system support in place when required.
- Managing long waits across some of key specialities at system level continues to be a challenge – ENT particularly has 2,872 pathways waiting over 52 weeks. Improvement and transformation programmes covering T&O, ENT and Gynaecology have been initiated.
- Increasing the use of A&G, PIFU and going further with validation will improve the Trusts ability to manage the demand and decrease waits.
- Additional capacity is being considered by all organisations currently off plan. The system financial position has impacted the ability to continue to use insourcing and outsourcing for some of the challenged specialities.
- Targeted delivery of the 65ww target will support improvement in 52ww position.

Delivery

- There is a continued focus on eradicating 52 week waits and this remains a key critical priority to meet our target for March 2026.

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

Latest ICB Performance (July-25)	1,098	National Ranking	n/a
ICB Trend (July-25)			Deteriorated



Issue

- Several organisations are off plan in relation to their 52 week-long waits position. There are 1,095 CYP patients waiting over 52 weeks.

Action

- The elective reform team have bi-weekly meetings with all Cheshire & Merseyside providers to review their plan vs actual position, to ensure specific recovery actions are managed and overseen with system support in place when required.
- Managing long waits across some of our key specialties at system level continues to be challenged, with all providers reporting challenges within ENT and Dental pathways.
- Significant improvements in the current waiting position were delivered in FY 24/25 with a continued focus in 25/26.

Delivery

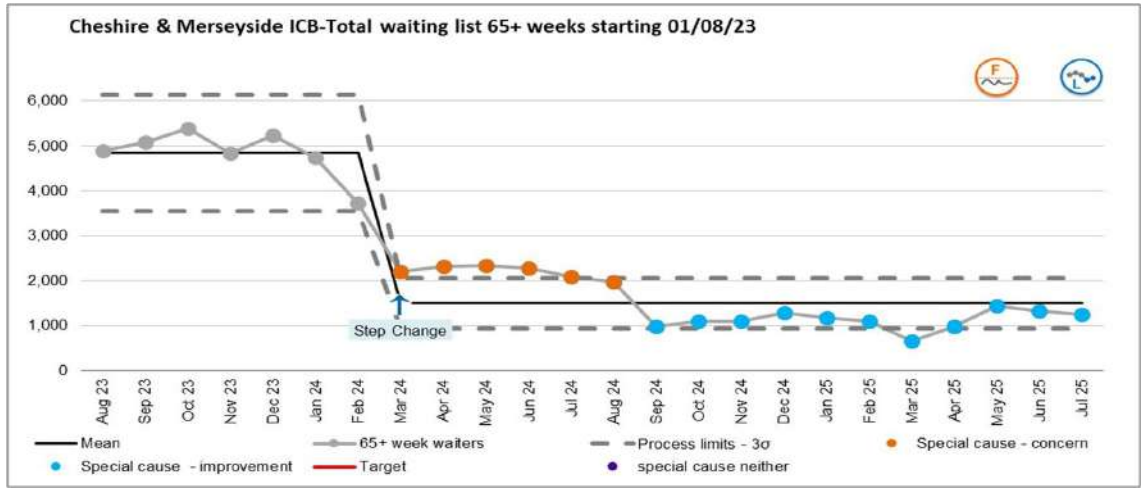
- There is a continued focus on eradicating 52-week waits and this remains a key critical priority to meet our target for March 2026.

5. Exception Report – Planned Care

NHS Cheshire and Merseyside

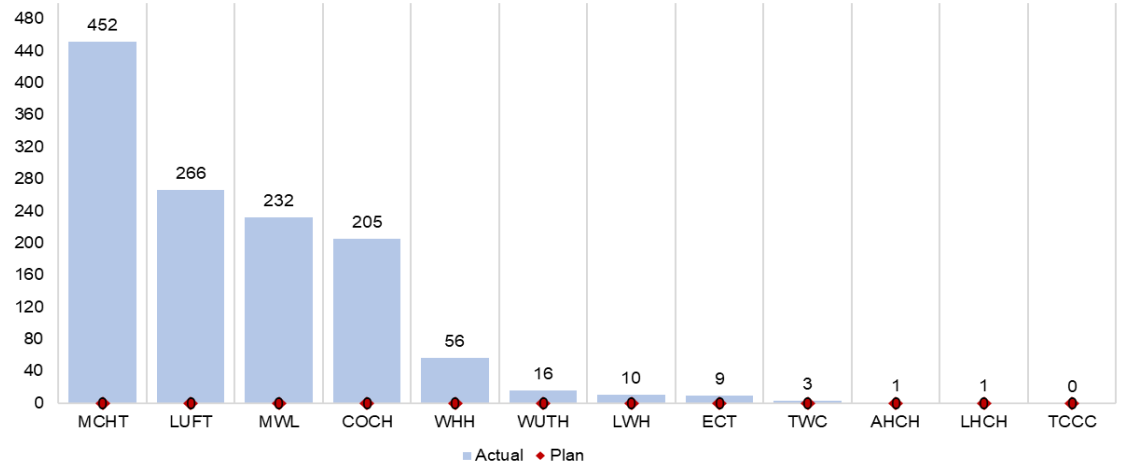
ICB incomplete RTT pathways of 65 weeks or more

Latest ICB Performance (July-25)	1,242	National Ranking	n/a
ICB Trend (July-25)			Improved



Trust incomplete RTT pathways of 65 weeks or more

Latest ICB Performance (July-25)	1,242	National Ranking	n/a
Provider Breakdown (July-25)			Improved



Issue

- Whilst special cause improvement is being seen, challenges remain in clearing 65 week wait patients. Planned activity for week ending 07th September is 1,513, actual position is 1,232. Most of the variance is attributable to Mersey and West Lancs, whose trajectory had been reprofiled, other providers are also exceeding their anticipated delivery.

Action

- The elective programme is working closely with providers to ensure that mutual aid and operational tactical measures are explored and expedited. Active mutual aid is being supported for Mid Cheshire in relation to Cardiology, Paediatric ENT, T&O. LUFT are receiving ENT support.
- The provider collaborative (CMPC) has initiated 90-day improvement plans covering ENT, Gynae, Theatre Productivity and are steering organisations into improved practice around PIFU and A&G Utilisation
- The weekly Elective Delivery and Performance meeting chaired by Elective Reform SRO (Janelle Holmes, Chief Executive of WUTH) is continuing to drive performance outputs on the delivery of 65 weeks. There is positive indication that the systems 65-week position will improve by September aligned with the groups ambition and objective to meet the national standard. Direct communications between CMPC and the provider COOs/CEOs continue for any organisations reporting an anticipated breach position into September 2025.
- CMPC continues to prioritise validation activity with current performance reporting at 12-weeks 64.18%, 26-weeks 67.12% and 52-weeks 83.02%, with 6 providers reporting above the national ambition of 90% for 52-weeks (no submission from ECHT & MCHT due to implementation of new EPR system).
- National Validation Sprint Q2 has commenced, the elective reform team have bi-weekly meetings with all Cheshire & Merseyside providers to review their validation position, to ensure specific recovery actions are managed and overseen with system support in place when required.
- At MCHT, there are significant pressures within several specialties and CMPC continues to offer support in relation to mutual aid, MSK, triage, additional valuation support and sharing best practice pathways.

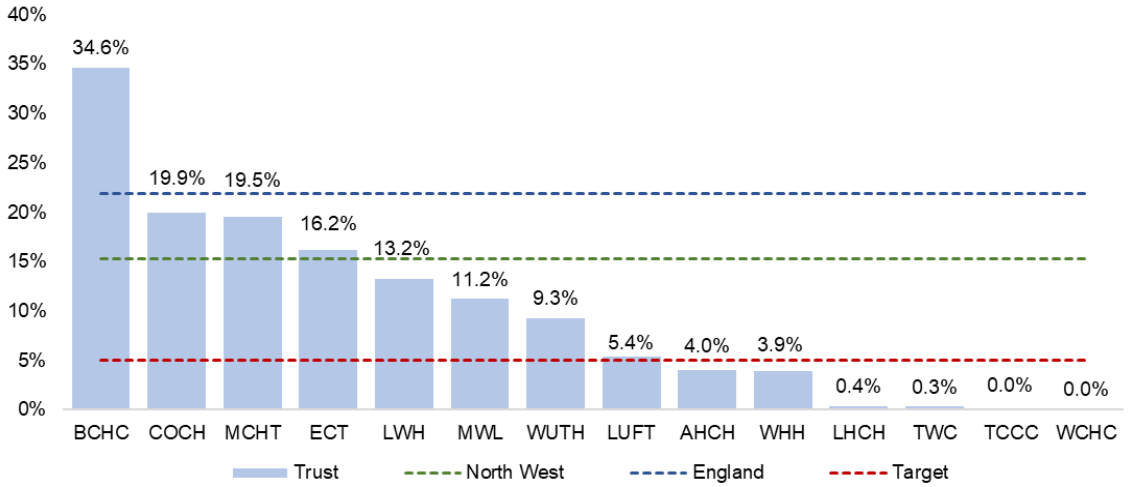
Delivery

- There is a continued focus on eradicating 65 week waits and to model the delivery of 52 and 18 weeks for future planning.
- CMPC continues to report into region on current performance and plans for immediate recovery.

5. Exception Report –Diagnostics

NHS Cheshire and Merseyside

Patients waiting more than 6 weeks for a diagnostic test			
Latest ICB Performance (July-25)	11.2%	National Ranking	3/42
Provider Breakdown (July-25)			Improved



Issue

- C&M performance has deteriorated since March, for various reasons including financial constraints reducing any waiting list initiatives and other premium rate activity alongside significant workforce challenges in some tests. C&M remain in the top 5 ICB areas nationally for Diagnostic performance and performance has increased over the past 2 months.

Action

- Mutual Aid Process – refreshed support for the process with Trust COOs and SOP review with additions scheduled for November for sign off and further implementation.
- System capacity continues to be maximised through Community Diagnostics Centres (CDCs) and the Mutual Aid Process, an increasing number of requests were successfully operationalised in August.
- Halton Endoscopy Hub – Agreement from Trust COO's in September for endoscopy surveillance patients to be sent to the hub via an opt out process.

Delivery

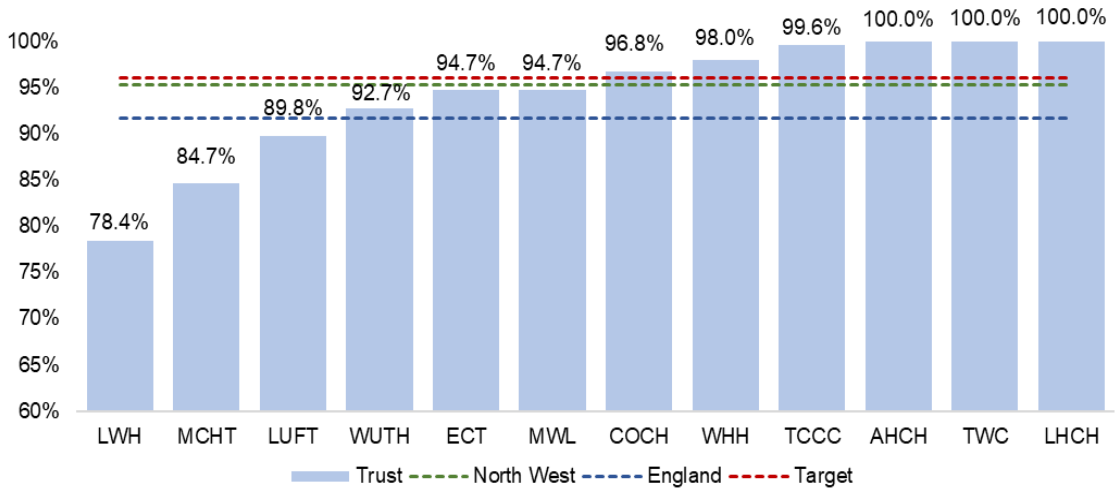
- No national diagnostic performance target set by NHSE for 25/26. However, the NHS constitutional standard remains at 99% and timely access to diagnostics is a key enabler for the achievement of RTT and cancer treatment targets.

5. Exception Report – Cancer

NHS Cheshire and Merseyside

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

Latest ICB Performance (June-25)	95.5%	National Ranking	14/42
Provider Breakdown (June-25)			Improved



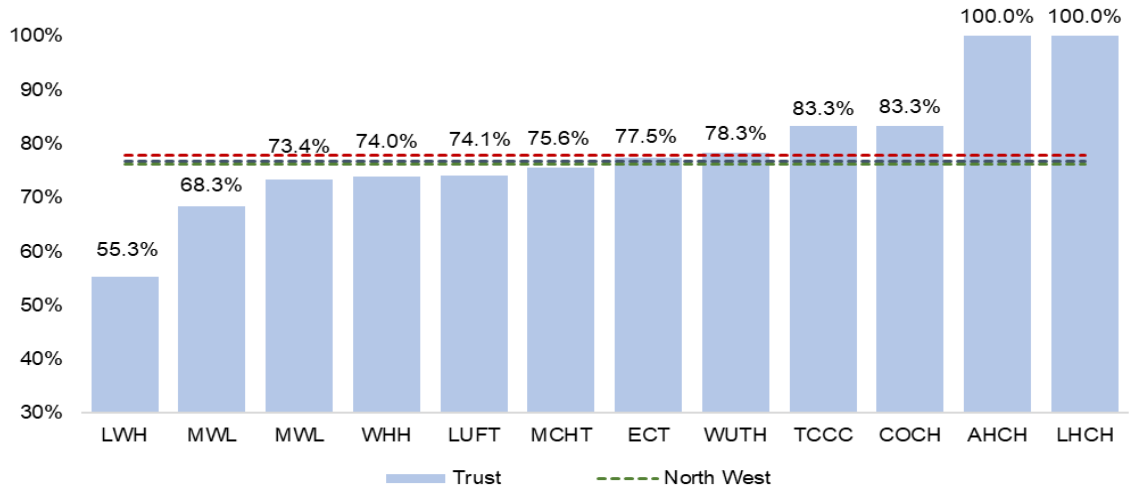
Issue
- C&M not yet achieving the 96% 31-day combined standard required. However, the figure of 95.5% is 4th amongst Cancer Alliances and 14th amongst ICBs. It should be noted that this figure is 3.8% points ahead of England and represents very good performance for C&M.

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

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

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

Latest ICB Performance (June-25)	73.6%	National Ranking	38/42
Provider Breakdown (June-25)			Improved



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

Action
- CMCA has produced bespoke improvement trajectories for each provider which are linked to improvement plans managed via the CMCA performance forum.
- The Pathways Improvement Programme continues to work across the nationally mandated priority tumour sites, implementing 'in depth reviews' to assess underlying performance drivers for cancer pathways (LGI, Breast, Skin, Gynae, Urology).
- A range of cross-cutting initiatives are underway such as an MDT bank, CDC optimisation group and single-queue diagnostic work.

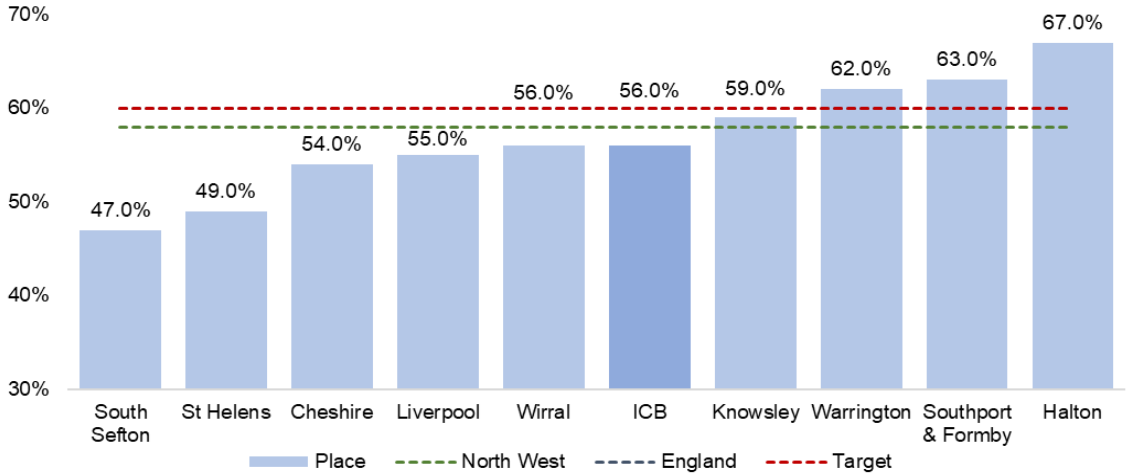
Delivery
- C&M is still expecting to meet the 80% ambition by the end of the financial year 25/26.

5. Exception Report – Mental Health

NHS Cheshire and Merseyside

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

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



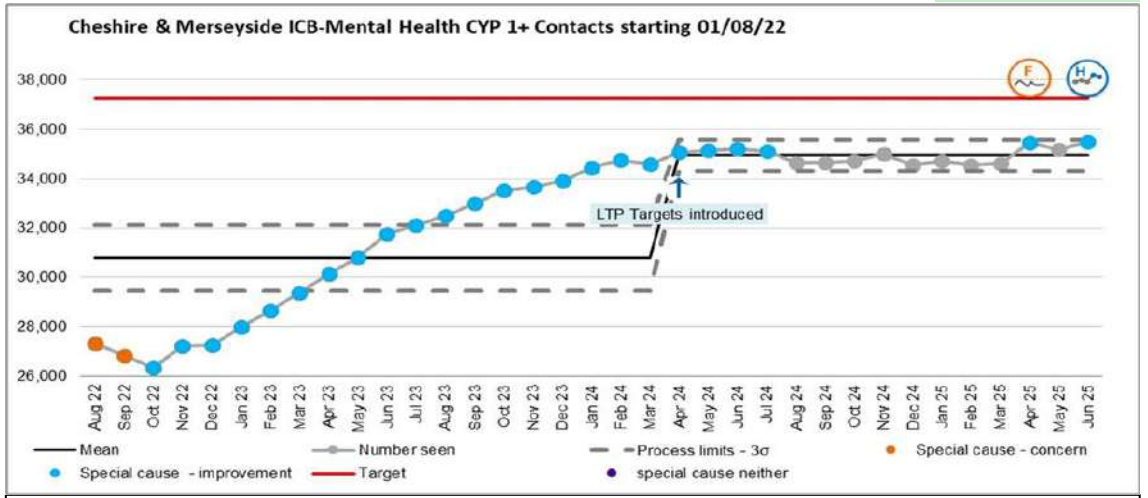
Issue
- ICB performance has fallen below the minimum 60% target. National ambition is to work towards 75% of people with SMI receiving all 6 physical health checks.
- Metric has been removed from MH operational planning metrics for 2025/26 and QOF incentive for GP practices has also been removed for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

Action
- Places to consider continuation of existing outreach schemes which promote and encourage uptake of physical health checks and note the risk of further adverse impact if serving notice.
- Consideration given to how monitoring of physical health in SMI will be incorporated in business-as-usual processes to satisfy requirements of the NHS Performance Assessment Framework.

Delivery
- 6 of 9 places met the minimum 60% target in Q4 of 2024/25 but this has reduced to 3 places this quarter.
- Historic trends generally indicate below plan performance in the first 2 quarters of the year.

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

Latest ICB Performance (June-25)	35,485	National Ranking	n/a
ICB Trend (June-25)			Improved



Issue
- Access remains circa 2,000 below target but has increased by 1% compared with the previous month, and 2% compared with the same period last year.
- Not all VCSE services are able to flow data to the national dataset so this activity is not captured in its totality, meaning the C&M position is understated.

Action
- A deep dive into activity undertaken by existing MH Support Teams in schools is progressing with a view to increasing access reported.
- Request made for "in-month access" report to be added to BIP as 12-month rolling activity can be misleading. Aim to identify in-month changes more quickly and address areas of concern.
- ICB place leads to develop a VCSE data improvement plan to address gaps in non-NHS funded activity, recognising digital and infrastructure variation across the sector.

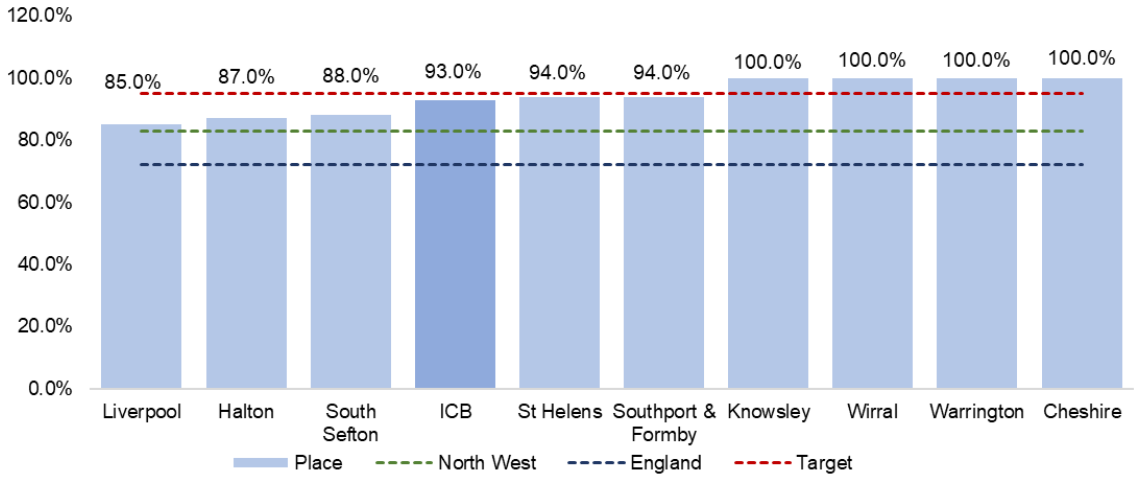
Delivery
- There has been no significant change in overall C&M access rates since 2024, however there is more significant variance in place level trends.
- Cheshire re-procurement of the contract for the Emotionally Healthy Schools (EHS) service in East Cheshire appears to be significantly impacting on 12-month rolling access.

5. Exception Report – Mental Health & Learning Disabilities

NHS Cheshire and Merseyside

CYP Eating Disorders Routine

Latest ICB Performance (June-25)	93.0%	National Ranking	7/42
Place Breakdown (June-25)			No change



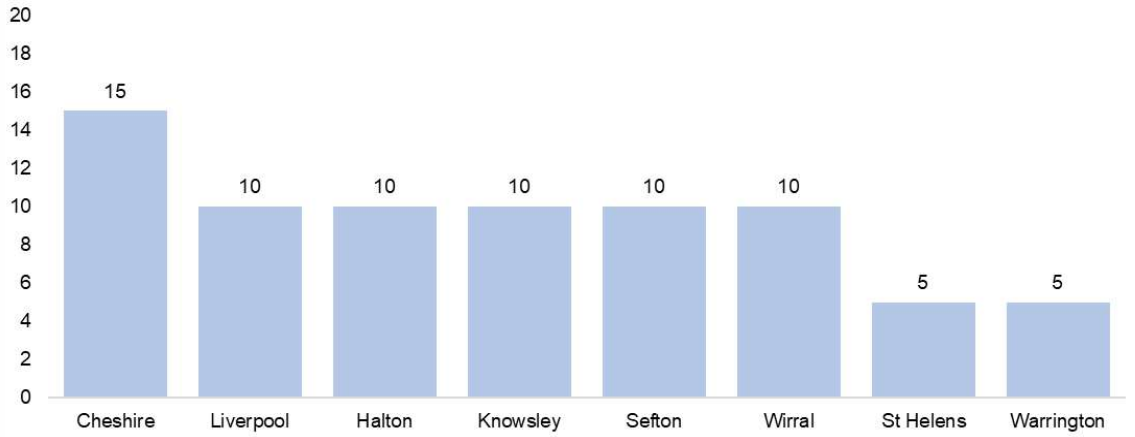
Issue
- National data indicates a 7% improvement in performance between Mar and Jun 25, however, the nationally reported position remains below the routine waiting time standard of 95% seen within 4 weeks.
- Mersey Care data quality issue has impacted on the overall ICB position, however, local data indicates that the target is being achieved by the trust and, therefore the ICB

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

Delivery
- Alder Hey nationally reported data has improved from 78% in Mar to 95% in Jun 25 and now meets the national target.
- CWP continues to achieve 100% of patients seen within 4 weeks.
- Mersey Care nationally reported data indicates 84%, however local data reports 100% achievement.

Adult inpatients with a learning disability and/or autism

Latest ICB Performance (July-25)	75 *	National Ranking	23/42
Place Breakdown * (July-25)			No change



Issue
- There were 75 adult inpatients, of which 48 are Specialised Commissioning (Spec Comm) inpatients commissioned by NHSE, and 27 ICB commissioned. The target identified for C&M (ICB and Spec Comm) is 46 LD/A or fewer by the end of Q4 2026 and 28 Autism only.

Action
- The Transforming Care Partnership (TCP) has scrutinised those clinically ready for discharge. Of those 75 adults, 8 individuals are currently on Section 17 Leave. It is expected that some of the existing section 17 leave individuals will be discharged in Q1 pending MOJ Clearance and transition progress. We have identified 33 people for discharge during 25/26 of this cohort of which 4 have been discharged.
- Data quality checks continue to be completed on Assuring Transformation to ensure accuracy.
- 2-weekly C&M system calls ongoing to address Delayed Discharges with Mersey Care and CWP.
- Housing Lead continues to work to find voids which can accommodate delayed discharges.
- Desktop reviews take place to address section 17 leave progress and those identified for discharge
- Transforming Care Lead is linking into Provider MADE calls .

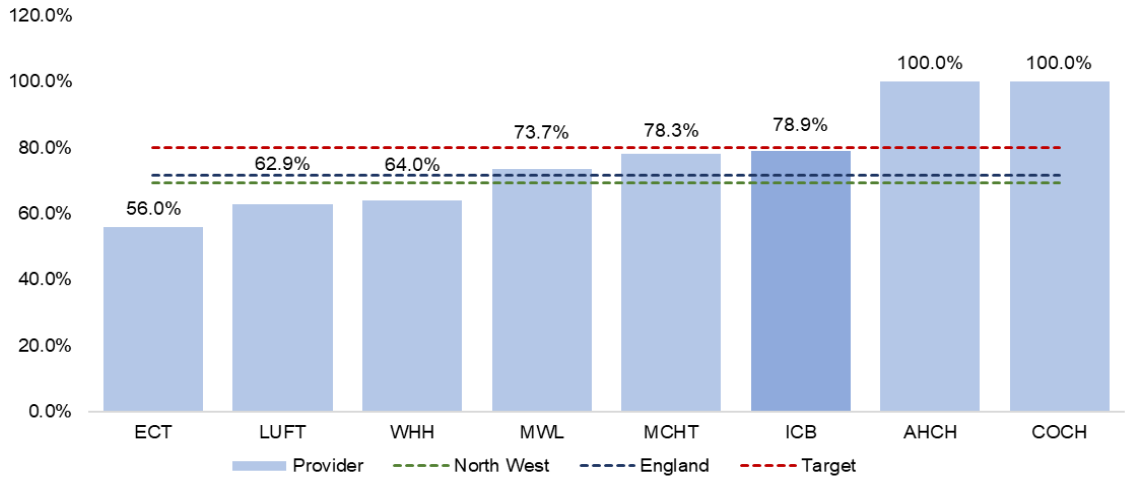
Delivery
- C&M ICB and NHSE aim to reduce the number of inpatients, where appropriate, by the end of Q4 2025/26, where the target is 46 for LD/A and 28 for people with Autism.

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

5. Exception Report – Community

Virtual Wards Utilisation

Latest ICB Performance (July-25)	78.9%	National Ranking	19/42
Provider breakdown (July-25)			Improved

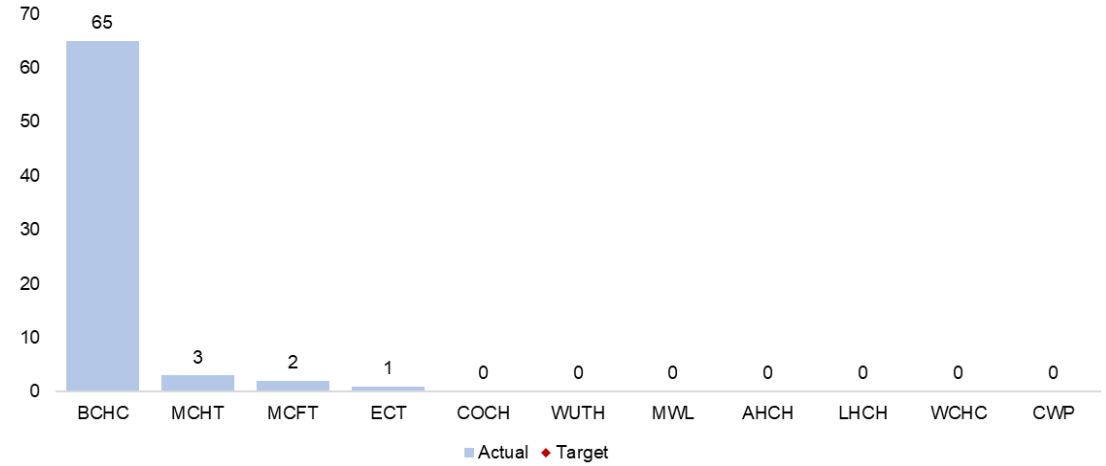


Issue
- The July 2025 Quality and Performance Report submitted to the ICB Q&P committee shows a discrepancy in utilisation data.
- There is variation between the performance data from the performance team and the data in the BIP system with BIP data for July showing a mean utilisation **of 84.3%.**

Actions
- The July 2025 data from the performance team and BIP has been compared, and a noticeable variation was identified.
- The reasons for the variation have been identified and changes made that will be evident in the August / September report.
- A discrepancy remains for MWL in relation to VW beds provided for L&SC reported in the C&M national data. This is being addressed

Community Services – Adults waiting over 52 weeks

Latest ICB Performance (May-25)	71	National Ranking	n/a
Provider breakdown (May-25)			Improved



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

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

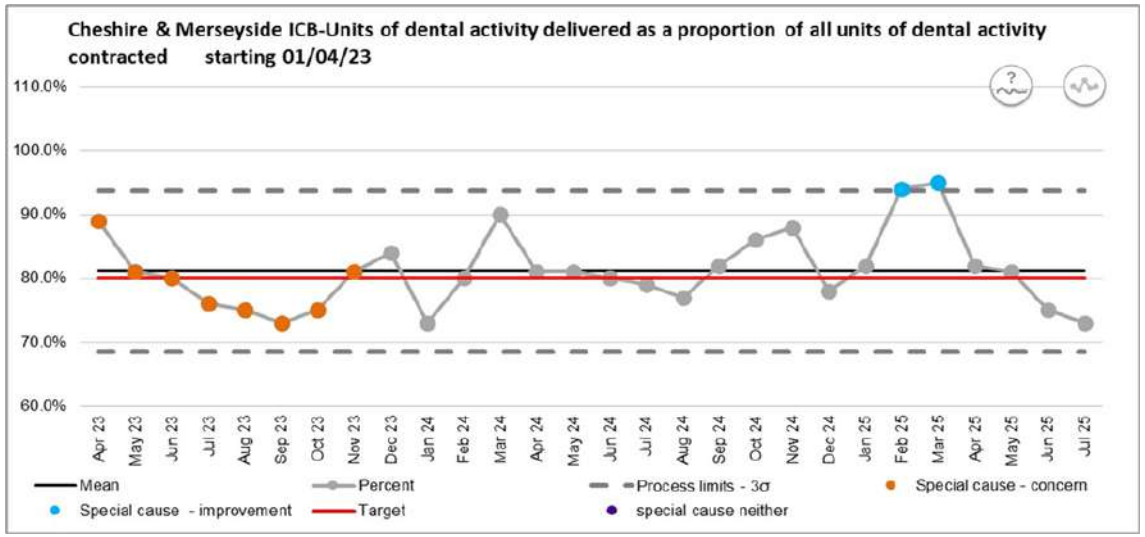
5. Exception Report – Primary Care

NHS Cheshire and Merseyside

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

Latest ICB Performance (July-25)	73.0%	National Ranking	33/42

ICB Trend (July-25)



Issue
- C&M does not currently meet the 100% target.

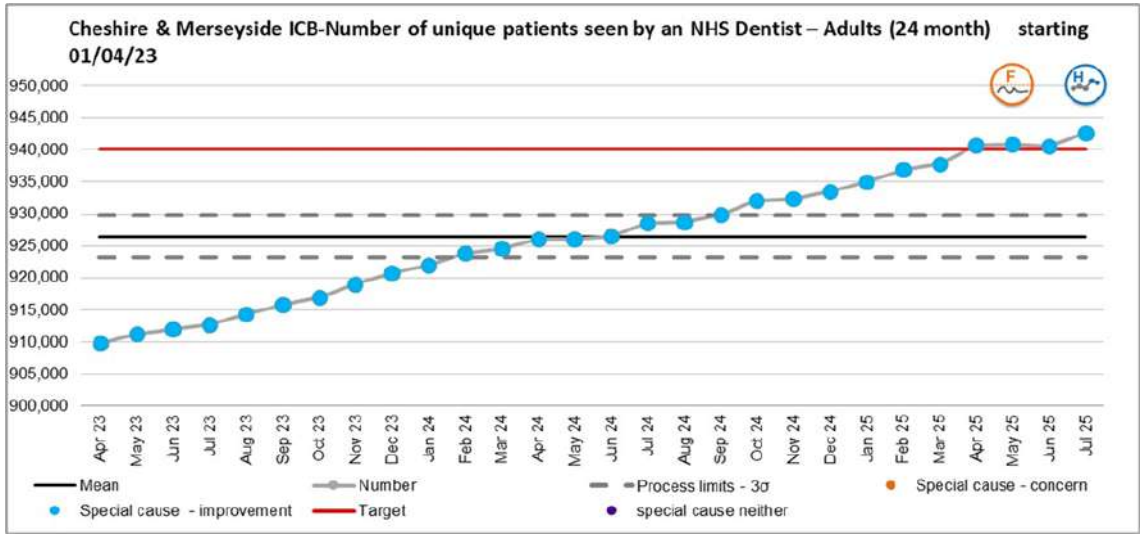
Action
- Local Dental Improvement Plan 25/26 implementation.
- Actions taken to increase activity regarding national urgent care scheme and C&M share

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

Number of unique patients seen by an NHS Dentist – Adults

Latest ICB Performance (July-25)	942,639	National Ranking	n/a

ICB Trend July-25)



Issue
- Performance has increased and C&M is currently above target.

Action
- Continue to support network of providers to see new patients who require an NHS dentist delivering Pathway 1/2/3 in local dental plan 25/26.
- Working with providers to ensure accurate and timely submission of data to BSA.
- Rapid evaluation of proof of concept completed and reviewed by commissioners.

Delivery
- Commissioners are using flexible commissioning arrangements to improve activity.

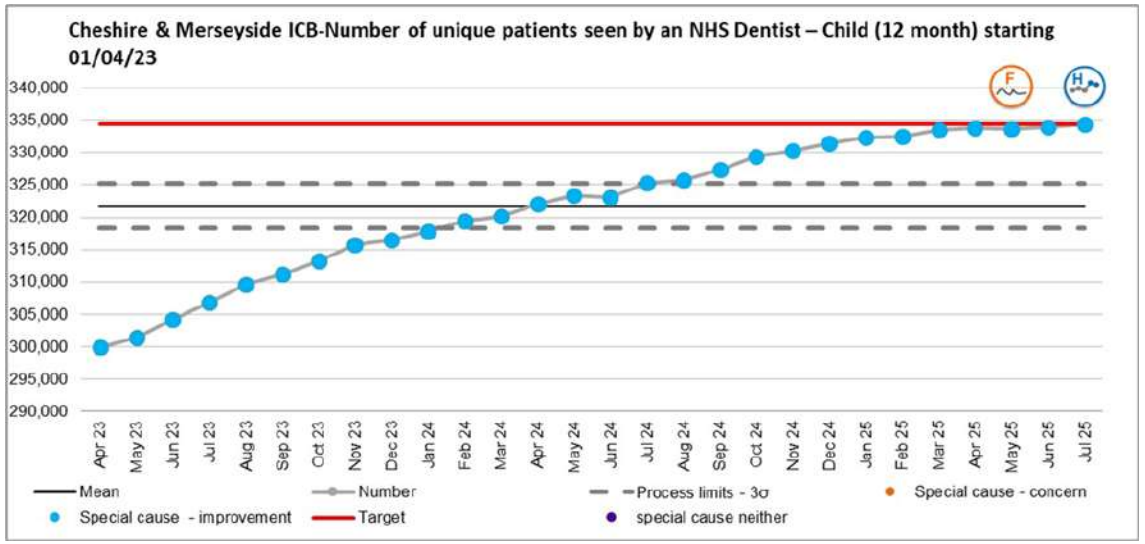
5. Exception Report – Primary Care

NHS Cheshire and Merseyside

Number of unique patients seen by an NHS Dentist – Children

Latest ICB Performance (July-25)	334,352	National Ranking	n/a

ICB Trend (July-25)



Issue
- Performance has slightly increased, and special cause improvement is being seen.

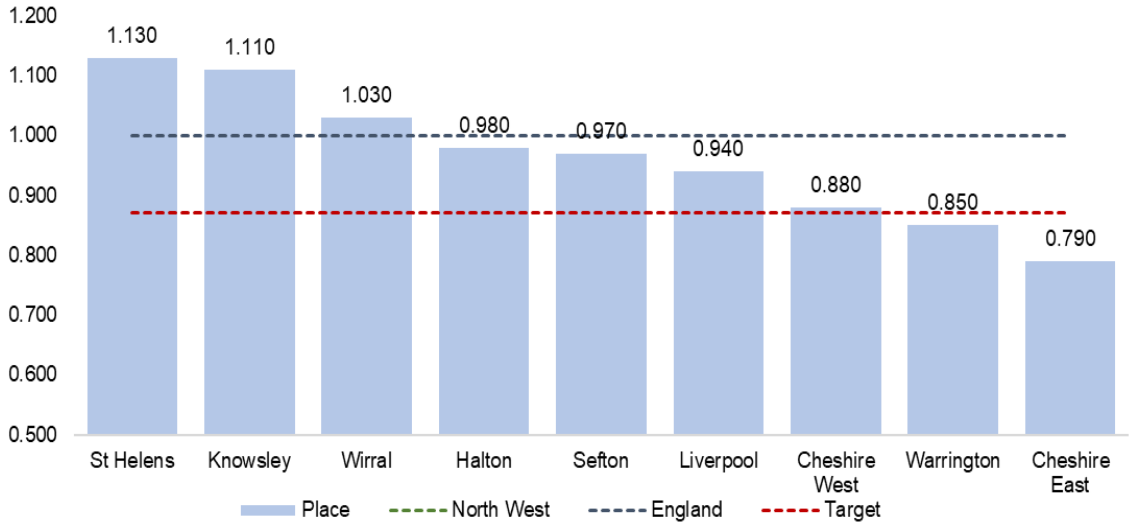
Action
- Continue to support network of providers to see new patients who require an NHS dentist delivering Pathway 1/2/3 in local dental plan for 25/26.
- Working with providers to ensure accurate and timely submission of data to BSA.
- Rapid evaluation of local proof of concept completed and commissioners have reviewed actions.

Delivery
- Commissioners are using flexible commissioning arrangements to improve activity.

Total volume of antibiotic prescribing in primary care

Latest ICB Performance (May-25)	0.94	National Ranking	n/a

Place breakdown (May-25) — Improved



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

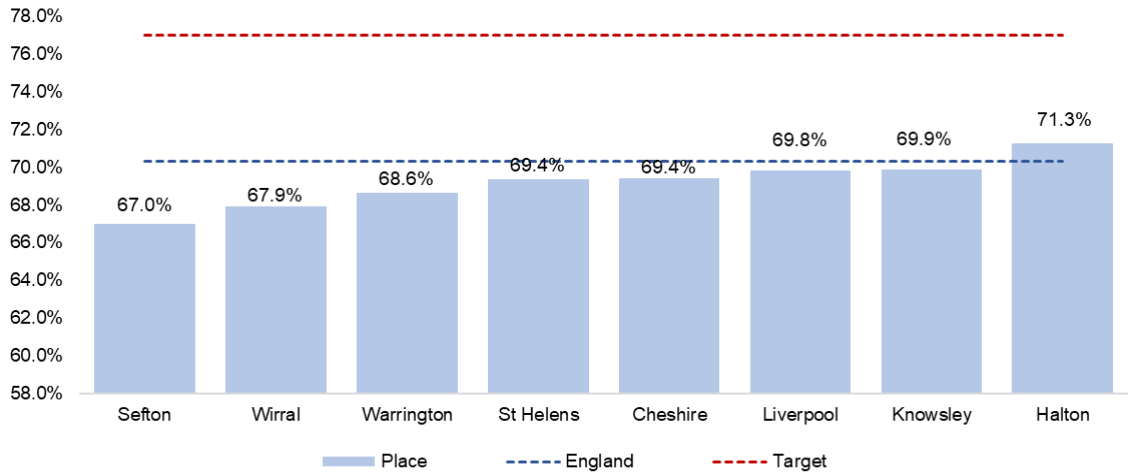
Action
- All Places continue the cascade of education, public communication work, reviewing prescribing data and decisions in relation to antibiotic prescribing.
- Central NHS C&M penicillin de-labelling process now live with LUHFT, AHCH and LHCH Trusts now piloting the new process.
- Request from Place based AMR leads to agree a communication pathway for district nurses when requested antibiotics to ensure the prescribers have all the information they need to make a clinically sound decision.
- Bid submitted to NHS England for ICB Leadership and Governance of AMR Funding.

Delivery
- Analysis to continue with Q1 2025/26 data at Place and ICB level to inform areas to focus on at Place and C&M level.

5. Exception Report – Health Inequalities & Improvement

NHS Cheshire and Merseyside

% of patients (18+), with GP recorded hypertension, BP below appropriate treatment threshold			
Latest ICB Performance (Q4-24/25)	69.07%	National Ranking	30/42
Place Breakdown (Q4-24/25)			Improved

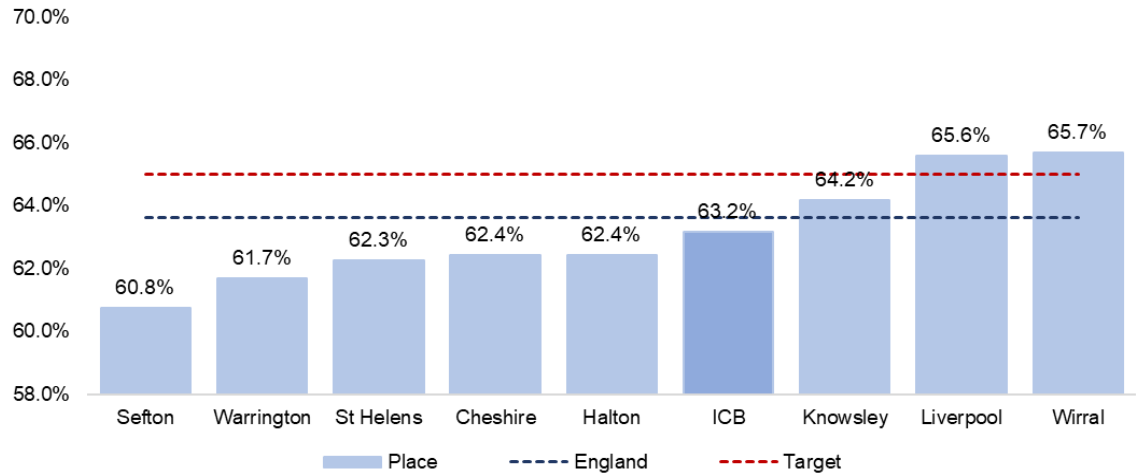


Issue
- Although improvements have been made this quarter, considerable variation remains between Places and C&M does not currently meet the national target ambition.

Action
- The hypertension case finding in optometry pilot is underway, with 60 optical practices taking part, with representation from each Place. Due for completion Q2 with national evaluation available in Q3. So far numbers identified with hypertension that need to be treated are in line with projections indicating that opticians are a viable venue for this work.
- Cycle 1 of the CLEAR programme with 5 PCNs is nearing completion. Cycle 2 is midway with a further 6 PCNs. Work will start with the last Cycle in Q3, with a further 5 PCNs to adopt a new model of care around their chosen aspect of CVD prevention which may include hypertension.
- The Health Inequalities blood pressure optimisation project is now complete, the evaluation has been shared with relevant parties. Next steps are to share the learning and support the spread of outcomes to other practices and measure the impact of any new ways of working.

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

% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with lipid lowering therapies			
Latest ICB Performance (Q4-24/25)	63.2%	National Ranking	19/42
Place Breakdown (Q4-24/25)			Improved



Issue
- Although improvements have been made this quarter, considerable variation remains between Places and C&M does not currently meet the national ambition.

Action
- A clinically led C&M Lipid Management group leads the Lipid work plan. A mapping exercise is being undertaken in partnership with Novartis, to understand the barriers and opportunities in both primary and secondary care to improve both the care and outcomes related to secondary prevention lipid management.
- Continuing to develop a suite of user friendly resources and educational opportunities for primary care colleagues to support lipid management
- Cycle 1 of the CLEAR programme with 5 PCNs is nearing completion. Cycle 2 is midway with a further 6 PCNs. Work will start with the last Cycle in Q3, with a further 5 PCNs to adopt a new model of care around their chosen aspect of CVD prevention which may include lipid management.

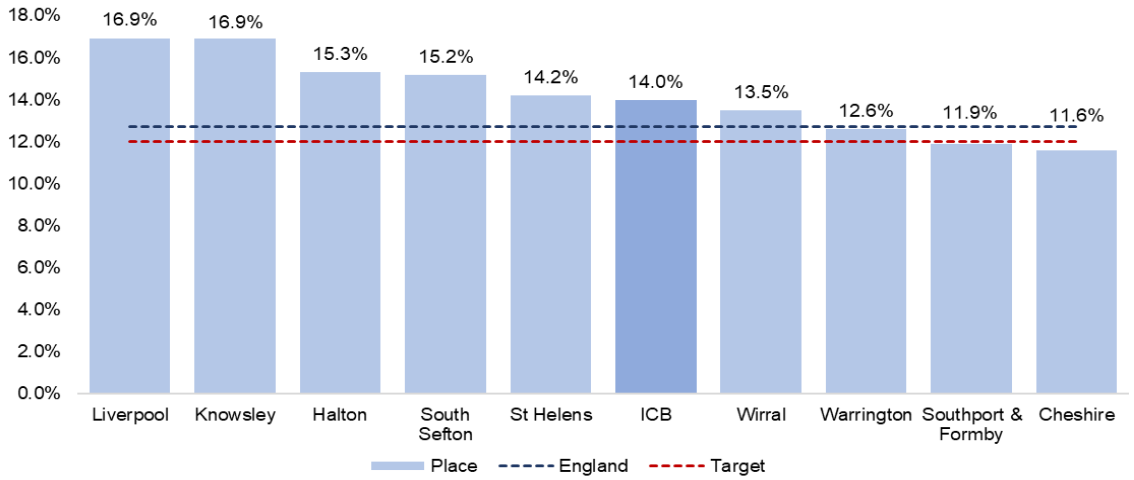
Delivery
- CVDP SRO, Programme lead, the C&M Lipid Management group and CVDP Board are the vehicles to coordinate C&M wide NHS activity alongside local Place CVD Prevention plans
- The role of primary care in achieving this ambition is key

5. Exception Report – Health Inequalities & Improvement

NHS Cheshire and Merseyside

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

Latest ICB Performance (Aug-25)	14.0% *	National Ranking	n/a
Place Breakdown (Aug-25)			No change



Issue

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

Action

- All Chief Executives of NHS Trusts have been written to by the All Together Smokefree board chairs requesting their support to maintain NHS sites as being smokefree environments and continuing to offer patients who smoke access to specialist advice and services.
- An NHS Smokefree toolkit has been developed to support NHS Trusts to deliver their responsibilities in achieving a smokefree site and delivering treating tobacco dependency services.

Delivery

- Supporting smokers to access specialist smoking cessation services to support them to quit should remain a key priority for all staff working in the NHS.

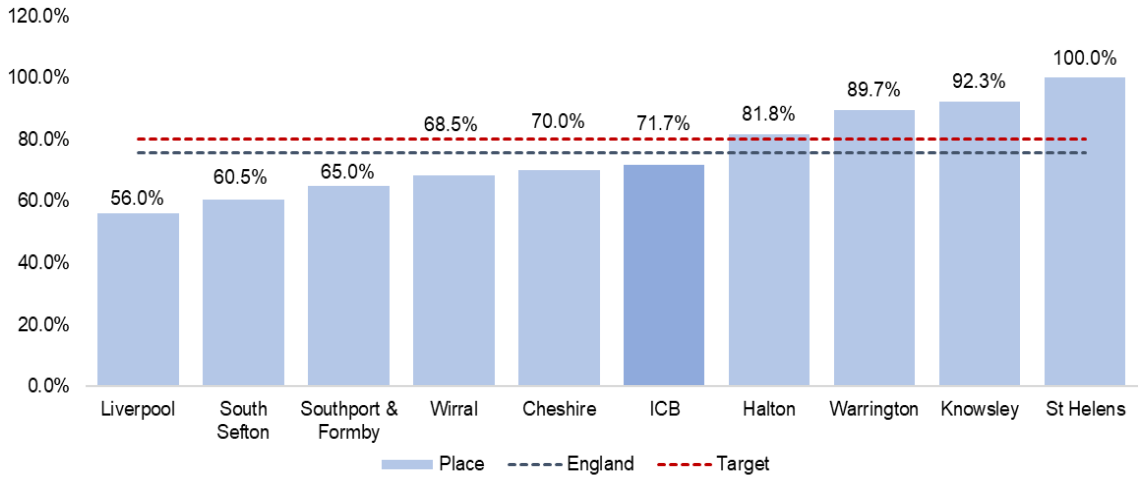
*The methodology for calculating smoking prevalence has changed from April 2025 we are now using the registered population aged 15+ as the denominator

5. Exception Report – Continuing Healthcare

NHS Cheshire and Merseyside

Standard Referrals completed within 28 days

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



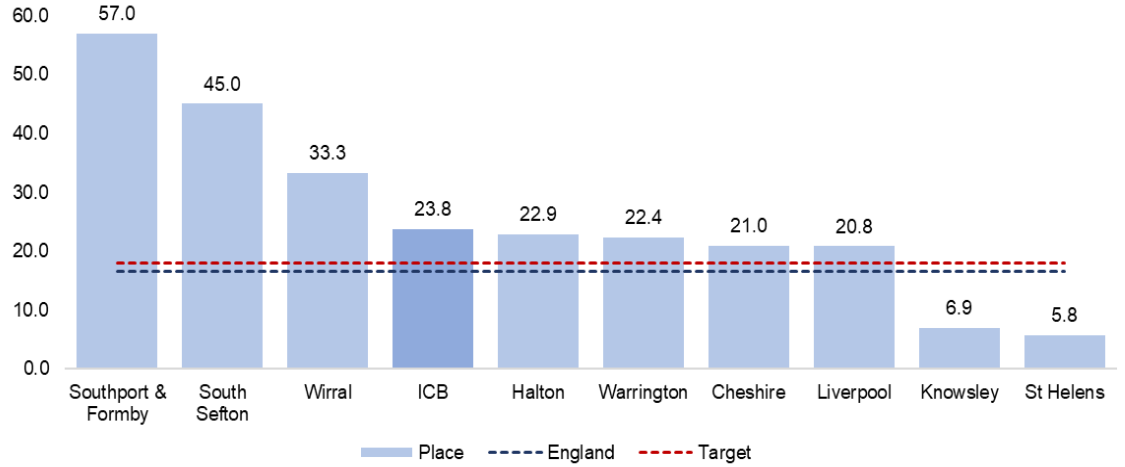
Issue
- Cheshire and Merseyside ICB is not currently meeting the NHS England KPI for Standard CHC referrals to be completed within 28 days. The target is 80%.

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

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

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

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



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

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

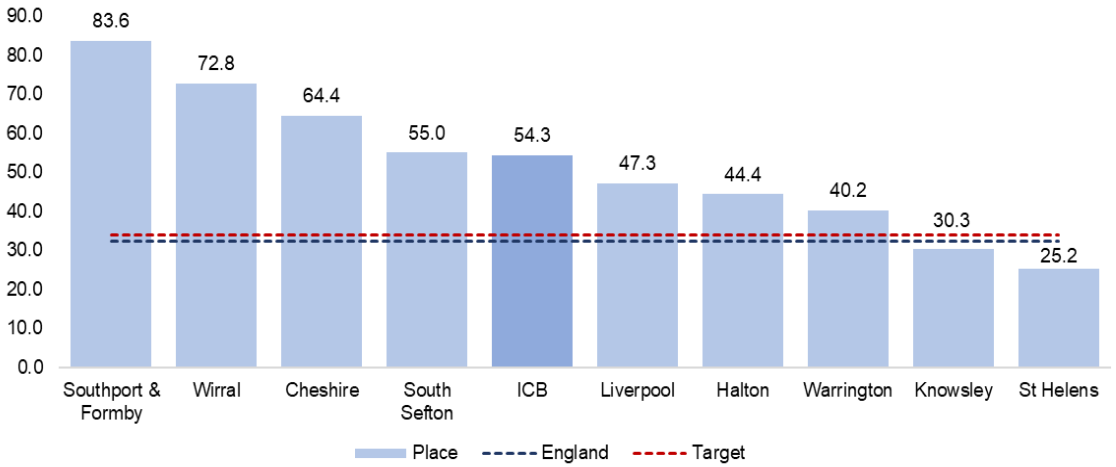
Delivery
- A focused piece of work in Liverpool and Sefton through outsourcing of Fast Track reviews as well as the implementation of the revised structure should ensure that only those individuals who are eligible for Fast Track are in receipt of the funding.
- There is an overall improved position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

**snapshot at end of quarter*

5. Exception Report – Continuing Healthcare

NHS Cheshire and Merseyside

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



Issue

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

Action

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

Delivery

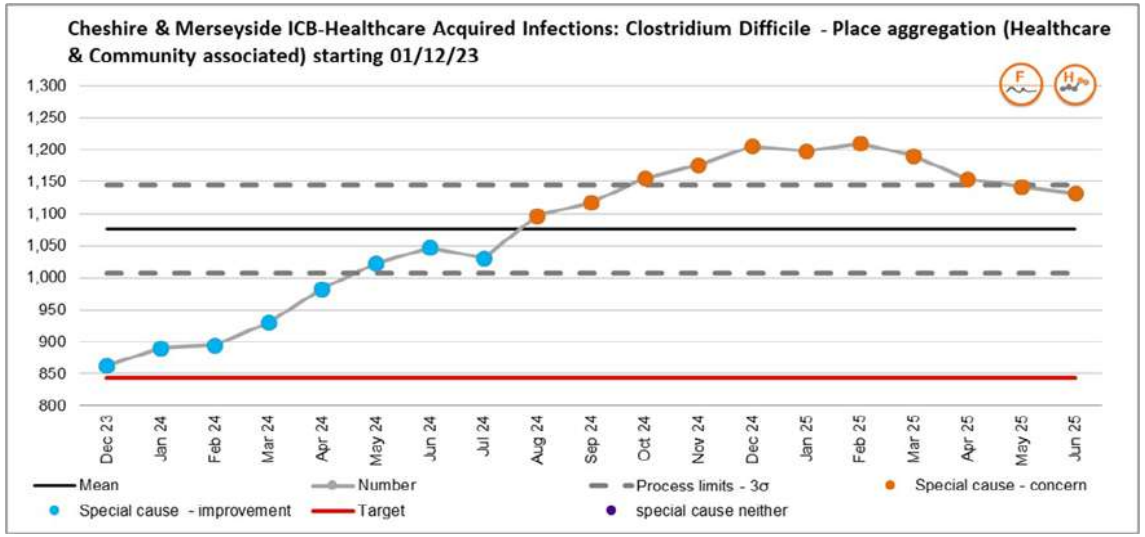
- Delivery is anticipated to improve through a consistent application of processes noting the historic and ongoing impact of formerly outsourced teams; any change would not be rapid due to the CHC processes. (Figures may also be impacted by demographics.)

**snapshot at end of quarter*

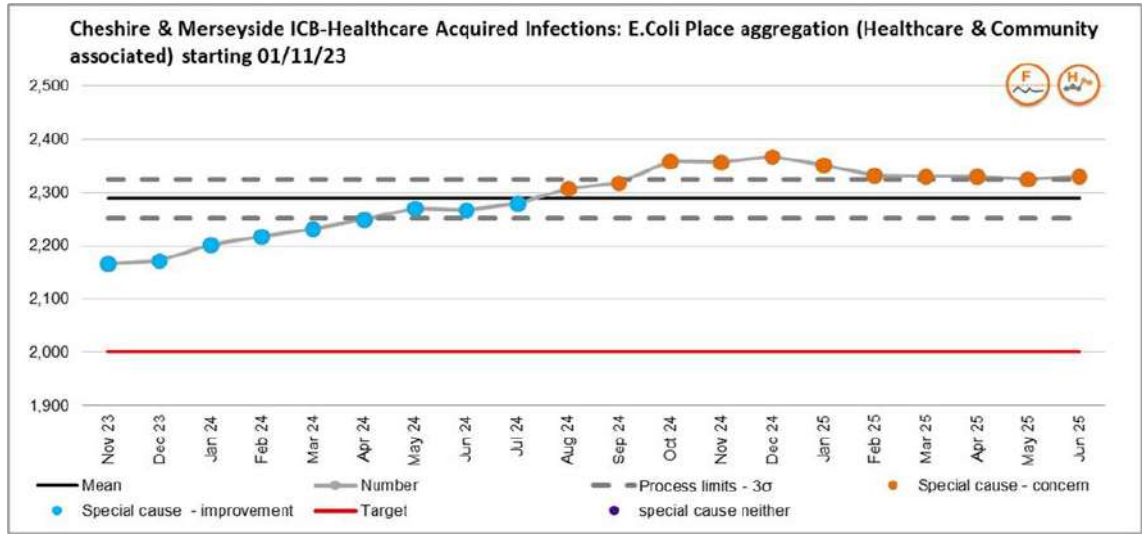
5. Exception Report – Quality

NHS Cheshire and Merseyside

HCAI: Clostridium Difficile - Place aggregation (Healthcare & Community associated)			
Latest ICB Performance (12 months to June-25)	1,131	National Ranking	n/a
ICB Trend (rolling 12 months to June-25)	Improved		



HCAI: E.Coli Place aggregation (Healthcare & Community associated)			
Latest ICB Performance (12 months to June-25)	2,328	National Ranking	n/a
ICB Trend (rolling 12 months to June-25)	Improved		



Issue

- The C&M rate of CDI has continued to show a decline and is an early sign of progress with CDI Toolkit. The overall decline is observed despite an increase in community cases (increase of 3 in rolling 12 months and reduction in 5 within hospital setting). Rolling 12-month reductions were observed at WUTH, WHH and MCHT, but with increases at Walton, MWL, LUFT, COCH and AHCH.
- Individual month fluctuations can be related to natural variation, therefore quarterly and annual rates are also observed and show both WUTH and COCH remain high outliers, but both have reduced rates in the last reporting month.
- Within local system data AHCH continues to raise concern with the highest rate of CDI per bed day in the local system, however increase is within the last 6 months and so not yet triggering national outlier alert on rolling 12-month rate.
- The E. Coli rate has stabilised but above previous rate. Looking at the rolling 12-month count, the overall hospital position has reduced (15) but community onset has increased (20). Reductions were seen at LUFT, MWL, CCC, WHH, but with increases at LHCH and Walton. TCCC continues to hold a high outlier alert, however the previous alert at LUFT has now been removed.

Action

- The CDI tool kit and IPC agenda within acute settings is demonstrating impact, with a targeted intervention require to understand the position at AHCH and CCC.
- A focused review of community onset cases is required with the greatest increase in this sector.

Delivery

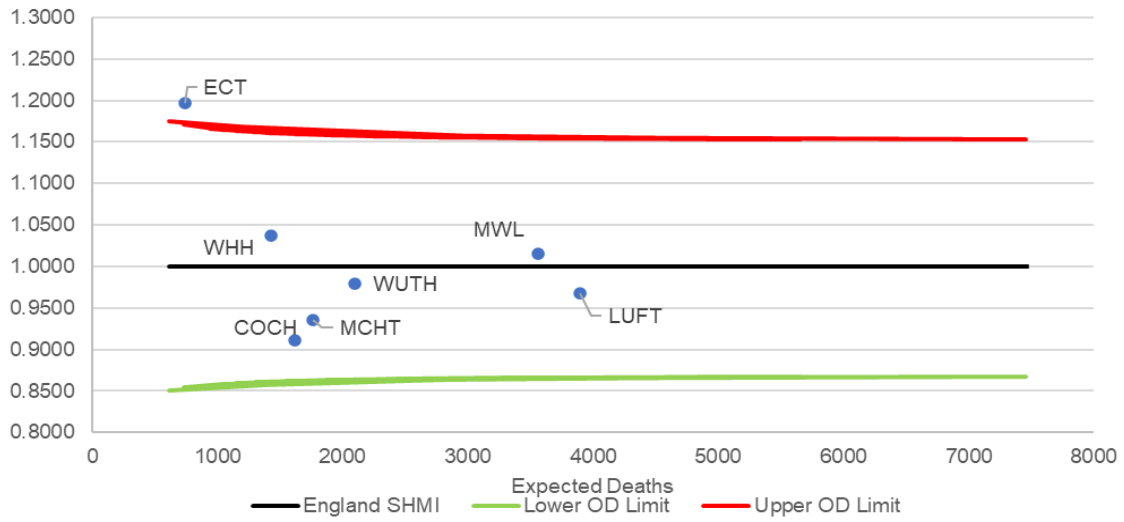
- The ICB tolerance for both CDI and E. Coli remains at risk with Q1 rates exceeding 25% of annual tolerance.

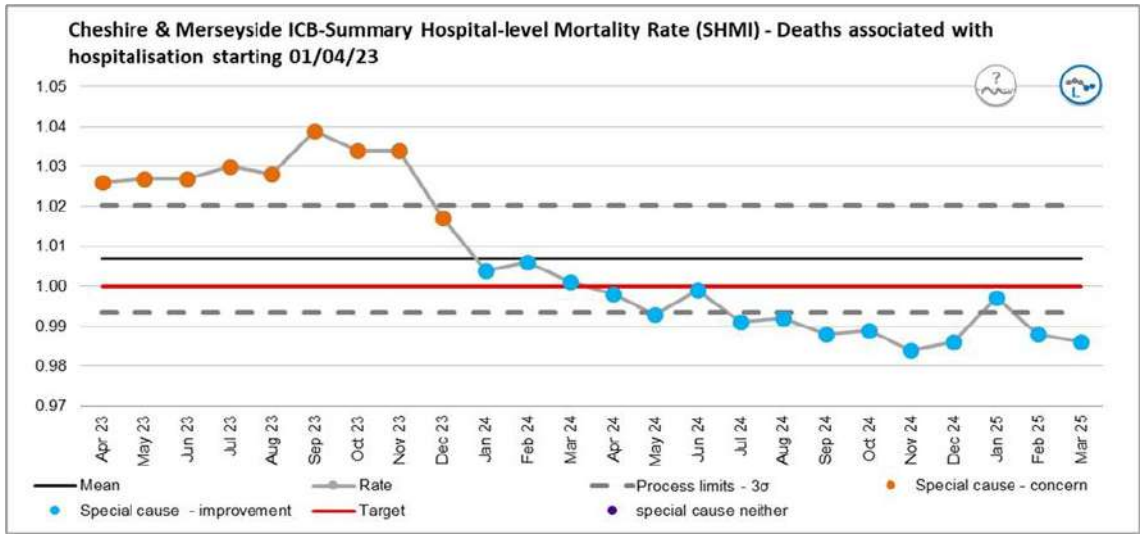
5. Exception Report – Quality

NHS Cheshire and Merseyside

Summary Hospital-level Mortality Indicator (SHMI)

Latest ICB Performance (Mar-25)	0.986	National Ranking	n/a
Provider Breakdown (Mar-25)*			Improved





Issue
- C&M trusts are within expected tolerances except ECT, with a current value of 1.2072 against the upper control limit for ECT of 1.1723.

Action (ECT only)
- The trust has moved to quality improvement phase of quality governance/escalation.
- Scrutiny continues between the ICB and trust in board-to-board meetings and system oversight reviews ensuring the optimal support is in place to bring about best patient outcomes.
- Following the meeting of ICB and trust execs and board, further developed improvement plans and support have been agreed and a detailed timetable of support and assurance created.
- Early indication of improved rates of hospital acquired infection will not be reflected in SHMI, but monthly reporting scrutinised by trust and ICB Medical Directors.

Delivery
- SHMI for ECT had moved to the upper confidence interval for the first time since July 2022 in July 2025, but has now deteriorated slightly.
- The improvement culture in the trust is palpably improved and a Board to Board review in November has led to next steps including a review using HSMR+ that has demonstrated a significantly frail elderly population and clear improvement in mortality when measured using the HSMR+ methodology. It is also inside the 95% confidence interval on a funnel plot and RAMI is in normal range. Oversight continues with deep dive meeting between ICB Medical Director and the Trust in September to further review dissonant data.

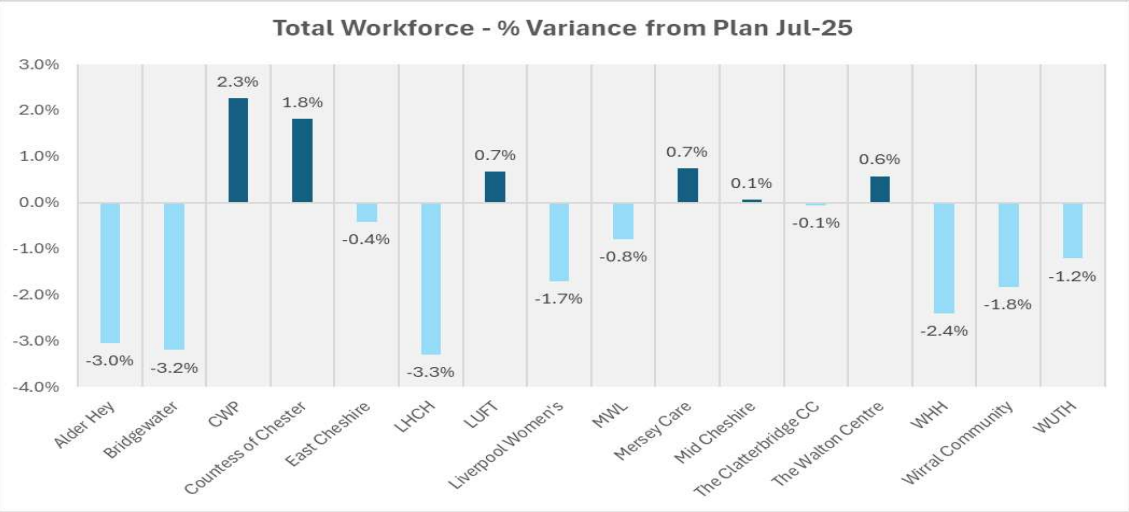
** OD, overdispersion, adds additional variance to the standard upper and lower control limits*

5. Exception Report – HR/Workforce

NHS Cheshire and Merseyside

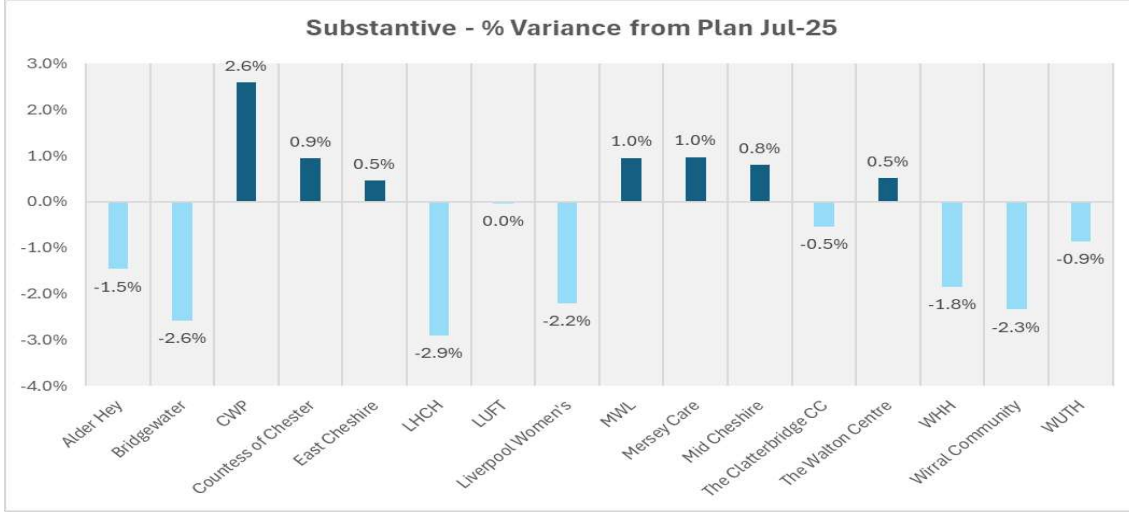
Total SiP (Substantive + Bank+ Agency) Variance from Plan % - via PFRs	
C&M ICB Performance (Jul-25)	**-0.3%**

Provider Breakdown (Jul-25)



Substantive Variance from Plan % - via PFRs	
C&M ICB Performance (Jul-25)	**0%**

Provider Breakdown (Jul-25)



Issue

- In Jul-25, nine of the sixteen C&M Trusts reported their total workforce WTEs were below their planned figure as at M04, with a C&M variance from plan of -0.3% (-220.9 WTE). These variances are based on the 2025/26 Workforce Operational Plan submissions with monthly forecasts for WTE for 25/26. Although overall WTE utilisation is lower than planned across C&M at this point in the year - a cross-check with finance / pay costs shows that the pay bill is above plan by £22.6m overall .
- Nine of sixteen C&M Trusts reported substantive staff in post numbers lower than that forecast in their operational workforce plans. The total system performance was a variance from plan of 0%. At a system level, substantive staff utilisation decreased by -109.5 WTE / -0.1% from the previous month.

Action

- Pay bill increases in M4 attributed in part to Industrial Action & Pay Award settlements – however further actions are required to understand the drivers of workforce pay bill increases.
- NHS C&M monitoring & acceleration of the workforce action plans has been initiated – with a key focus on productivity & efficiency opportunities in temporary staffing (Bank & Agency) & corporate services/enabling functions. NHS C&M is supporting Trusts with their workforce (WTE), activity & finance (pay bill) triangulation.
- Greater scrutiny of workforce and pay costs data at organisational and system level is now taking place. The workforce WTE monitoring dashboard is shared with Trusts monthly

Delivery

- Workforce / Pay Deep Dive scheduled in August 2025 to further understand the drivers of workforce pay bill in Trusts in C&M NHS Trusts.
- Workforce workstreams for Sustainable Nursing Workforce Changes & Medical Workforce Changes has been stood up in May 2025 – reporting into FCOG – Financial Control & Oversight Group.
- Proactive monitoring of workforce data & proposed actions now takes place with Trust Chief People Officer & workforce/resourcing teams as part of the Financial Control & Oversight Group.

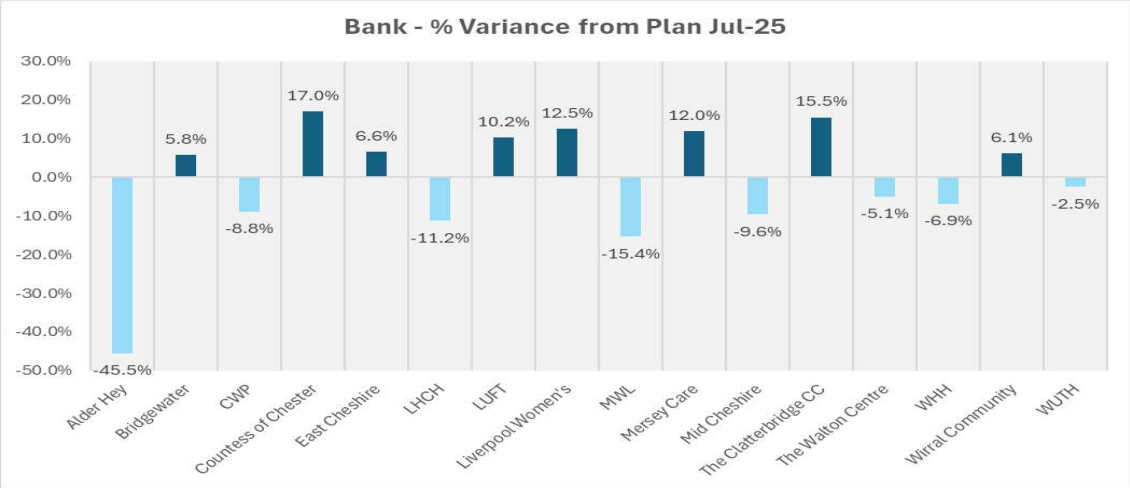
5. Exception Report – HR/Workforce

NHS Cheshire and Merseyside

Bank Variance from Plan % - via PFR

C&M ICB Performance (Jul-25)	-1.0%

Provider Breakdown (Jul-25)



Issue

- Eight of sixteen C&M Trusts had Bank usage higher than that forecast in their operational workforce plans for the month of Jul-25. The total system performance was a variance from plan of -1.0% / -50.2 WTE.
- At a system level, the total bank usage increased by 180.1 WTE / 3.9% from the previous month.

Action

- Trusts with increased Bank Usage cited cover for Resident Doctors Industrial Action in M4.
- All Trusts are reviewing their internal workforce resourcing processes & specific organisational actions around temporary staffing data, premium staffing costs (WTEs Utilised and Rates Charged) & cross-checks between financial & workforce returns, which continues to be a focus for all Trusts, as part of the 25/26 planning process & financial recovery programme (FCOG).
- Bank rates / cost of temporary staffing is currently being reviewed through FCOG workstreams alongside agency & locum rates to ensure consistency across the system.

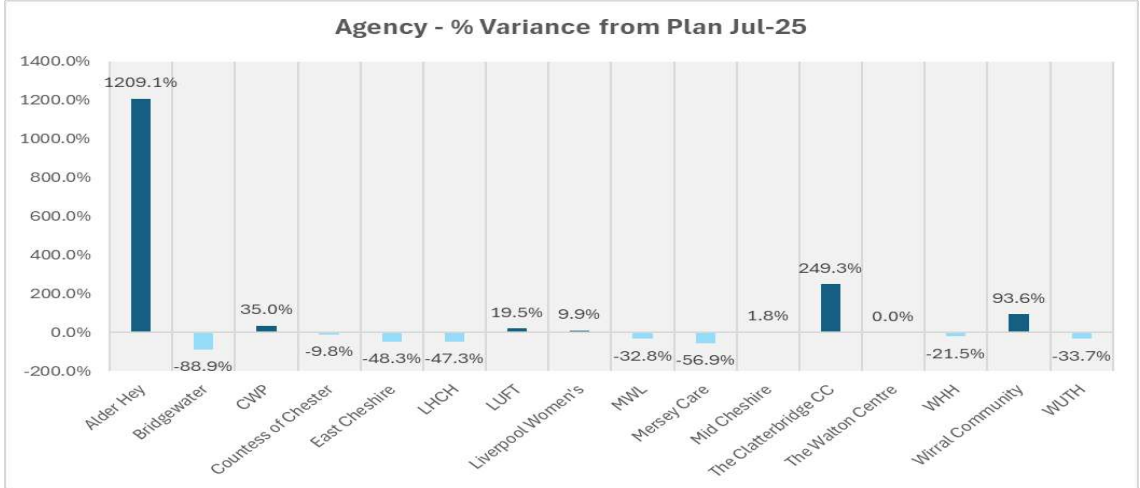
Delivery

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

Agency Variance from Plan % - via PFR

C&M ICB Performance (Jul-25)	-25.3%

Provider Breakdown (Jul-25)



Issue

- Eight of sixteen C&M Trusts had Agency usage lower than that forecast in their operational workforce plans for the month of July. The total system performance was a variance from plan of -25.3% / -186.9 WTE
- At system level, Agency usage reduced by -51.5 WTE / -8.5% from the previous month.

To note: *small numbers/WTE for Planned v Agency usage at Alder Hey & The Clatterbridge Cancer Centre are skewing % change figures but are still above plan.*

Action

- Temporary staffing data (Agency Spend & Off Framework Usage) is being reviewed across all Trusts in C&M – in line with their 25/26 Operational Plan submissions & assumptions.

Delivery

- Proactive monitoring of workforce data & proposed actions/controls with Chief People Officers C&M Trust PDN Network focussed workstream
- Proactive communication to Chief People Officers, Workforce & Resourcing Teams about Off-Framework (OF) and Agency Spend data (by staff group) is shared monthly with additional input provided by NHSE North West. With the expectation that OF will be zero in M5.

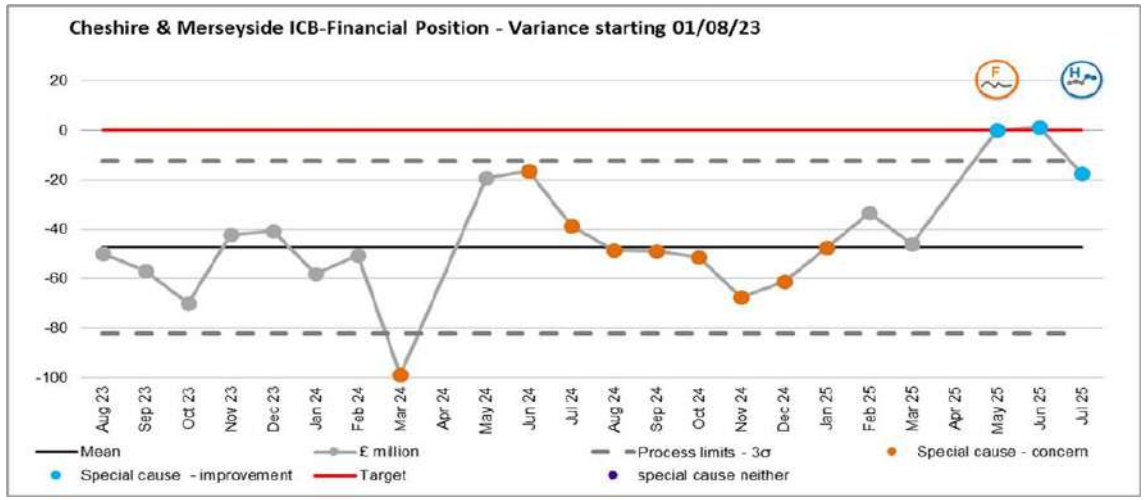
5. Exception Report – Finance

NHS Cheshire and Merseyside

Overall Financial position Variance (£m)

Latest ICS Performance (July-25)	-17.3	National Ranking	n/a

ICS Trend (July-25)



Issue

- System reported deficit of £78.5m against at year-to-date deficit plan of £61.1m as at M4 (ICB - £16.5m surplus, providers £94.9m deficit). This is an adverse system variance of £17.3m.
- The reported position for M4 is based on the system not being in receipt of deficit support funding (DSF) for month 4 – which has an adverse YTD impact of £14.9m on provider plans.
- DSF has been withheld by NHS England for Q2 due to concerns over the deliverability of financial plans. The system continues to forecast on the assumption that 100% of DSF will be provided and the withheld element retrospectively issued.
- Total deficit support funding assumed in the 2025/26 plans is £178.3m. Only Q1 (£44.6m) has been issued to date. Achievement of DSF will rely on the system fully delivering its efficiency plans and mitigating any unplanned pressures.
- **Please note –** the total system YTD variance is shown in slide 12 as a deficit of £2.48m. This represents the position excluding the impact of the withheld deficit support funding.

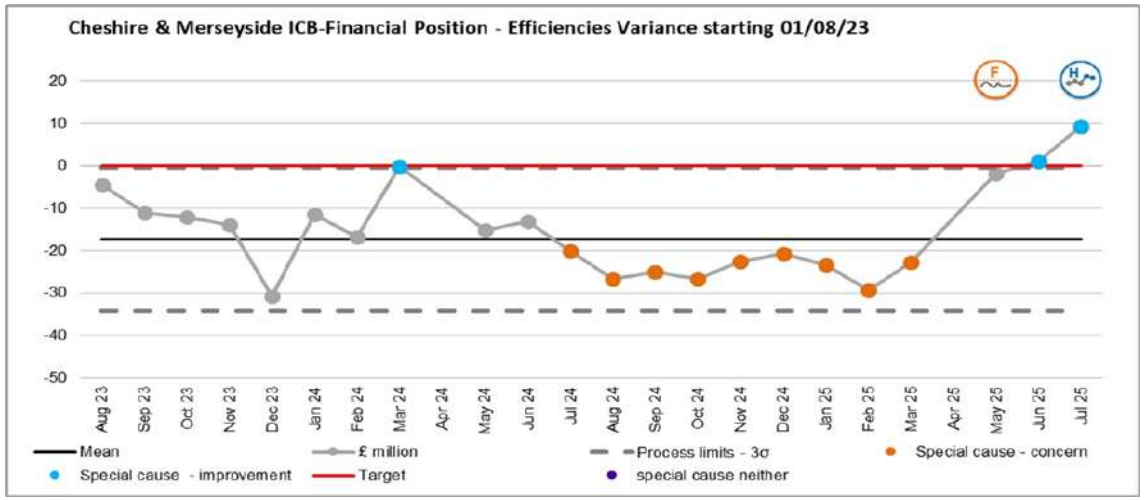
Action

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

Efficiencies Variance (£m)

Latest ICS Performance (July-25)	+9.3	National Ranking	n/a

ICS Trend (July-25)



Issue

- System delivered £147.8m of efficiencies as at month 4 against a plan of £138.5m leading to an over-delivery of £9.3m.
- Over-delivery relates to £2.7m across providers and £6.5m for the ICB.
- ICB reports over-delivery primarily on All-age Continuing care savings. All ICB efficiencies are recurrent.
- 98% of ICB efficiency plans are either fully developed or plans are in progress.
- System forecasting full delivery of the £572.5m efficiency programme.

Action

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

Delivery

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

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 September 2025

Highlight report of the Chair of the ICB Audit Committee

Agenda Item No: ICB/07/25/10

Committee Chair: Mike Burrows, Non-Executive Member

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	09 September 2025

Key escalation and discussion points from the Committee meeting

Alert

The Audit Committee at its 09 September 2025 meeting:

- received and approved the Committees Annual Report for 2024-25 which outlined the committee activities, effectiveness, and attendance for that period. The Committee approved the report (Appendix One)

- reviewed the current risk register, noting three high risks under its purview and a recommendation to reduce the score of a fraud risk related to NHS patients due to effective mitigation, moving it to the corporate risk register but not closing it entirely. There was significant discussion about whether the current risk scores, especially for G5 (governance and financial control during organisational change), accurately reflect the increased risks due to resource constraints, vacancies, and ongoing organisational changes. The committee agreed that the risk register needs a thorough review and possible reset to ensure it reflects the current and future environment, with an updated version being brought to the December meeting. The committee supported the reduction of the fraud risk score but expressed concern about the adequacy of current risk scores and the need for a deep dive and reset.

Advise

The Audit Committee at its 09 September 2025 meeting:

- received an update on the ICBs Freedom To Speak Up (FTSU) processes, case work and ongoing developments. Progress was noted in raising awareness, removing barriers, and recruiting diverse FTSU ambassadors. Risks highlighted around lack of follow-up and the need for improved training compliance, especially for managers and senior leaders. Next steps discussed included further development of FTSU arrangements, targeted communications, and continued focus on inclusion and psychological safe. The Committee noted the report.

- received an update on the ICB Information Governance Service. The update provided included progress on the Data Security and Protection Toolkit (DSPT), Record of Processing Activities (ROPA), IG training, and digital/data programmes. The report emphasised cyber security with a focus on preventing cybercrime and maintaining compliance with new requirements. Key actions discussed included ongoing improvements to DSPT compliance, enhancement of ROPA, and targeted training for staff handling patient data. The Committee noted the report.

- received an update paper providing details on the robustness of cyber security arrangements across the Cheshire and Merseyside system and progress in delivering the Cyber Security Strategy. Discussions included the need for a unified

digital service provider to streamline cyber requirements and reporting. The Committee noted limited advancement due to resource constraints and awaiting national funding. Key risks and mitigations discussed included migration to Windows 11 by 11 October 2025, secure email accreditation, and incident management planning. It was noted that the system-wide cyber resilience programme and consolidation of digital providers was underway and that risks remain high but are being actively managed. The committee underscored the critical nature of cyber security investments, balancing financial constraints with risk appetite, and the potential high costs of cyber incidents to patient safety and organisational reputation. The Committee noted the report.

- received the quarter one 2025-26 ICB Freedom of Information (FOI) report. The report outlined that the ICB received 80 FOI requests and responded to 88 during the quarter, achieving a 93% compliance rate in responding within the statutory 20 working days. There were 5 breaches of the statutory deadline, all due to delays in receiving information from internal departments (notably Clinical, Contracts, Finance, and CHC Services). Themes of requests included commissioning, weight management, mental health, and asylum seeker services. The Committee noted the continued focus on improving internal processes and timely responses. The Committee noted the report.

- received the quarter one ICB Subject Access Request (SAR) report. The report outlined that 21 SARS were opened during this quarter and highlighted that a significant portion remained either open or breached. The breaches were primarily due to delays in receiving necessary information, complexity of the ask or clarification from applicants. The Committee discussed the breaches and plans for addressing, noting improvements brought by use of AI technology, and noted that challenges remain in meeting statutory obligations and the need to look at future service models. The Committee noted the report.

- received a quarter one update report that outlined the current status of the ICBs Conflicts of Interest (COI) Management Framework and Declarations of Interest (DOI) compliance. The report reinforced the importance of effective DOI handling to ensure NHS decisions are transparent, fair, and legally sound. The report provided up to date information on the compliance of ICB staff in declaring any interests on the ICBs Civica Declare system (82%) as well as undertaking their COI training (84%) as well as receiving assurance on there being no significant issues with regards declarations received and submitted during the quarter. The Committee noted the work underway with regards pharmaceutical company sponsorships and the development of a policy around working with technology/digital firms and sponsorship. The Committee noted the report.

- received the Internal Audit Plan progress report which provided Committee with an update on audit activity since the last report to Committee. The report highlighted recent reviews including Fit & Proper Person Test (moderate assurance), Risk Management Core Controls (substantial assurance), and DSPT (high risk areas identified). The report highlighted the actions agreed to address gaps in FPPT checks, ESR record-keeping, and risk management training. The Committee noted the report.

• received an Internal Audit Follow-Up Summary report which provided an update on the implementation status of audit recommendations from previous reviews. No critical or high-risk recommendations were overdue at the time of reporting. The report highlighted that the ICB was demonstrating good progress in implementing actions. The Committee noted the report. • received the Anti-Fraud Progress Report for the ICB which outlined that all areas of the anti-fraud work plan are progressing as planned. The report further outlined to Committee members that staff training on fraud was at 85.5% compliance and provided details on the new 'failure to prevent fraud' offence highlighted, with measures being developed to ensure compliance. No significant losses or recoveries were also reported. The committee discussed the complexity of fraud cases, the importance of prevention, and the need for benchmarking data on return on investment in fraud prevention activities. A change in the counter fraud team to support the ICB was announced, with plans for continued reporting and scrutiny. The Committee noted the report • received a report which contained feedback from the NHS Counter Fraud Authority (NHSCFA) following the May 2025 Counter Fraud Functional Standard Return (CFFSR) submission. The report highlighted that nationally that fraud prevention had increased by 17% from the previous year, fraud recovery increased by 140% from the previous year and criminal sanctions increased by 65%. The report highlighted the effective joint working and collaboration across the NHS counter fraud community, including NHSCFA. The Committee noted the report. • received the External Auditors progress reports which provided an update on external audit responsibilities, confirming completion of all the deliverables within the 2024-25 audit and outlined plans for the 2025-26 cycle. The report provided sector updates No significant issues were reported. The Committee noted the report.
Assure
n/a

The next meeting of the Committee is scheduled for **02 December 2025.**

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 September 2025

Highlight report of the Chair of the System Primary Care Committee

Agenda Item No: ICB/07/25/10

Committee Chair: Mike Burrows, Non-Executive Member

Highlight report of the Chair of the System Primary Care Committee

Committee Chair	Erica Morriss
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	15 July 2025, 01 August 2025

Key escalation and discussion points from the Committee meeting

Alert

- **M4 – Pharmacy Budget** - Agreement from FIRC that the SPCC meeting in October will include a deep dive on this budget with the focus on what can be achieved in addition to existing efficiency plans through the help and support of the attending Contractors. Head of Pharmacy Susanne Lynch will lead the review.

Advise

- At the Meeting held on 15 July 2025 a Local Enhanced Service was approved for access to Tirzepatide (Weight Loss Medication) in line with ICB procurement and NICE Guidance.

- At the Meeting held on 01 August 2025 the Committee were updated on the development of an Enhanced Service for the treatment of adults with ADHD, subject to further discussion in relation to finance and a potential phased approach – this issue was further discussed at the main Committee meeting in August when the phased approach was agreed but further finance discussions were still ongoing and to be agreed through FIRC.

- **Governance and Risk** – the Committee agreed a re-categorisation and drafting of key risks against each contractor group, organised thematically – Estates, Workforce, Finance and Digital – and the recommendation to step down to the Committee BAF risk P6, which will be subject to Board agreement. These risks will now be developed further into the full templates and return to the committee in December for agreement. As part of the discussion around these items, system challenges around demand were recognised which should be reflected in the ICBs approach to risk mitigations moving forward.

- **Strategic Priority Area – Neighbourhood Health** - The Committee discussed the importance of primary care in this major policy area and there was an update on some of the key asks and work currently underway. There was discussion as to the overall governance of this within the ICB across place and system - and some further thoughts/assurance requested as to the role of this Committee in oversight of this area.

- **Strategic Priority Area – Access to General Practice**
- **Patient Experience**

  The Committee received an update on actions to support improved access to general practice including the recently submitted 'June Plan' required by NHS England, noting there were no further immediate asks in this respect – but the ICB were awaiting the subsequent reporting to NHS England commence. Two major

areas of patient experience were presented – the GP Patient Survey and local Healthwatch survey, both of which had previously been reported to this Board. Specific actions regarding outlier/variation would be picked up as part of the 'June Plan' work, and a further update on GP Access would be received at the December Committee meeting.

- **Estates –** An approach to service charges was discussed and agreed

- **Escalation from Place –** A contract for 10 years for an APMS (Alternative Provider of Medical Services) was agreed, having been through due process at place and via procurement processes.

- **Digital – Blinx Paco** – The findings of the pilot report were presented and discussion around support for this to be rolled out further with ICB funding – it was agreed that further engagement was required and another meeting would be held in September to make this decision.

Assure

- **Primary Care Quality –** The Committee received an update on primary care quality which covers all four contractor groups, noting that general practice/medical issues are managed at place. The development of a single set of indicators for medical quality was supported but further discussion was requested in relation to vaccinations/immunisations where for example further support/deep dives may be required for outbreaks – a further discussion on this will be picked up at the primary care quality meeting.

- **Primary Care Quality – When A Child Dies Framework for General Practice -** This framework has been designed to support practices to support bereaved families and was endorsed by the Committee.

- **Contracting, Commissioning and Policy Update –** Key points of the Ten Year Plan and Primary Care were highlighted as was the Dental contract reform consultation which launched on 8 July and closed on 19 August 2025.

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

Focus Area	Key actions/discussion undertaken
Access to General Practice	As above
Development Of Neighbourhood Health services	As above

Date of Next Meeting: 16 October 2025.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 September 2025

Highlight report of the Chair of the ICB Remuneration Committee

Agenda Item No: ICB/09/25/12

Committee Chair: Tony Foy, Non-Executive Member

NHS
Cheshire and Merseyside

Highlight report of the Chair of the ICB Remuneration Committee

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	25 July 2025

Key escalation and discussion points from the Committee meeting
Alert
n/a
Advise
The Remuneration Committee at its 25 July 2025 meeting: • received a report considering a VSM Pay Uplift request from an individual Director. Following consideration of the paper the Committee did not approve the pay uplift request, citing fairness, equity, and affordability. The decision was consistent with that made at the Committees previous meeting where the Committee decided not to apply the 3.25% VSM pay uplift for 2025/26 at this time for all of the ICBs VSMs, due to the ICB's significant financial challenges, likely redundancies, and the need to demonstrate financial leadership and control. • received an update report on the proposed structure of the new Executive Team for the ICB with their associated Directorate structures and the timeline for progressing consultation with staff affected, as well as the proposed process. The Committee noted the report. • received an update report on the work underway to appoint a new Chair to the ICB. The Committee was informed of the process being undertaken to appoint an external recruitment partner to support the ICB as well as the NHS England requirements for the ICB to adhere to in running an appointment process. The Committee was also informed of the process required if the ICB was to appoint an acting Chair for the time period following the departure of the current Chair and start date of the new Chair leaving. The Committee noted the report.
Assure
n/a

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

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 September 2025

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

Agenda Item No: ICB/09/25/13

Committee Chair: Raj Jain, ICB Chair

NHS
Cheshire and Merseyside

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

Committee Chair	Raj Jain
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	13 August 2025

Key escalation and discussion points from the Committee meeting

Alert

- n/a

Advise

The Children and Young Peoples Committee at its 18 August 2025 meeting:

- received its Single Line of Sight report which provided to Committee members an update on key programme of work by the various partner agencies across Cheshire and Merseyside working with Children and Young People (CYP). The Committee discussed in detail some of the issues services are facing in relation to CYP with mental health problems coming through services, health neighbourhoods, and winter plans. The Committee noted the report.

- received a report which provided detail on the CYP mental health spend across Cheshire and Merseyside. The report highlighted that there has been a year on year growth in funding however the spend per head is still lower than the national average. The Committee discussed the challenges to CYP services at a time where budgets are being reduced due to the financial environment across the ICB, and concern was raised regarding impact on VCFSE services and CYP themselves. The Committee also discussed the importance of ensuring aspirations for CYP services are captured in ICB discussions around commissioning intentions. The Committee noted the report.

- received a verbal report on the Youth in Mind programme that is run out of the Youth Zone in Warrington, and which is a support service that is accessible for all children from age 7 up to 19 and if with additional needs up to the age 25. The Committee heard how the staff in the service are trained, interact with and provide support to CYP who make contact and how support is provided to access other services where needed. The Committee discussed the service and whether the model could be adopted across other areas in Cheshire and Merseyside, noting the funding challenges. The Committee noted the report.

- received an update report on the Gateway work underway across Cheshire and Merseyside and which is a multi-agency framework in designed to address complex unmet needs of young people by enabling timely, person-centred action through structured, cross-professional discussions. Committee members heard about the evaluation of the service and evidence showing how it had contributed towards cost avoidance as well increased engagement by professionals. Committee members heard about the work around continuous improvement, the proposal to create a complex needs forum which would report to the Committee. The Committee requested that members consider the proposed TOR and for it

some back to the Committee for further discussion. The Committee noted the update report.

- received a report on the All Together Smiling programme, a supervised toothbrushing initiative across Cheshire and Merseyside. Committee members heard how this programmme which targets children in areas with high levels of dental decay, was progressing and how it estimated that in its first quarter of operation that nearly 11,000 children had benefitted from the programme. The Committee discussed the importance of the scheme, how well it was being received, how it needed to be linked to the new national funding Loal Authorities had received for such programmes and how it could be enhanced to maximise its impact. The Committee noted the report.

- Received an update on the recent publication of the BEYOND Annual report, which outlined the impact and outcomes of the programme. It was noted that this programme heavily involves and is influenced by CYP and is continuously adapting. The Committee noted the excellent work that the programme has undertaken over the last four years and noted the report.

Assure

n/a

The next meeting of the Committee is scheduled for **08 October 2025.**

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 September 2025

Highlight report of the Chair of the North West Specialised Services Joint Committee

25 September 2025

Agenda Item: ICB/09/25/14

Committee Chair: Dr Ruth Hussey

Leading integration through collaboration

Highlight report of the Chair of the North West Specialised Services Joint Committee

Committee Chair	Dr Ruth Hussey
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/media/ev1dushd/2024-25-nw-sp-jc-terms-of-referencev14-final.pdf
Date of meeting	04 September 2025

Key escalation and discussion points from the Committee meeting

Alert

- Findings of the NHS England review of roadmap for integrating Direct Commissioning functions into Integrated Care Systems has concluded the following:
  - No additional/new delegation to ICBs
  - Transfer of accountability and responsibility for most of Specialised Commissioning; Health & Justice commissioning; and Screening and Immunisation commissioning to ICBs on 1 April 2027
  - Creation of an 'Office of Pan-ICB Commissioning' (OfPIC) in each region to be hosted by one of the ICBs in the region.
  - Running Cost Allowance for the OfPIC expected to be published shortly.

Advise

- Joint committee made decisions relating to the successor arrangements for current contracts for Mental Health Lead Provider Collaboratives which expire in 2026 covering Adult Eating Disorders; Tier 4 CAMHS; Perinatal Mental Health; and Low and Medium Secure Mental Health.
- Joint Committee endorsed revisions to the programme timeline for work to transform Neonatal Critical Care services to achieve new volume based standards.
- Joint Committee agreed to initiate a provider selection process for Autologous Chondrocyte Implantation/ Osteochondral Allograft
- Joint Committee noted progress on securing an interim Adult Critical Care Transport service in advance of a formally procured service from April 2027.

Assure

- Joint Committee received an update on work to investigate an unplanned market entrant into the CAMHS market and received assurance that this provider was not undertaking services that fell within scope of the Specialised Services National Definition.
- Joint committee received an update on the work being undertaken to unpick the block elements of Acute Contracts that were instigated as part of the COVID interim financial regime.

Committee risk management, reporting and escalation

The following risks with a score of 16 and above were reported to the Committee in accordance with the agreed Specialised Commissioning risk management, reporting and escalation Standard Operating Procedure.

Risk Title
Risk discussed included: • Reform of NHS England • Risk that premature babies will have avoidable lifetime visual disability due to lack of Retinal screening in neonatal units across the NW. • Patients unable to access mechanical thrombectomy at LTH OOH and at weekends as the provider is unable to offer a weekend and OOH service • Avoidable inequalities, poor outcomes and harm associated with non compliance with neonatal service standards • NHSE Gateway 2 being further delayed for NW Safe and Sustainable(SAS) Babies & Children Transformation Programme • Risk of challenge against NW SAS Babies & Children Transformation Programme • The hub is unable to provide a safe and effective service as set out in the Target operating model for Delegated Service Commissioning • Due to the number of vacancies within the finance team, unless there is the ability to recruit to the retained and delegated staff vacancies, there is not the critical mass to have separated NW delegated and a North retained finance teams from 1 July 2025. • The cost of commissioning adult secure services for GM resident population from the 1 April 24 is more than the LPC recurrent allocation for 2024/25 and cannot be met from within the MH Specialised commissioning allocation. • Inability of Specialised Services providers to meet demand and deliver the required activity to reduce waiting times and achieve required RTT improvements, which could result in patient harm. There is a risk that the recovery and delivery plans for these improvements in Specialised Elective Care may not be achieved.

Specialised Commissioning Programmes and Areas of Focus

Service Programme / Focus Area	Key actions/discussion undertaken
Regional Director Update	Andrew Bibby (AB) provided a comprehensive update on the evolving commissioning landscape following the planned abolition of NHS England. Key points included: • Full transfer of specialised services, Section 7A (vaccinations/screening), and Health & Justice commissioning to ICBs by 31 March 2027. • Introduction of Offices of Pan-ICB Commissioning (OfPIC) to promote consistency and efficiency. • Funding to be allocated via a fair share formula. • A new neurology service specification is proposed for April 2026, which is raising regional concern due to cost implications. • National team visits to joint committees have been beneficial Action 48: Invite national colleagues to a future meeting.
ICB update	• KS reported resolution of concerns around a children's mental health service. • Delay in decision on major trauma configuration to assess financial impacts. • CH confirmed governance arrangements and raised the need for monthly finance reporting. • FL acknowledged Simon Kendall's support in resolving paediatric neurology issues.
Items for decision/endorsement	Several decisions were made regarding Mental Health LPCs: • **Adult Eating Disorders LPC**: Extend contract by one year; direct award for 2027/28. • **Tier 4 CAMHS LPCs**: Develop federated model; direct award for 2027/28. • **Perinatal Mental Health LPCs**: Integrate GM footprint into LSCFT LPC; direct award.

Service Programme / Focus Area	Key actions/discussion undertaken
	• **Adult Secure Services LPCs**: Proceed with two LPC footprints (GM & C&M, LSC); three-year contracts. • **Adult Critical Care Transfer Service**: Interim contract until March 2027; procurement discussions ongoing. • **OCA/ACI Procurement**: Move to full open procurement; approved.
Quality Update	• **MRSA outbreak** at Manchester Oxford Road under review; ribotyping results pending. • **CQC review** of thrombectomy incidents at Lancashire Teaching Hospital. • **CAMHs provider visit** confirmed Tier 3 service status; environment improvements planned. • **SSQD Development**: Improved data access via Model Hospital and Opera; mental health data more timely.
Finance Update	• All contracts agreed except Northern Care Alliance NHS Foundation Trust. • National costing exercise underway; GM piloted. • Q1 shows surpluses in C&M and LSC; GM under pressure due to independent sector usage. Action 49: ICB finance leads to ensure specialised commissioning budgets are reflected in recovery systems.
Risks	No new risks were highlighted.
Women's and Children's programme Timelines	• Collaborative work with C&M team on configuration timelines. • Patient engagement for neonatal services to launch in October. • FL raised need for a maternity review alongside neonatal review in Cheshire & Merseyside.

Service Programme / Focus Area	Key actions/discussion undertaken
	• Welsh neonatal activity stable; ongoing dialogue with Welsh colleagues.
Focus on: - Internal Medicine Programme of Care - Overview, Transformation and Improvement Programmes	• LS and FSJ emphasised prevention opportunities in cardio-renal-metabolic conditions. • Integration into ICB commissioning and early intervention are key priorities. • RH requested annual updates on progress of the transformation activities.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 September 2025

Highlight report of the Chair of the Women's Hospital Services in Liverpool Committee

Agenda Item No: ICB/09/25/15

Committee Chair: Prof. Hilary Garratt, CBE

Highlight report of the Chair of the Women's Hospital Services in Liverpool Committee

Committee Chair	Prof. Hilary Garratt, CBE
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	09 July 2025

Key escalation and discussion points from the Committee meeting
Alert
N/A
Advise
The Committee considered the following at its meeting on 09 July 2025: **Options Appraisal Process** Feedback from Workshop 2 There was good attendance at the workshop with representation from across the relevant clinical services. Contributions and engagement were excellent, and the group were worked hard in what is complex subject matter. There was excellent engagement from clinicians, the lived experience panel, Healthwatch and voluntary sector groups; contributions have helped to refine the longlist options. Some options were removed based on the feedback received. **Lived Experience Panel Member Update** One of the Lived Experience Panel Members attended both workshops and the Committee meeting; they felt the process was fascinating, commenting that there was a lot of consistency on the day, with all the working groups coming up with similar views about the potential long list of options. **Longlist Discussion** The Independent Clinical Programme Lead presented the long list of options that were under consideration at the workshops and talked through some of the clinical pros and cons. At Workshop 2 the long list of options was evaluated against the previously agreed evaluation criteria. There was a discussion about the further work required to develop the clinical detail and financial impact of each of the long-list options. The Programme Board will be working with clinicians over the summer to refine the detail of the options and will bring recommendations for the short list of options to the next Committee meeting. **The Committee noted for assurance the work undertaken in the Options Appraisal Process including feedback from workshop 2, LEP member update, longlist discussion and work in progress.**

Assure

The Committee considered the following:

Programme Update

The Chair of the Programme Board provided an update which included -

An update from workshop 2.

Detailed discussions with clinical teams are underway to clarify clinical models for critical care, emergency care and neonatal, and to further understand the data about higher risk women. This will inform the workforce and financial modelling for the long list.

Reassessment of previous estates work is underway; assumptions have changed since the last time this work was completed. The LUHFT estates team are supporting.

Mersey Internal Audit Agency are currently supporting the financial modelling work.

The Committee noted the programme update and progress made since the last meeting

Clinical Engagement

A workshop is taking place on 13th August with LUHFT and LWFT clinicians to explore and test options further. The wider clinical reference group (CRG) will be reconvened for an update on the options process and to undertake further validation work on the potential options.

The Committee noted the update.

Programme Risk Register -

No new risks have been added to the risk register. Risk 6 concerning onsite clinical safety, has been reviewed by the LWH team, and the risk score remains at 20. The scoring of Risk 7, concerning programme delivery during upcoming NHS changes, has been reduced from 20 to 16.

The Committee noted the update.

NHS
Cheshire and Merseyside

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

25 September 2025

Cheshire and Merseyside Urgent and Emergency Care Improvement Update

Agenda Item No: ICB/07/25/16

Responsible Director: Dr Fiona Lemmens
Deputy Medical Director

Mandy Nagra
Chief System Improvement and Delivery Officer

Cheshire and Merseyside Urgent and Emergency Care Improvement Update

1. Purpose of the Report

1.1 To update the Board on the approach to recovery and improvement in Urgent and Emergency Care (UEC) for the population of Cheshire and Merseyside.

2. Executive Summary

2.1 The Board receives information on the system urgent and emergency care performance through the regular integrated performance report. At the board meeting in July 2025 the board requested a more detailed presentation of the activities being undertaken to improve UEC performance in Cheshire and Merseyside in order to achieve our overarching aim of reducing corridor care by 50% by March 2026, deliver performance improvements in line with the national UEC plan, improve value for money from UEC services, and importantly to improve outcomes and experience for our population.

2.2 This paper and supporting presentation (Appendix One) provide an update on the work being undertaken to improve the urgent and emergency care system in Cheshire and Merseyside. The paper outlines the new, strengthened oversight and governance arrangements that have been designed to bring system partners together to collectively improve the UEC system. It sets out the continuous improvement approach being established and the ambitions of the UEC improvement Group. The paper also provides the Board with an overview of the system UEC Improvement Plans, how they are being monitored and highlights areas where the improvement plans have shown benefit.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- Note the strengthened governance arrangements for urgent and emergency Care
- Provide feedback on the UEC improvement plans outlined in the paper
- Support the continuous improvement approach to UEC recovery.

4. Officer contact details for more information

Dr Fiona Lemmens
fiona.lemmens@cheshireandmerseyside.nhs.uk

5. Appendices

Appendix One: Cheshire and Merseyside Urgent and Emergency Care Improvement update

NHS
Cheshire and Merseyside

Cheshire and Merseyside Urgent and Emergency Care Improvement Update

ICB Board

24th September 2025

This update will provide the board with information on

1. How we are organising and governing our UEC Improvement Programme.

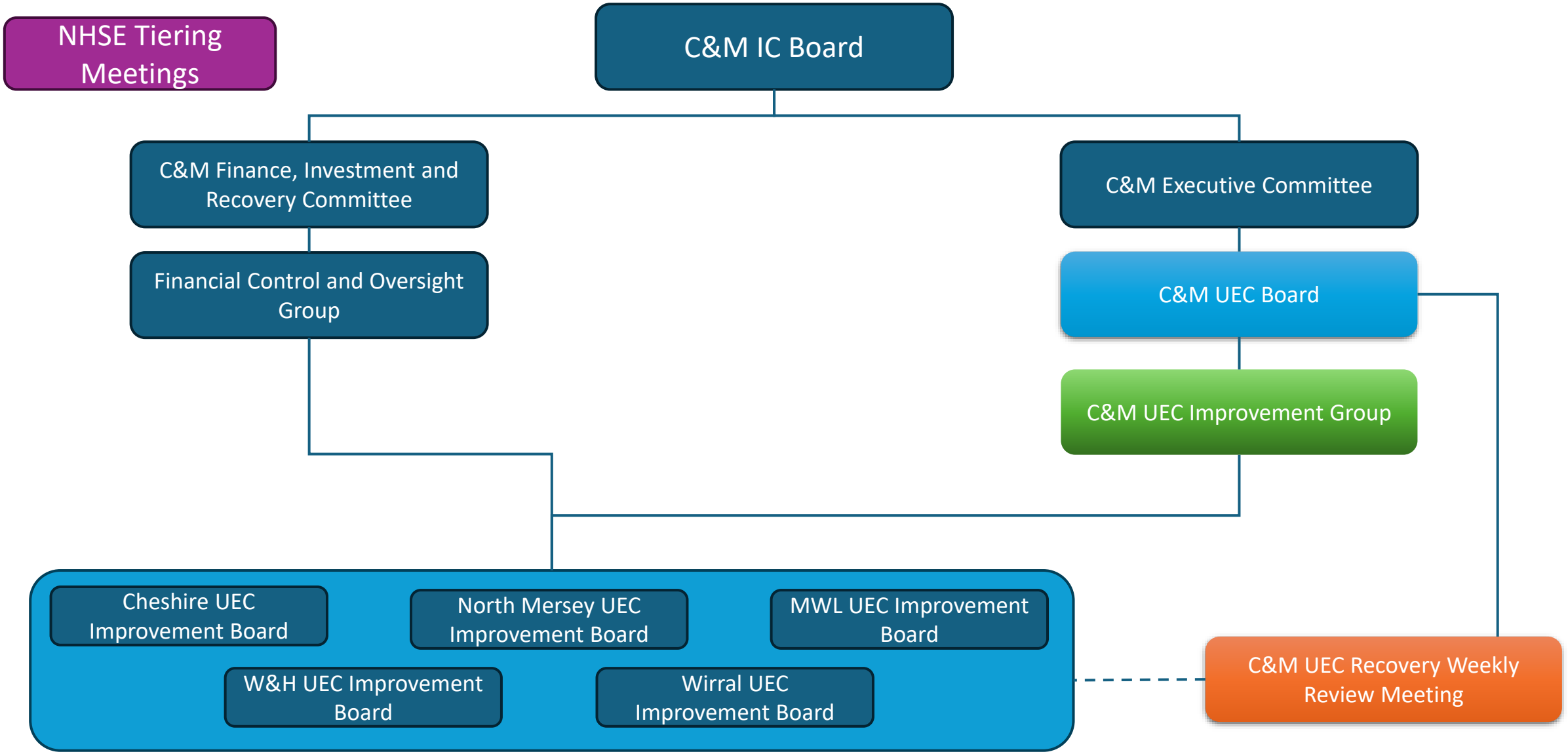
2. Our overarching UEC Improvement approach and ambition based on the NHS IMPACT principles.

3. Our UEC improvement plans and how we are monitoring improvement

4. Some of the progress we have made so far

C&M UEC Oversight & Governance

NHS
Cheshire and Merseyside



C&M UEC Oversight & Governance

NHS
Cheshire and Merseyside

System Control Centre Lead: Claire Sanders AD of UEC operations and Improvement.
Day to day management of UEC system

Review and Recovery meeting : weekly Chair Mandy Nagra
Whole system, triumvirate attendance
Review of weekly 4 hour, 12 hour, NCTR, ambulance handover performance

UEC Improvement Group: fortnightly Chair Fiona Lemmens
Programme SROs and improvement experts
Oversight of system improvement plans
Fostering an improvement culture and driving a consistent improvement approach

UEC Board : monthly Chair Mandy Nagra
Whole system, CEO, COO, DASS and clinical attendance. All organisations represented.
Strategy, oversight & assurance

FCOG Chair Mandy Nagra
Review of financial performance and CRES plans in UEC system

Winter Planning Anthony Middleton

Working with Sam James and Performance team at NHSE NW to ensure alignment with new **National Tiering** approach and consistency of focus and concentration of improvement support.

NHS
Cheshire and Merseyside

Aims of the UEC Improvement Group

The Urgent and Emergency Care (UEC) Improvement Group exists to bring the whole system together to:

- **Provide System Oversight** – coordinate and oversee delivery of the UEC Improvement Programme, ensuring alignment with national standards, local priorities, and the wider health and care strategy.
- **Foster an Improvement Culture** – embed continuous improvement methodology across all partners, encouraging collaborative working, innovation, and problem-solving.
- **Share Best Practice** – create a forum for learning by sharing what works across localities, providers, and sectors, reducing unwarranted variation and accelerating adoption of proven approaches.
- **Promote Consistent Improvement Approaches** support partners to use common improvement frameworks, tools, and metrics to enable comparability and collective progress.
- **Build Energy and Momentum for Change** – engage clinical, operational, and system leaders in a shared mission, creating enthusiasm, ownership, and accountability for improvement.
- **Ensure Value for Money** – maximise use of resources by aligning investments, minimising duplication, and focusing on interventions that deliver measurable impact.
- **Improve Safety and Outcomes for Patients** – ensure that all improvement efforts ultimately deliver safer, more effective, timely, and person-centred urgent and emergency care.

Aligned to NHS IMPACT

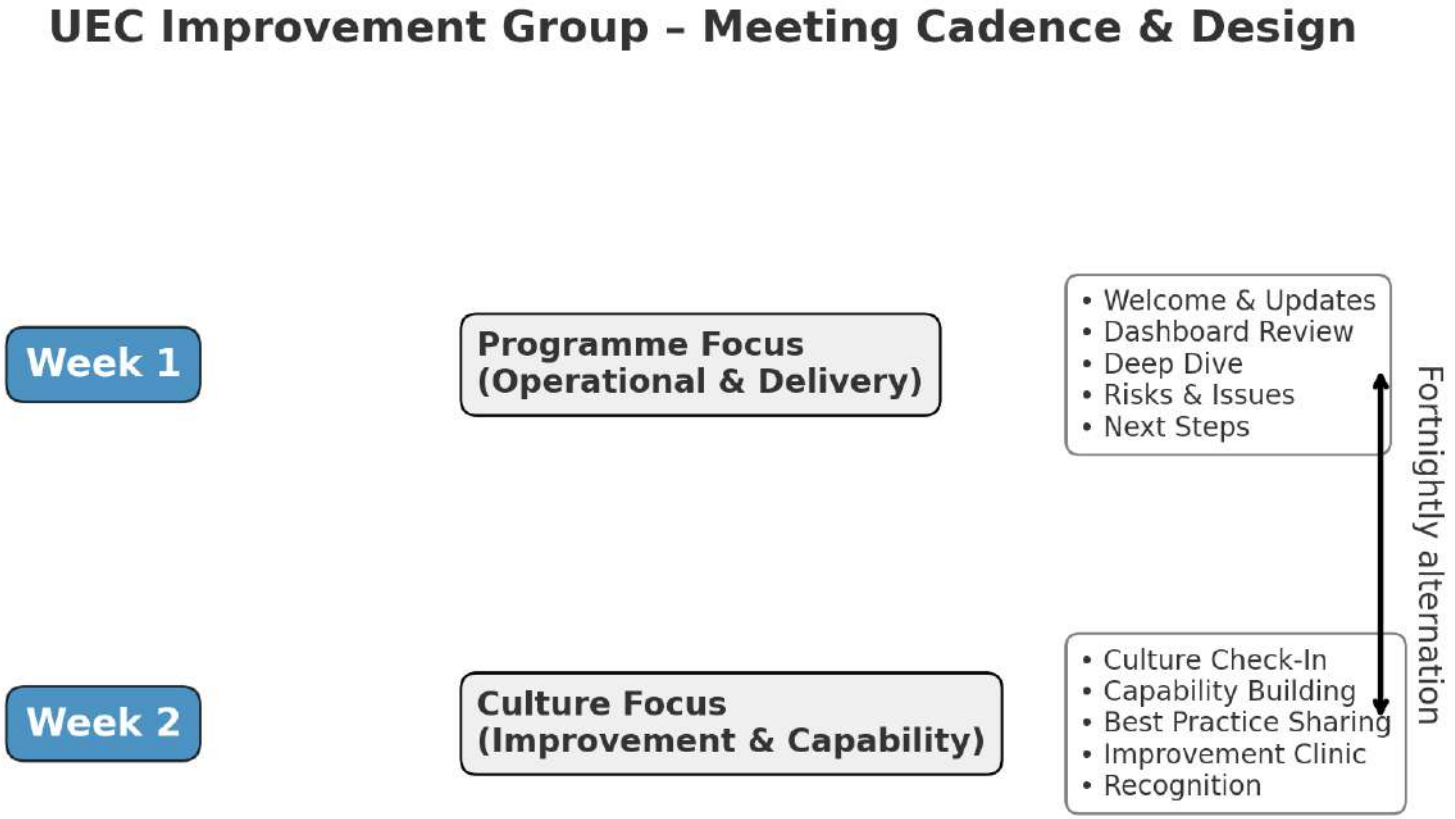
NHS England » NHS IMPACT

UEC Improvement Group
Meeting design and cadence

NHS
Cheshire and Merseyside

Fortnightly meetings alternating between:

- **Programme Focus** (operational delivery, performance, milestones)
- **Culture Focus** (building improvement capability, behaviours, and sustainability)



Improvement Group Ambitions: Energy-Building Activities

NHS Cheshire and Merseyside

Knowledge Hub / Repository

Single platform where all tools, presentations, minutes, and case studies are stored and searchable.

"What works well" case studies uploaded from each trust or locality.

Lunch & Learn Sessions

Short (30-45 min) informal sessions spotlighting:

- External SMEs (e.g., ECIST, NHSE Improvement, NWAS ops leads).
- Internal exemplars (trusts with recent HO45 or 4-hour breakthroughs).
- Broader system innovations (frailty, discharge, digital flow).

System Learning Events

Quarterly **UEC Improvement Assembly** bringing together all Places, with thematic workshops.

In reach to locality programmes to support improvement activites.

Recognition & Celebration

Regular **"Spotlight on Success"** in meetings/newsletters.

Recognition certificates for teams showing measurable improvement.

Publish **monthly "quick wins" bulletin** highlighting small but meaningful changes.

Practical QI Support

Access to a **QI toolkit** (driver diagrams, run chart templates, Lean observation guides).

Offer "Improvement Clinics" for teams to bring real problems and co-design solutions with peers.

Cross-System Mentorship

Peer-to-peer buddying between high-performing and challenged sites.

Draw upon CAMIN as a Faculty of "Improvement Fellows" drawn from across trusts and community services.

Improvement Group Ambitions

Building improvement culture as a programme in its own right

Signal importance – it isn't an "add-on" but as critical as delivery of the UEC plan.

- **Give it structure** – with its own SRO, milestones, measures, and governance.
- **Secure resources** – programme management, faculty, time.
- **Create visibility** – colleagues see "culture change" as tangible, trackable, and celebrated.

Governance & Alignment

Establish a **dual-track structure**:

Track 1: UEC Improvement Programme (operational, performance, national standards).

Track 2: Improvement Culture Programme (capability, behaviours, sustainability).

Both programmes report into the **UEC Improvement Board** and the ICB Quality & Performance Committee.

Assign an **Improvement Culture SRO** to mirror the UEC Programme SRO.

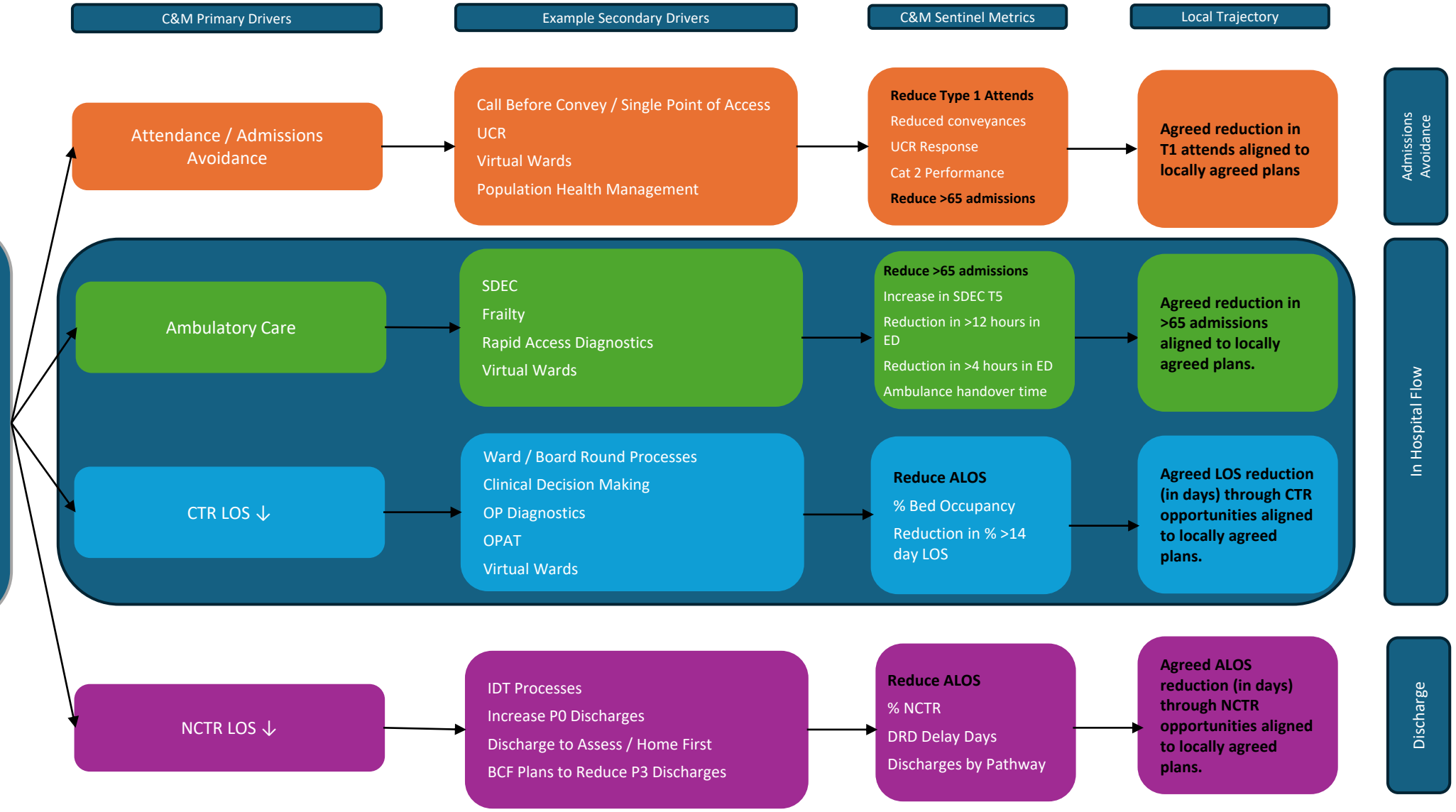
Once established this can be a blueprint for improvement approach in other / all ICB programmes

C&M UEC Improvement Programme Plans

NHS Cheshire and Merseyside

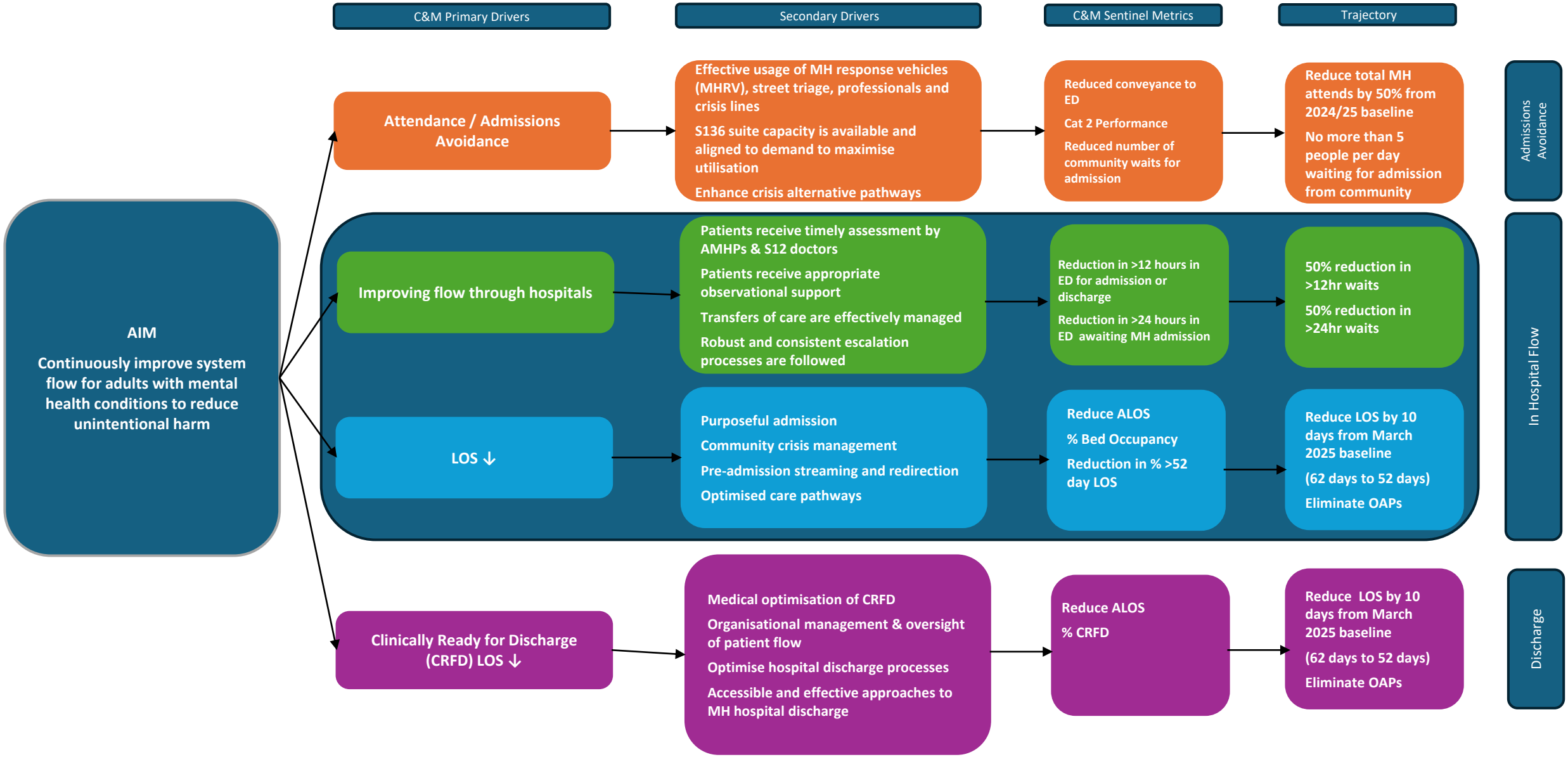
SYSTEM AIMS

- Reduce corridor care by 50% by March 2026
- Deliver performance improvements in line with National UEC plan 2025/6
- Improve value for money from UEC services.



Mental Health System Plan

NHS Cheshire and Merseyside



Cheshire & Merseyside UEC Improvement Plan: FRAILTY

***draft in progress**

NHS Cheshire and Merseyside

This plan outlines a coordinated, system-wide approach for Cheshire and Merseyside to enhance outcomes for people living with frailty. It is aligned with the national FRAIL strategy and supports local system priorities, focusing on:

Prevention – reducing the risk and impact of frailty through proactive population health measures.
Early intervention – identifying and supporting individuals at the earliest opportunity to maintain independence.
Reversing frailty – proactively identify people whose frailty symptoms have the potential to be reversed and putting interventions in place to achieve reversal
Timely crisis response – ensuring rapid access to appropriate care and support during episodes of deterioration.
Rehabilitation – promoting recovery and restoring functional ability following illness or injury.
Long-term support – enabling sustained wellbeing through coordinated, person-centred care.

The plan sets out actions across three-time horizons:
Short-term – measures to address winter pressures and immediate service demands.
Medium-term – service transformation to strengthen pathways and integrate care delivery.
Long-term – building a sustainable, community-based model that fully integrates with wider health and care services

OBJECTIVES Short Term (0–6 months – Winter Pressures)

1. Boost front-door frailty capacity
- Maximise Frailty SDEC utilisation
- Achieve frailty screening within 30 minutes of ED arrival.

2. Prevent avoidable admissions
- Maximise *Call Before Convey* (CB4C) and *Single Point of Access* (SPOA) redirection of patients to frailty pathways without ED conveyance.
- Ensure all SPOAs include access to frailty pathways.
- Fully utilise front-door frailty streaming to trigger early comprehensive geriatric assessment.

3. Targeted prevention blitz
- Undertake rapid polypharmacy reviews for the top 200 high-risk patients per Place (To be agreed with Meds management lead)
- Deliver multifactorial falls assessments with direct access to intervention.

4. Strengthen discharge-to-assess
- Prioritise frailty cases with reablement needs.
- Embed discharge planning across the whole patient journey from earliest opportunity, engaging patients and families to reduce length of stay.
- Refresh existing deconditioning prevention programmes across acute trusts.
- Utilise discharge comms toolkit for winter

5. Asset mapping

- Map out frailty services across NHS Community and Acute providers, including (but not limited to) falls pick-up services, frailty-at-the-front-door / frailty SDEC services and care home services
- Collect quantitative and qualitative evidence about the impact of existing services
- Develop target operating model for system frailty services

OBJECTIVES Medium Term (Aligned to planning round 2025/26)

1. Embed frailty identification system-wide
- Implement standardised frailty screening in primary care, community, ambulance, and acute settings.
- Introduce a frailty 'flag' in the shared care record, accessible to all providers.

2. Scale Urgent Community Response (UCR)
- Embed standard UCR service specification, with a focus on increasing consistency in offer and in the rate of accepted referrals per weighted population.
- Link UCR provision to care home in-reach and GP rapid access services.

3. Integrated rehabilitation & reablement model
- Enable seamless transfers from hospital to community rehab beds or home-based therapy.

4. Workforce development
- Provide frailty training for 100% of front-line staff in ED, ambulance, primary care, and community teams.

5. Cancer pathway integration
- Develop, agree, and commence implementation of frailty assessment and management guidance for patients with suspected or diagnosed cancer.

6. End of life pathway integration
- Improve identification of people who may be in their last year of life
- Increase the number of end-of-life patients who have care plans in place, using EPACCS and / or Advanced Care Planning

Proposed metrics Once finalised, metrics trajectories and associated financial benefits will be developed.

Metric Type	Metric	Target
Process	% patients screened for frailty within 30 mins of arrival	≥ 90%
Process	% polypharmacy reviews completed for high-risk cohort	≥ 80%
Process	% of people who die who had an end-of-life care plan in place (EPACCS or ACP)	+15%
Outcome	Reduction in non-elective admissions for patients with frailty	-10% from baseline
Outcome	Reduction in average length of stay for frailty admissions	-15% from baseline
Outcome	Reduction in non-elective admissions for patients on gold standards framework (GSF)	-5% from baseline
Outcome	Reduction in average length of stay for patients on GSF	-15% from baseline
Outcome	Reduction in people aged 65+ being discharged onto pathway 3 after an acute hospital stay	Achieve target of <5%
Outcome	Bed days as a result of a fall for people aged 65+, 75+ and 85+	Move from upper quartile to mean
Balancing	Readmission rate within 30 days	≤ 10%
Balancing	Community service caseload growth rate	Monitor

NHS
Cheshire and Merseyside

Example of Provider Trust Improvement monitoring

Each Provider Trust has a monthly improvement trajectory for 4 hour and 12 hour performance with key enabling actions. Each organisation has been assessed for delivery confidence alongside the national UEC tiering rating which determines the levels of support and scrutiny applied.
This is the focus of weekly ICB recovery meeting and NHSE tiering conversations
Example shown below

TRUST	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
4 HR	70.82	70.89	70.96	71.02	71.09	71.23	71.22	71.3	71.34	71.4	71.47	71.53
Actual	78.1%	77.7%	77.1%	77.0%								
12 HR	16.43	15.93	16.67	16.63	18.02	16.68	15.96	15.74	16.38	16.31	16.24	16.17
Actual	17.7%	17.5%	18.4%	18.7%								

Key enabling actions **Delivery Confidence:** HIGH / MED/ LOW

- Continuation of call Before Convey approach initiated in Q4 2024/5 supported by NWAS
- Development of SDEC models with focus on extending access 12/24, 7/7.
- Multi-agency ‘front door’ SDUCU with focus on identification of complex needs at point of attendance to start holistic care planning.
- Adopt recommendations from recent AtED audit
- Focus on ward-based processes and regular point prevalence audits through Valuing Patient Time Collaborative.
- Review of diagnostic capacity aligned to IP demand to reduce delays for IP diagnostics.
- Development of internal flow performance dashboard to provide real time management insight into internal flow KPIs down to ward-level.

Cheshire & Merseyside UEC Improvement Plan
Monitoring performance and improvement trajectories

NHS
Cheshire and Merseyside

For providers that are off trajectory for achieving 4 hour and 12 hour performance a detailed recovery plan outlining the “what by when” has been requested.

On the right is an example of a plan to recovery a Trust’s 12 hour performance

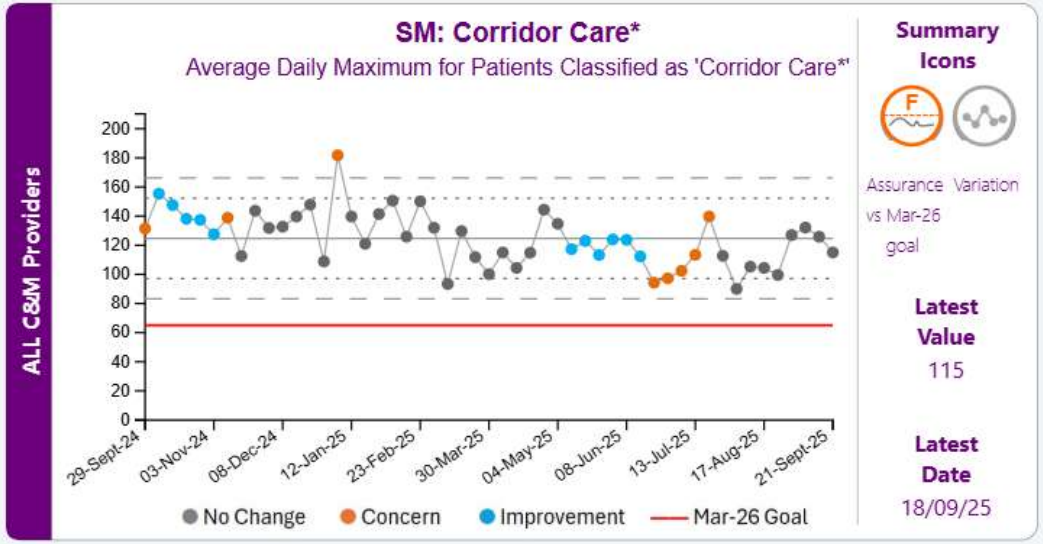
Local UEC recovery teams and the UEC improvement group will work with providers to support their recovery efforts.

Breaches prior to intervention	Timescale	
Current Position		**56.4**
DDU Phase 1	Aug-25	-3
Continuous flow and direct access to specialty beds	Aug-25	-2
Housekeeping/ quick wins (e.g. transfers on chairs not beds, real-time movement of patients, real time discharging of patients)	Aug-25	-1
Validation of 12-13 hour breaches	Aug-25	-0.5
Afternoon Discharge huddles, pharmacy support for flow and early discharges	Sep-25	-1.5
ED Triage	Sep-25	-1
DDU Phase 2	Sep-25	-4
Specialty reponse/Hot clinics	01-Oct	-1
Criteria Led Discharge/OOH Medical Cover	Oct-25	-1
Wait to be seen	01-Nov	-4
Loss of current EAU function		4.7
Breaches following intervention		42.1
Target		42

Cheshire & Merseyside UEC Improvement Plan
Examples of Progress : Corridor Care

NHS Cheshire and Merseyside

Corridor Care: C&M Provider-Specific Indicators



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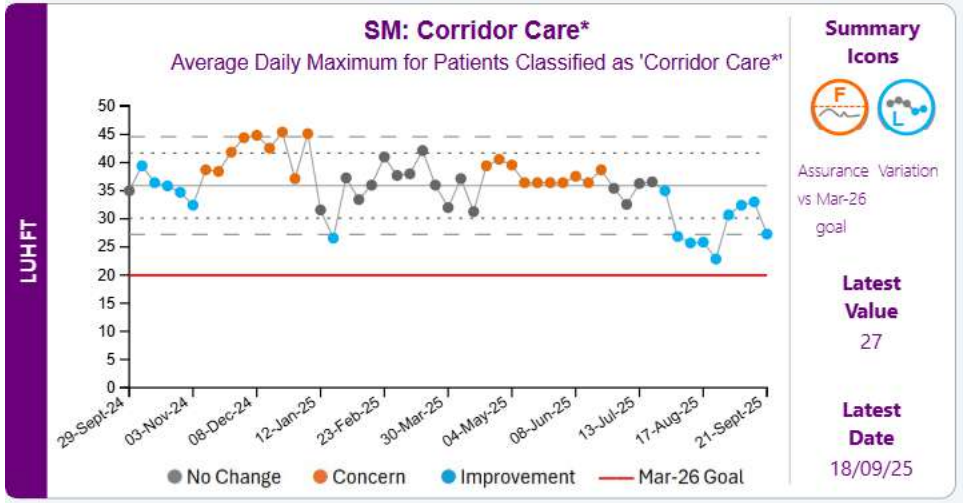
Corridor Care: C&M Provider-Specific Indicators



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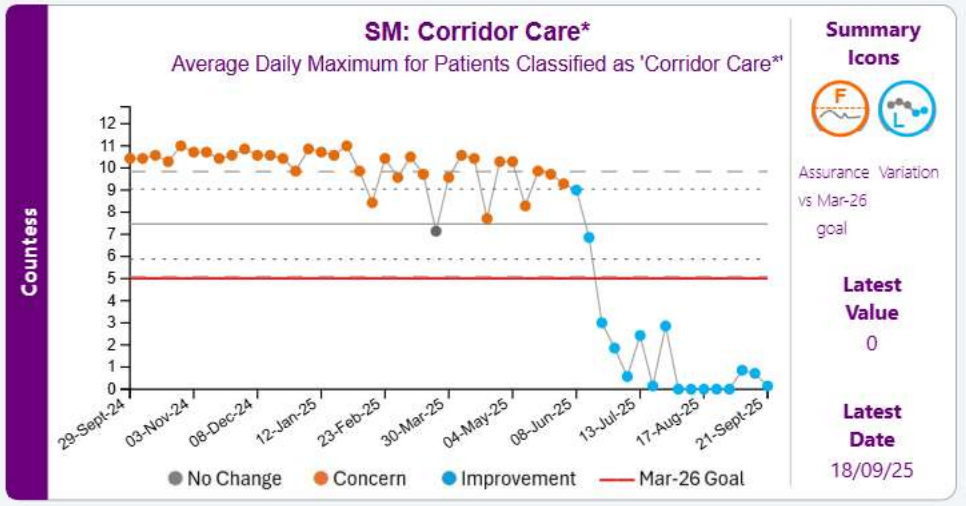
Corridor Care: C&M Provider-Specific Indicators



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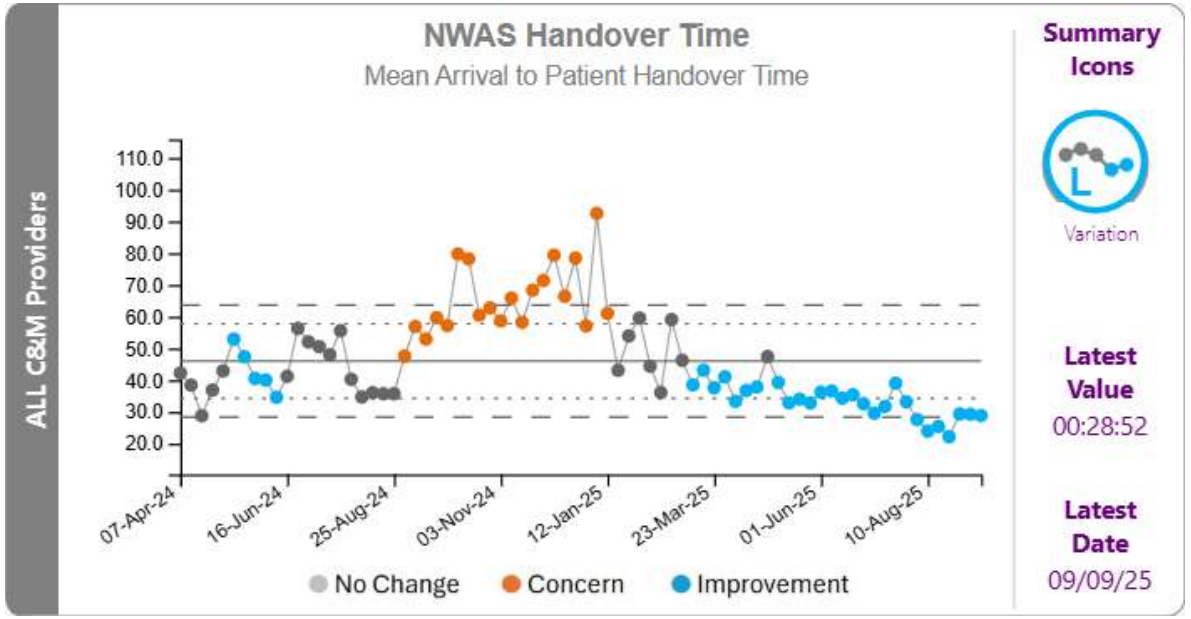
In past 12 months there has been progress on our overarching aim of reducing corridor care by 50% which suggests that the actions being taken are the right ones.

On the right are examples of strong improvement in some of our organisations but there is variation across C&M.

There is still more to do to be confident that improvement will be sustained and to increase pace of improvement ahead of winter.

Cheshire & Merseyside UEC Improvement Plan
Examples of Progress: Ambulance Handover 45

NHS
Cheshire and Merseyside



Latest variation shows consistent improvement for the C&M aggregate position since Mar-25. Mean handover time for all C&M Providers is 00:28:52.

- Countess, LUHFT, MWL and Wirral are consistent with the C&M trend, ie statistically significant improvement since Mar-25.
Mid Cheshire and Warrington have both shown statistically significant improvement over the last 11 weeks.

- East Cheshire are currently reporting no recent statistically significant change to handover time.

Handover 45 implementation

Since launch on 1st August, HO45 has:

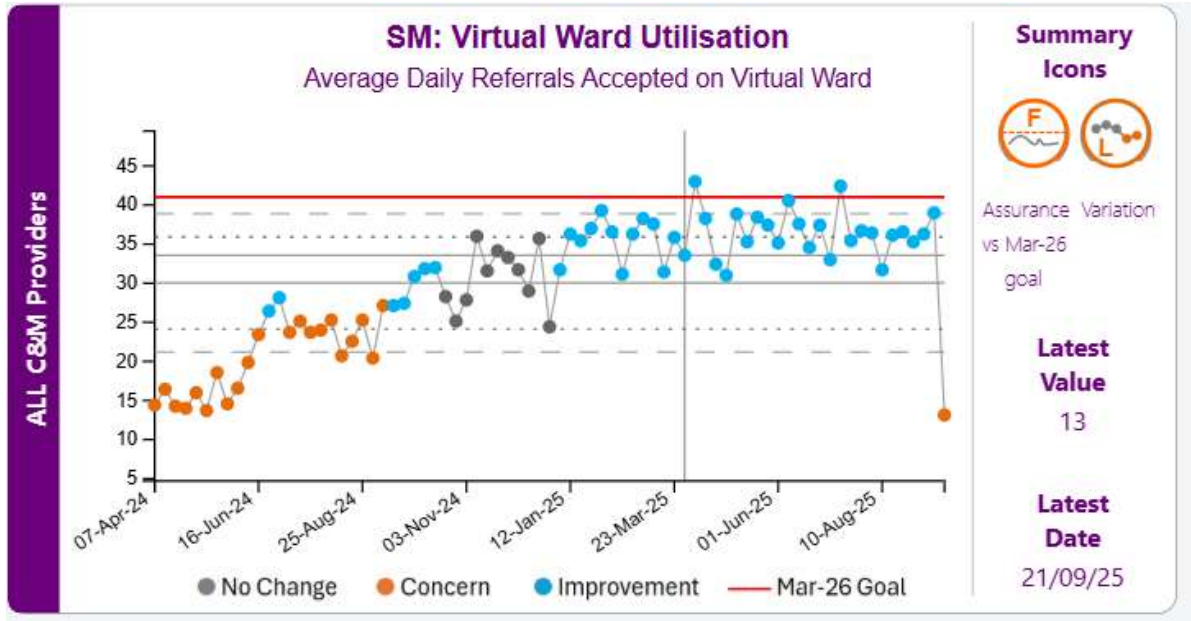
- Set a clear operational standard — maximum 45 minutes from arrival to handover.
- Introduced real-time monitoring and rapid escalation for breaches.
- Driven shared ownership between NWAS crews and ED teams for patient flow.
- Triggered downstream improvements in discharge before noon, SDEC utilisation, and inpatient flow.
- Data can now be seen in real time around handovers taken over 15,30 and 45 minutes on SHREWD allowing teams to target actions and review.

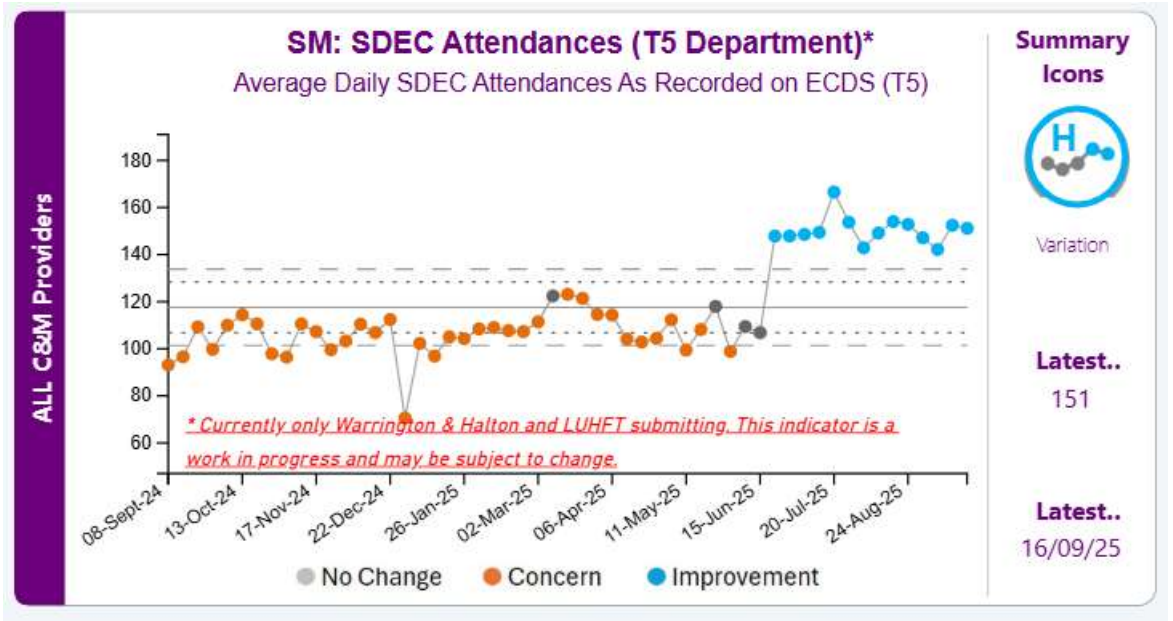
A comparison of the 6 weeks since HO45 implementation vs the same period in 2024 shows there have been notable improvements in emergency ambulance response and handover times:

- Category 1 mean response – 58 seconds faster
- Category 2 mean response – 1:31 minutes faster
- Category 2 long waits >60 minutes – reduced by 3%
- Average handover – 16 minutes faster per incident
- HAS compliance – improved to 99%
- Handovers > 45 minutes – reduced by 57%

Cheshire & Merseyside UEC Improvement Plan
Examples of Progress: Virtual Wards

Cheshire and Merseyside





The provider collaborative has led this improvement by

1. Moving from condition specific pathways to less restrictive criteria based on the right patient rather than the right condition
2. Establishing lead provider model
3. Actively sharing the learning between teams

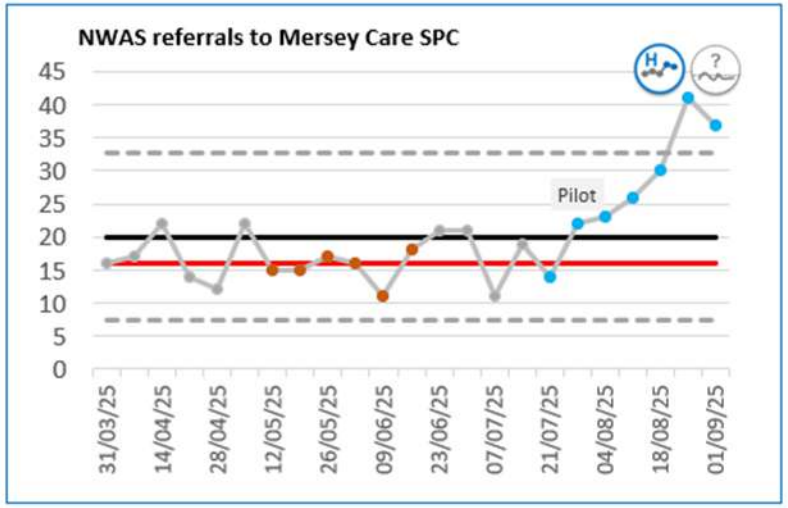
Same Day Emergency Care pathways allow patients to bypass ED and avoid admission

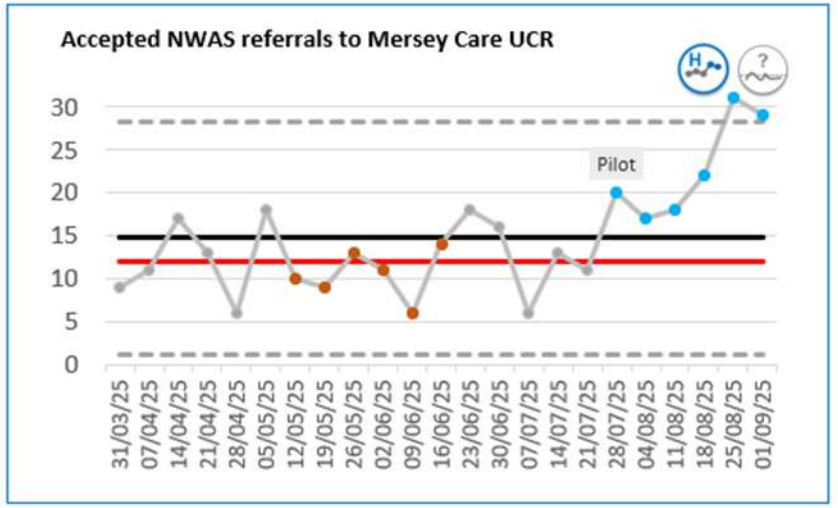
Cheshire & Merseyside UEC Improvement Plan
Examples of Progress: Single Point of Access

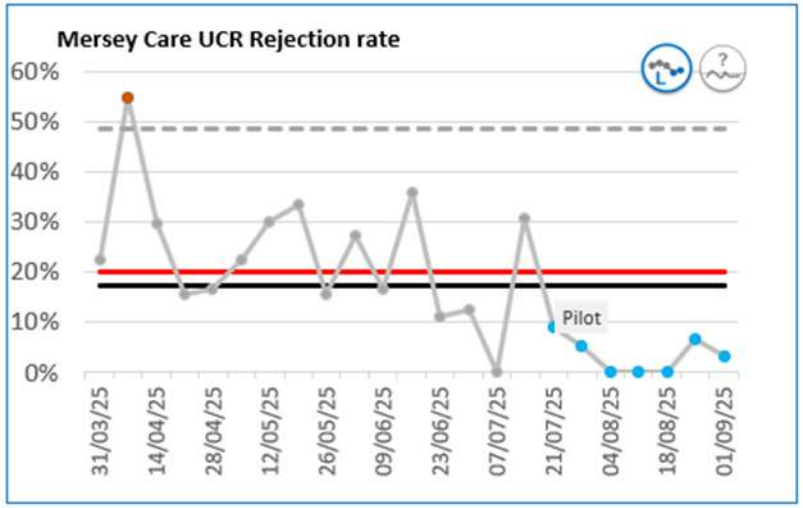
NHS Cheshire and Merseyside

The C&M Provider Collaborative has put a Single Point Of Access (SPOA) in place for NWAS crews to refer to when they have a patient who they feel could be actively managed at home rather than being admitted to hospital.
The SPOA can then refer the patient into the Urgent Care Response (UCR) service in the community. The work is aligned to another piece of work that is standardising the UCR response across C&M.

Since commencing the pilot NWAS conveyance rates have dropped below 50 % for the first time and ED arrivals for 65 year + from care homes has shown a statistically significant reduction.







Cheshire & Merseyside UEC Improvement Plan

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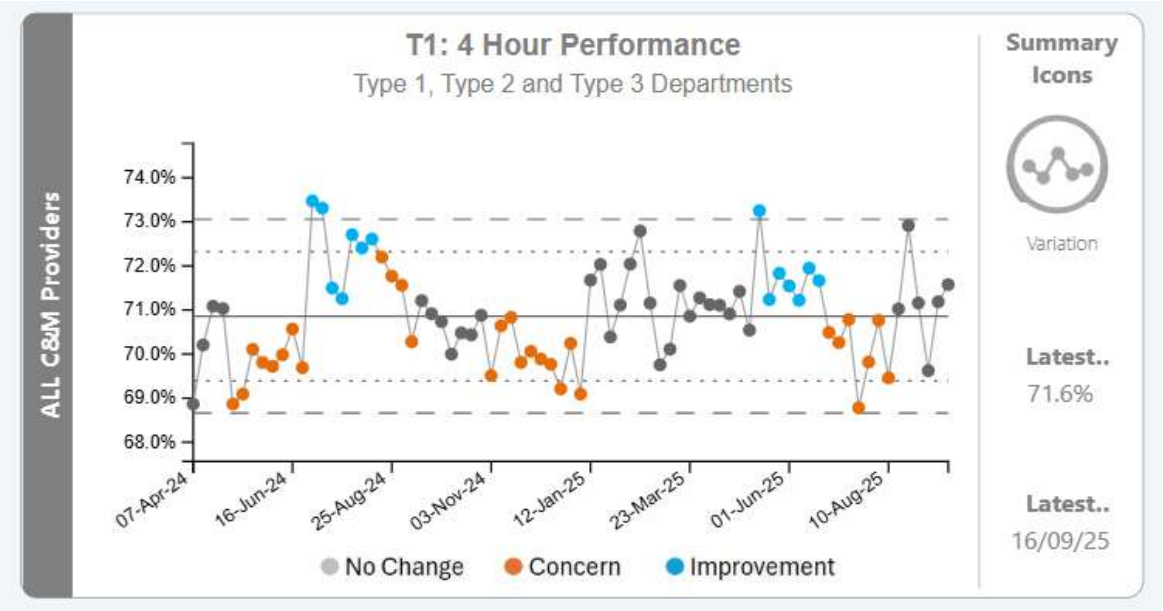
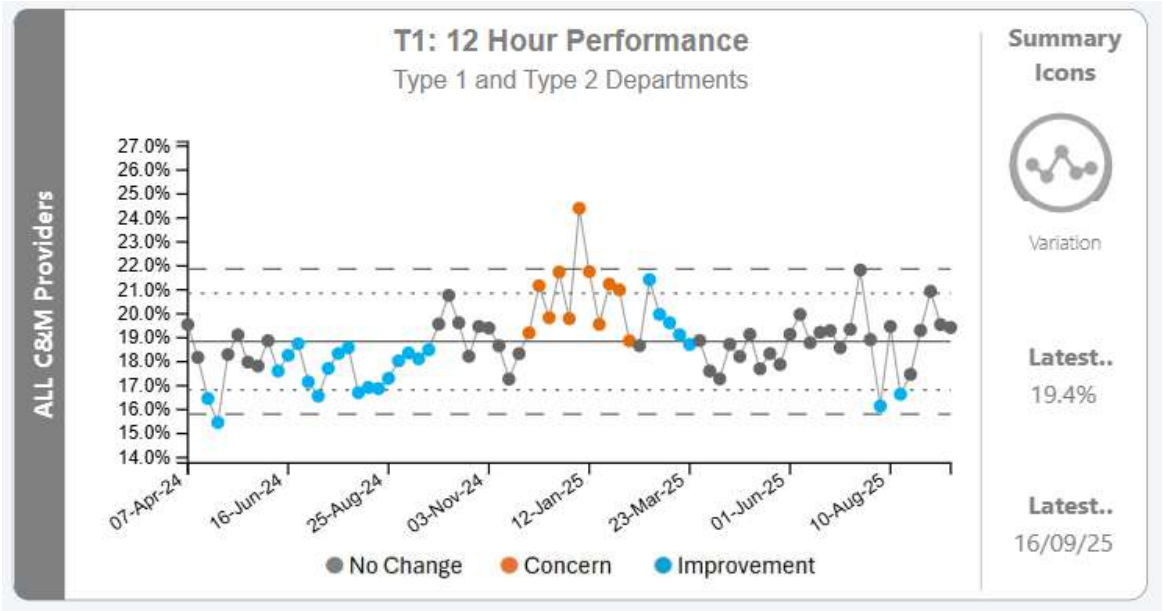




Although we are seeing statistically significant improvement in some of our projects, we are still to see a sustained improvement in the 4 hour and 12 hour performance measures.

This is the focus of the weekly recovery meetings and the NHSE NW tiering meetings.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 September 2025

Winter Planning 2025/26

Agenda Item No: **ICB/09/25/17**

Responsible Director: Anthony Middleton
Director of Performance & Planning

NHS
Cheshire and Merseyside

Winter Planning 2025/26

1. Purpose of the Report

1.1 This paper provides an update to the Board following the Winter Planning 2025/26 paper discussed in July 2025. It summarises the planning activities undertaken over the summer and describes how the outputs inform completion of the Board Assurance Statement (BAS), which the Board is asked to approve for submission to NHS England by 30 September 2025.

2. Executive Summary

2.1 NHS Cheshire and Merseyside's winter plan outlines how the ICB will address NHS England's urgent and emergency care priorities for 2025/26. Key targets include faster ambulance response times, reduced A&E and mental health delays, and improved discharge processes. The plan addresses system risks and supports strategic objectives around urgent care improvement.

2.2 No extra revenue funding is available, though national capital investment supports urgent care infrastructure.

2.3 Plans are coordinated through five locality areas, each led by a Senior Responsible Officer, feeding into a system-wide plan.

2.4 The ICB and NHS providers across Cheshire & Merseyside have continued to progress its winter planning process in line with national guidance and the approach agreed by the Board in July 2025. Key steps include:

- Participation in Exercise Aegis on 8 September 2025.
- A sequence of locality-level Check & Challenge sessions, informed by a structured agenda and checklist, to test and assure plans.
- Submission of completed winter readiness checklists from each of the five UEC localities (See Appendix Two).
- Completion of the ICB's Board Assurance Statement, (see Appendix One) drawing on locality evidence, for Board approval today and submission by 30 September 2025.

2.5 The outputs of this process will ensure the Board can be confident in affirming that the ICB's plan addresses national requirements and is supported by robust local delivery arrangements, whilst also recognising that plans will need to be further refined in the coming months.

3. Ask of the Board and Recommendations

3.1 **It is recommended that the Board:**

- **Approve the Board Assurance Statement (BAS) (Appendix One) for submission to NHS England by 30 September 2025.**
- Note the sequence of events underpinning completion of the Winter Plan and Board Assurance Statement (BAS) and the five locality checklists.
- Endorse the continued approach to further developing and testing the plans and assuring winter readiness.

4. Background

4.1 **National Context and Priorities:** Noting that there is no additional revenue funding to support winter planning and response, the NHS is nonetheless expected to deliver a significant improvement in urgent and emergency care (UEC) performance during winter 2025/26 against the following priorities:

- **Ambulance Response Times**: Category 2 average response <30 minutes.
- **Ambulance Handover**: Meet the 45-minute handover target.
- **A&E Four-Hour Standard**: Achieve a minimum of 78%.
- **Eliminate Long Waits**: Reduce 12-hour waits, end corridor care.
- **Mental Health**: Reduce >24-hour waits for beds; eliminate inappropriate out-of-area placements.
- **Discharge**: Reduction in 21+ day delayed discharges.
- **Children's UEC**: Improve timeliness of care for children in emergency settings.

4.2 **System-Wide Requirements:** Each ICB must ensure submission of a signed-off winter plan and associated Board Assurance Statement by 30 September 2025. All NHS Providers are also required to complete and return their own Board Assurance Statement to the same deadline.

4.3 **Key dates and timeline:**

- 11 July: Trusts to submit 1st cut winter plans to locality SROs.
- 17 July: SROs to submit locality plans to central ICB planning team.
- 21 July: Submission of 1st cut system plan to NHSE North West.
- 4-8 August: Feedback to localities from ICB / NHSE.
- 21 August: SROs submit 2nd cut winter plans to central ICB team.
- 1-19th Sept: C&M Locality winter stress testing by ICB & SME's.
- 8 September: Stress-testing of winter plans at NHSE Exercise Aegis.
- 25 September: ICB Board approval.
- 26 September: ICB and Trust winter plan templates to be submitted to NHS England North West.
- 30 September: Submission of Board Assurance Statement to NHSE National UEC team.

4.4 **Cheshire & Merseyside Approach:**

- The Cheshire and Merseyside Urgent and Emergency Care Programme consists of five locality programmes, and cross cutting at scale schemes.
- C&M has therefore set winter plans at locality and ICB level, with the winter planning process managed through the 5 UEC Locality SROs, who have each produced a single plan for their area.
- Locality SROs have engaged and worked with providers and system partners including local authorities and VCSFE representatives to develop their winter plan tailored to population needs and operational capacity.
- Each Trust will identify an SRO for winter who will oversee winter planning and operations across the period.
- At a Locality level, SROs are identified as leads for winter and at a system level, the role of ICB winter director will be taken up by the Director of Planning and Performance.
- Subject Matter Experts have been identified within the ICB to support the development and assurance of the plans across the following themes:
  - Patient Safety and risk
  - Vaccination and wider prevention
  - IPC
  - Leadership and control
  - Primary care and Community
  - Mental health
  - Workforce
  - Children and Young people
  - Health Inequalities and prevention
  - EPRR and System Resilience
- Key SRO roles and responsibilities are detailed in Appendix Three.

5. Progress Since July and Next Steps

5.1 **NHS England feedback on draft plans:** The first draft of the winter plans were shared with NHS England at the end of July, with feedback received in August. The feedback themes were:

- Cheshire & Merseyside's winter preparedness plans were generally detailed, but with variable levels of assurance across trusts.
- NHS England encouraged the ICB in its plans to aim for more ambitious flu vaccination rates than the minimum requirement.
- Some parts of the plans required further development on the response to periods of extreme pressure, and on the mitigations for high-risk areas.
- There was limited evidence of how plans addressed health inequalities.
- Clearer narrative was required on addressing mental health ED delays, and adoption of national action cards.

5.2 This feedback has been fully incorporated into the second full iteration which was completed in August and tested at the exercise on 08 September.

5.3 **Exercise Aegis – 8 September 2025:** The ICB participated in Exercise Aegis, a regionally-led winter stress test exercise. This provided an opportunity to test governance, escalation and system response arrangements under winter scenarios. The exercise was well attended with all five UEC localities bringing a mix of ICB, NHS Trust, Local Authority and VCSFE colleagues together to test plans against a variety of scenarios, spanning baseline 'business as usual' operation through to extreme pressures. These scenarios were designed to prompt strategic reflection and collective action across systems with a focus on:

- Clinical and operational safety
- Urgent and emergency care performance
- Emergency department oversight
- Strategic response to pressure
- Governance and decision making
- Workforce Resilience.

5.4 **Locality Check & Challenge Sessions:** Following Exercise Aegis, structured Check & Challenge sessions have been undertaken with each of the five UEC localities in Cheshire & Merseyside. These sessions have covered governance, risks, capacity, workforce, partnerships, prevention and safety. The purpose is to provide internal assurance and constructive challenge ahead of finalising locality winter plans. Key lines of enquiry focused on any gaps or issues identified in the first draft, as well as how well the plans address the locally agreed readiness checklist.

5.5 **Submission of Locality Checklists**: Each UEC locality Senior Responsible Officer has been asked to complete a Winter Readiness Checklist, reflecting the learning from the exercise, the Check & Challenge sessions and local discussions. These are set out in Appendix Two providing a structured self-assessment against national requirements and have informed completion of the BAS.

5.6 It would not be expected that by mid-September every element of the winter response would be finalised, however the completed checklists and the check and challenge sessions indicate a good level of progress with winter planning, and a level of readiness in line with what would be expected for this stage. Per locality, self-assessed Amber or Red areas requiring further work as at 12 September 2025 were identified as follows (see Appendix Two for detail):

Locality	Green	Amber	Red
Cheshire	16	6	
Mid Mersey	24	3	
North Mersey	17	8	2
Warrington	17	10	
Wirral	16	6	

5.7 The ICB will be producing a further iteration of the winter plan templates, including updated locality and provider level templates to NHS England, by the 26th of September. It is anticipated this will demonstrate further mitigation of outstanding issues.

5.8 The key themes which have emerged from the exercise, the checklists and the check and challenge meetings are as follows:

- Governance & Oversight: This area is well developed, however learning from the exercise will be used to further strengthen arrangements.
- Operational Grip & Escalation: Systems are well developed, with good situational awareness, but with further work required to prepare for the most intense levels of pressure identified in the exercise, and the periods e.g. in early January that are known to be the most challenged.
- Planning, Risks & Mitigations: Learning from the exercise indicated more can be done to embed the mitigations for known risks.
- Capacity & Flow: Some systems recognised the need for further work to agree seven-day discharge profiles with local authorities.
- Workforce & Wellbeing: Systems have identified the need to further test surge plans for workforce.
- System Working & Partnerships: Whilst VCSFE organisations have been involved and were represented at the exercise, there is more work to be done to engage the VCSFE sector.
- Prevention & Vaccination: The ICB is working closely with NHSE as the commissioners of all routine vaccinations and is working as a system with partners to improve vaccination rates.
- Patient Safety & Clinical Pathways: Further work required to embed national ED MH Action Cards into escalation processes and ensure the sustainability of key pathways such as SDEC and Frailty.

5.9 **Completion of QEIA:** NHS England requires the completion of a Quality and Equality Impact Assessment for the Winter Plan, this is managed by the ICB via our Quality Impact and Equality Impact processes (QIA and EIA). See section 8 and section 12.

5.10 **Completion of the ICB Board Assurance Statement:** The five completed locality checklists have been collated and reviewed by the ICB planning team. Together they provide an evidence base to complete the ICB's Board Assurance Statement (BAS), see **Appendix One.** The BAS is due to be submitted to NHS England's national UEC team by 30 September 2025, following Board consideration.

5.11 It should be noted that further the process of winter planning and assurance will continue past the 30 September deadline, as plans are further refined. The BAS presents an overview of the current status of the planning process.

5.12 The Quality and Performance Committee will receive further updates as plans are strengthened and refined.

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

6.1 The winter planning process and delivery of the winter response are most relevant to the following ICB Strategic Objectives:

- **Objective One: Health Inequalities in access, outcomes and experience**
- **Objective Two: Improving Population Health and Healthcare.**

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

7.1 Urgent Care Improvement is one of the four top priorities set out in the Annual Delivery Plan for 2025/26. This is supported by plans to address Admission Avoidance, In Hospital Flow, Discharge, Ambulance Improvement, Urgent and Emergency Care at Scale and Mental Health System Flow.

7.2 The winter planning process links directly to the achievement of this objective.

8. Link to meeting CQC ICS Themes and Quality Statements

8.1 The metrics in NHS England's *Urgent and Emergency Care Plan 2025/26* are key to the delivery of quality and safety along the UEC patient pathway, and the focus of winter planning is on the leadership and integration required to deliver this.

8.2 **Patient Experience:** Locality SROs have sought to incorporate patient experience insights into local plans, for example using feedback from Healthwatch as well as feedback through voluntary sector partners.

8.3 **Quality Impact Assessment:** Although the winter plan does not result in a change to services that would warrant a QIA in line with the ICB policy, in response to the requirements in the Board Assurance Statement to undertake a QEIA, a structured assessment has been carried out of the winter plans and is scheduled to be considered by a QIA panel on 19 September.

8.4 It should be noted that the winter plan is designed to mitigate risks and achieve the best possible performance over winter within our current resources, and within the plan itself, there is a detailed focus on quality that relate to the three CQC ICS themes and quality statements:

- **Quality and Safety:** Patient Safety & Risk, Infection Prevention & Control, vaccination and prevention, support for at risk groups.
- **Integration:** Winter plans include acute, community, mental health, primary care

- **Leadership:** Leadership and Control, System working, EPRR and system resilience

9. Risks

9.1 The winter planning process is most pertinent to Board Assurance Framework Risk P15: *There is a risk that the system will be unable to deliver timely and effective urgent and emergency care services due to rising demand, workforce pressures, capacity constraints, and delayed patient discharges. This may result in non-compliance with key NHS 2025/26 planning guidance standards, including the 4-hour ED target, 12-hour decision-to-admit (DTA) breaches, and ambulance handover delays. These risks may contribute to patient harm, regulatory scrutiny, and reputational damage.*

9.2 The winter plan will be a key control against this risk, along with the wider UEC Programme. Completion of locality checklists, Exercise Aegis, and the ICB BAS are intended as key elements of assurance to strengthen confidence in delivery.

9.3 A key risk to note is that there is no additional revenue funding for enhanced capacity through winter, plans are predicated on making the most effective use of current resources and the UEC improvement programme.

10. Finance

10.1 There is no additional revenue funding outside of normal allocations to support winter preparations and the winter response.

11. Communication and Engagement

11.1 Locality SROs will engage and work with providers and system partners to develop their winter plan tailored to population needs and operational capacity. In due course a wider communications and engagement plan will need to be developed.

12. Equality, Diversity and Inclusion

12.1 The planning function has undertaken an assessment of the winter plans from an equality, diversity and inclusion perspective, alongside the Quality Impact Assessment referred to above.

12.2 Although the winter plan does not directly result in a change to services that impacts on patients or workforce, it is a plan that is designed to mitigate risks and achieve the best possible performance over winter within our current

resources, and within the plan itself, there is a focus on reducing health inequalities, and a number of targeted interventions for people with protected characteristics, for example:

- Older adults (flu, RSV, frailty pathways)
- Children and young people (school immunisations)
- Pregnant women (RSV, flu vaccination)
- People with SMI, LD, autism (health checks, housing support)
- Ethnic minorities and migrant communities (interpretation services, cultural support)
- Use of CORE20PLUS5 framework to identify and address inequalities.

13. Next Steps and Responsible Person to take forward

13.1 The ICB and providers are required to submit their finalised winter plans by 26 September and their Board assurance templates by 30 September 2025. NHS Boards are expected to:

- Provide oversight of risk-rated areas and escalate any concerns.
- Confirm that plans are supported by clear operational leads and clinical governance.
- Ensure local delivery is aligned with national performance priorities.

14. Officer contact details for more information

- Responsible Director: Anthony Middleton, Director of Performance & Planning
- Responsible Officers: Claire Sanders Associate Director of Urgent & Emergency Care Operations and Improvement

15. Appendices

Appendix One: C&M ICB Winter Plan Board Assurance Statement

Appendix Two: Locality Winter Readiness Checklists as at 12/09/2025

Appendix Three: Winter SRO Role cards

Appendix One: C&M ICB Winter Plan Board Assurance Statement

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the ICB Winter Plan for 2025/26.	Y	Subject to agreement at Board 25/09
A robust quality and equality impact assessment (QEIA) informed development of the ICB's plan and this has been reviewed by the Board.	Y	As per summary in section 8 & 12 above, and considered by QIA panel on September 19
The ICB's plan was developed with appropriate levels of engagement across all system partners, including primary care, 111 providers, community, acute and specialist trusts, mental health, ambulance services, local authorities and social care provider colleagues.	Y	Planning led by Locality SROs
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Y	Exercise attended by all C&M providers and ICB on 08/09/2025, with lessons learned fed back into Localities
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Y	Director of Planning & Performance
Plan content and delivery		
The Board is assured that the ICB's plan addresses the key actions outlined in Section B.	Y	Subject to approval by Board 25/09
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Y	As per Section 9 of this paper
The Board is assured there will be an appropriately skilled and resourced system control centre in place over the	Y	

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
winter period to enable the sharing of intelligence and risk balance to ensure this is appropriately managed across all partners.		

ICB CEO/AO name	Date	ICB Chair name	Date
Cathy Elliott		Raj Jain	

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
• Vaccination programmes across all of the priority areas are designed to reduce complacency, build confidence, and maximise convenience. Priority programmes include childhood vaccinations, RSV vaccination for pregnant women and older adults (with all of those in the 75-79 cohort to be offered a vaccination by 31 August 2025) and the annual winter flu and covid vaccination campaigns.	Y	The ICB is working closely with NHSE as the commissioners of all routine vaccinations and is working as a system with partners to improve vaccination rates.
• **In addition to the above, patients under the age of 65 with co-morbidities that leave them susceptible to hospital admission as a result of winter viruses should receive targeted care to encourage them to have their vaccinations, along with a pre-winter health check, and access to antivirals to ensure continuing care in the community.**	Y	Per locality checklists
• **Patients at high risk of admission have plans in place to support their urgent care needs at home or in the community, whenever possible.**	Y	Per locality checklists
Capacity		
• **The profile of likely winter-related patient demand across the system is modelled and understood, and individual organisations have plans that connect together to ensure patients' needs are met, including at times of peak pressure.**	Y	Per locality checklists
• **Seven-day discharge profiles have been shared with local authorities and social care providers, and standards agreed for P1 and P3 discharges.**	Y	Per locality checklists
• **Action has been taken in response to the Elective Care Demand Management letter, issued in May 2025, and ongoing monitoring is in place.**	Y	Via Elective Care Programme

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Leadership		
• **On-call arrangements are in place, including medical and nurse leaders, and have been tested.**	Y	
• **Plans are in place to monitor and report real-time pressures utilising the OPEL framework.**	Y	Via SCC

Appendix Two: Locality Winter Readiness Checklists as at 12/09/2025

Cheshire:

Domain	Question	R	A	G	Commentary / Evidence
Governance, Oversight & Assurance	Are governance and escalation arrangements clear, mature, and ready to test in Exercise Aegis?		X		Whole system Bronze, silver & gold command (strategic & operational escalation) arrangements being strengthened following Exercise Aegis SROs - Laura Marsh (Cheshire West); Rich Burgess (Cheshire East) In Cheshire East, Exercise Aegis flagged some gaps in pre-incident escalation, intelligence sharing and mutual aid, within the governance structure. This has now been addressed through the development of a number of operational cells, which report through to existing Place Governance structures. This will be fully resolved by the end of September
	Are command structures and escalation triggers documented and understood by all teams so that decisions in surge conditions are made quickly and risks are not transferred to patients			X	In Cheshire West - The strategic and tactical commanders will utilise the bronze, silver and gold escalation process to respond to additional pressures over winter as required. This operates on triggers which are being widened to ensure system oversight. Winter planning exercise has enabled enhanced arrangements for the busiest periods to be developed further. Cheshire East uses a similar approach to identify additional pressures at key times over winter. In addition, General Practice data will be reported weekly into operational pressures reporting to give advance insight of emerging pressures. Regular review of UEC / performance plans to support NCTR, pathway performance and system flow across all Cheshire Trusts
	Is Board oversight in place to support winter planning, with clear path to sign-off by end of Sept?			X	In Cheshire West - UEC Board is well established and due to meet on 24th September and will be used to review outcomes of Exercise Aegis and agree further mitigations to outstanding risks within winter plan. Cheshire East have set up a Winter Planning Oversight Group, which reports into the Operational Delivery Group meeting 19th September. Final plans are being endorsed at Place Leadership Group (CEO Group) on the 26th of September.
	Are EPRR frameworks and leadership structures understood and consistently applied across teams?			X	Yes, EPRR Frameworks are fully embedded across both Cheshire East and Cheshire West Partnerships. On-call protocol is well established, with in and out of hours handover between System Control Centre and Directors on Call

Domain	Question	R	A	G	Commentary / Evidence
Operational Grip & Escalation	Are OPEL processes set up for real-time visibility of pressures across all services?			X	SCC meeting each day at 9:30am and send out a summary at 10am. SHREWD and other triggers received/monitored by ICB UEC Team and system ops managers to Bronze command meeting, cascading and escalating as required.
	Are escalation/de-escalation protocols clear and ready to demonstrate in the exercise?			X	OPEL escalation meetings with triggers being widened in response to Exercise Aegis. System partner OPEL escalation cards are in place.
	Are operational teams prepared to coordinate across urgent & emergency pathways under pressure?			X	In Cheshire West; all partners part of weekly bronze calls with the ability to call additional (daily) meetings on basis of agreed triggers and with the ability to escalate to same day silver/gold calls. In Cheshire East, all system partners attend joint escalation calls and work alongside Cheshire East Local Authority and providers
Risk Management & Mitigations	Do draft winter plans include risk scores for all high-risk areas (workforce, discharge, MH ED waits)?			X	Yes
	Are mitigations for known risks sufficiently developed to test in Aegis?			X	Tested in Aegis with additional mitigations now developed.
	Have additional risks already been identified that must be addressed before Board Assurance Statement completion?			X	For both Places, further work has been undertaken to identify mitigations that are now being implemented
Workforce & Wellbeing	Are staffing/surge plans robust and ready to be stress-tested?		X		The Trusts have already responded positively and tested as part of Exercise Aegis. Outstanding areas of risk remain under review
	Have concrete steps been taken to improve staff vaccination uptake?		X		The Trusts have already responded positively. CoCH have solid plans in place. MCHFT are due to present to their Governance and at Winter Planning Oversight Group ahead of Home First Oversight meeting. In Cheshire East an Immunisation Cell led by Public Health is being established to offer additional assurance throughout the planning period
	Are wellbeing and resilience offers for staff well-developed for winter pressures?			X	The Trusts have already responded positively. Further staff wellbeing opportunities being explored as a system in terms of what could be offered Place-wide to complement organisational offers

Domain	Question	R	A	G	Commentary / Evidence
System Working & Partnerships	Are local authority and social care partnerships sufficiently embedded in plans to test in Aegis?			X	Yes, attendance from all key partners.
	Are systems able to flex capacity to support direct access of flu patients into community bedded capacity?		X		Concerns remain around introducing Flu to the Community Bed base. In Cheshire West the Hospital@Home Team are able to flex in to supporting this. This remains a gap in Cheshire East.
	Have BCF, predictive analytics, and shared dashboards been incorporated into planning?			X	BCF Capacity & Demand Planning has already been utilised. Further work underway on community intermediate capacity
	Are VCSE, care homes, and community providers ready to support escalation and discharge?			X	Yes, positive responses received during the winter planning and Exercise Aegis. To be taken forward through Place Urgent Care Boards to further strengthen plans.
Patient Safety & Clinical Pathways	Are plans in place to maintain patient safety for high-risk groups under winter scenarios?			X	Working towards Advanced Care Plans for individuals who need them. Vaccination & prophylaxis plans for care homes.
	Has progress been made embedding national ED MH Action Cards into escalation processes?		X		Place teams have requested assurance on the use of Mental Health Flow in the ED over 72 Hour Action Cards. Assurance on the use of Action Cards to be part of Trust updates with the SCC Daily Call. Evidence is requested by the ICB as a quarterly update. CoCH have produced an action card and gained approval thorough their governance. There are weekly Mental Health MADE events in both Cheshire East and Cheshire West, reporting through to a weekly Supermade event. Escalation processes are clear and working well. However capacity remains a limiting factor."
	Are elective care, SDEC, frailty, and streaming pathways resilient enough to sustain under pressure?		X		Front door services including SDEC/UTC/frailty offer are already under pressure on a regular basis and therefore plans have sought to develop further opportunity to flex resources as much as possible to meet further increases in demand however this is limited by both the physical footprint, financial position and capacity. Transformation ahead of winter continuing to focus on improving performance and resilience
	Are processes in place to capture learning from Aegis and use it to strengthen final plans?			X	Actions from Aegis directly leading to strengthened plans through Place governance

Domain	Question	R	A	G	Commentary / Evidence
Learning & Readiness for Assurance	Overall, how confident is the trust/system that the Board Assurance Statement can be completed affirmatively by end Sept?			X	Both Cheshire East and Cheshire West are confident to deliver board assurance statement by end of September.

Mid Mersey and West Lancs:

Domain	Question	R	A	G	Commentary / Evidence
Governance & Oversight	Are governance and escalation arrangements clear, mature, and learning taken from Exercise Aegis?			x	Mid Mersey and West Lancs system escalation policy in place with triggers clearly defined and associated meeting structure agreed.
	Is locality oversight in place to support winter planning, with clear path to sign off by the end of Sept			x	Locality oversight in place with a joint plan to ensure MWL Board assurance by the end of September
	Has a robust Quality and Equality Impact Assessment (QEIA) been completed and reviewed?			x	This forms part of providers Business continuity plans including reducing non urgent services to support urgent services and the relevant risk assessments
	Have all relevant SRO roles been allocated for the locality?			x	Winter planning governance is in place. SROs are clearly defined for Admission Avoidance, In Hospital and Discharge. There is an overall SRO for the Mid Mersey and West Lancs locality UEC, a Deputy has also been identified for times of leave.
	Are EPRR frameworks and leadership structures understood and consistently applied across teams?			x	EPRR frameworks are understood alongside leadership structures and escalation routes within partner organisations. These will be re-iterated at an MWL system workshop scheduled for the 22nd of September
Planning, Risks & Mitigations	Are risks to quality identified with mitigations for base, moderate, and extreme pressures?			x	Risks are identified via OPEL action cards. These will be tracked and monitored through the MWL Programme Oversight Group.
	Are mitigations for known risks sufficiently developed?			x	A robust winter plan is in place with key risks identified. The mitigations are outlined but further work is needed to ensure they are fully embedded across the system
	What additional risks remain to be addressed before Board Assurance Statement (BAS) completion?		x		NWAS response risk within the organisation remains dynamic, currently scored at a 10, whilst we have mitigations in place, ultimately the control of the response sits with NWAS
Capacity & Flow	Is winter demand modelled across the system and shared between partners?		x		Winter demand is modelled and performance is monitored throughout the year. Key triggers are linked to demand related performance and will ensure mobilisation of the escalation plan.

Domain	Question	R	A	G	Commentary / Evidence
	Are seven-day discharge profiles agreed with local authorities and social care (including P1 and P3 standards)?			x	Discharge trajectories have been set with every place and are monitored daily. Stretch targets for these pathways will be established for Winter and daily updates to place and SROs provided. These are linked to the triggers within our escalation plan.
	Has action been taken in response to the May 2025 Elective Care Demand Management letter, with monitoring in place?			x	There is an elective recovery programme and Transformation work in place to support the challenging elective position experienced in C&M.
	Are elective services protected through hubs, cold sites, or ring-fenced capacity?			x	The Trust has elective activity running through both cold sites and their elective hubs.
Workforce & Wellbeing	Are staffing/surge plans robust and ready to be stress-tested?		x		Well established staffing plans and reviews are in place across all sites within NHS providers, further work is required to gain assurance from our LA colleagues. This will be completed at the 22nd of September system workshop.
	Have concrete steps been taken to improve staff vaccination uptake (flu, covid)?			x	There is mandatory reporting and communications and access plans for staff to support vaccinations and will include Public Health colleagues this will be monitored weekly.
	Are staff wellbeing and resilience offers developed and in place for winter?			x	Staff wellbeing and resilience offers are available within all providers. The importance of these is understood across the system.
System Working & Partnerships	Were all relevant partners engaged in developing the plan (primary care, 111, community, acute, MH, ambulance, LA, social care)?			x	All partners engaged across the system.
	Are local authority and social care partnerships sufficiently embedded in planning and escalation?			x	LA's form part of the discharge workstream and are fully understand the OPEL framework and escalation
	Have Better Care Fund mechanisms, predictive analytics, and shared dashboards been incorporated?			x	The BCF dashboard has been used to ensure spend is aimed at the current services and support the Urgent Care system. This dashboard will be monitored through winter within the discharge workstream.
	Are VCSE, care homes, and community providers engaged to support escalation and discharge?			x	Care Homes are aware of their role in supporting and expediting discharge, a more risk-based approach will be taken during winter which links to the work the DASS group have been progressing and the learning during last years critical incident. Place have VSCE schemes to

Domain	Question	R	A	G	Commentary / Evidence
					support patients discharge, this varies across places but ultimately there is support available.
Prevention & Vaccination	Are vaccination programmes (flu, covid, RSV, childhood) designed to reduce complacency, build confidence, and maximise convenience?			x	Local delivery focused and will be monitored weekly
	Are high-risk patients under 65 with co-morbidities targeted for vaccination, health checks, and antiviral access?			x	Care home and Primary Care plan in place to contact vulnerable patients. Public Health will form part of the MWL Programme Oversight Group to enable additional oversight.
	Are plans in place to support high-risk patients' urgent care needs at home or in the community whenever possible?			x	Patients who are high risk of admission via Primary Care to ensure there are same day appointments available. The single point of access is live across Merseyside to ensure, as much as possible, urgent needs are met within the community
Patient Safety & Clinical Pathways	Are plans in place to maintain patient safety for frail elderly, CYP, and mental health patients under pressure?			x	We have identified additional medical support for urgent community services and urgent care services will be prioritised to ensure available capacity. There are commissioned services within each place to support such cohorts.
	Has progress been made embedding national ED Mental Health Action Cards into escalation processes across providers?			x	MCFT have led on this work and form part of the triggers for escalation.
	Are SDEC, frailty, streaming, and elective pathways resilient enough to sustain during peak winter pressures?			x	Yes, all steps have been taken to ensure appropriate resilience e.g. staffing models during this time. This is within both MWL and MCFT providers.
Learning from Exercise Aegis & Assurance	Are processes in place to capture and act on learning from Aegis before finalising plans?			x	Yes, a System Executive UEC workshop is scheduled for the 22nd of Sept to focus on learning and ensure actions are embedded in our plans.
	Overall, how confident is the organisation that the BAS can be completed affirmatively by 30 Sept, with evidence to support this?			x	BAS is scheduled and will be completed by the 30th of Sept.

North Mersey

Domain	Question	R	A	G	Commentary / Evidence
Governance & Oversight	Are governance and escalation arrangements clear, mature, and learning taken from Exercise Aegis?			x	
	Is locality oversight in place to support winter planning, with a clear path to sign-off by end of Sept?		x		
	Has a robust Quality and Equality Impact Assessment (QEIA) been completed and reviewed?	x			QEIA completed for providers but not for overall locality plan
	Have all relevant SRO roles been allocated for the locality?			x	
	Are EPRR frameworks and leadership structures understood and consistently applied across teams?			x	
Planning, Risks & Mitigations	Are risks to quality identified with mitigations for base, moderate, and extreme pressures?			x	Local desk top exercise to be completed to build on learning from Exercise Aegis
	Are mitigations for known risks sufficiently developed?		x		Further review and challenge needed for areas of increased activity from CCL
	What additional risks remain to be addressed before Board Assurance Statement (BAS) completion?			x	No additional risks identified but LUHFT CIP/ bed closures required will challenge operational delivery
Capacity & Flow	Is winter demand modelled across the system and shared between partners?		x		Full system model not collated but providers have individual plans
	Are seven-day discharge profiles agreed with local authorities and social care (including P1 and P3 standards)?	x			Weekend discharge levels are low and plans need further development
	Has action been taken in response to the May 2025 Elective Care Demand Management letter, with monitoring in place?			x	
	Are elective services protected through hubs, cold sites, or ring-fenced capacity?			x	
Workforce & Wellbeing	Are staffing/surge plans robust and ready to be stress-tested?		x		UCR referrals increased which has potential staffing impact which needs to be monitored

Domain	Question	R	A	G	Commentary / Evidence
	Have concrete steps been taken to improve staff vaccination uptake (flu, covid)?			x	
	Are staff wellbeing and resilience offers developed and in place for winter?			x	
System Working & Partnerships	Were all relevant partners engaged in developing the plan (primary care, 111, community, acute, MH, ambulance, LA, social care)?			x	
	Are local authority and social care partnerships sufficiently embedded in planning and escalation?			x	
	Have Better Care Fund mechanisms, predictive analytics, and shared dashboards been incorporated?			x	
	Are VCSE, care homes, and community providers engaged to support escalation and discharge?		x		VCSE call to take place in Liverpool
Prevention & Vaccination	Are vaccination programmes (flu, covid, RSV, childhood) designed to reduce complacency, build confidence, and maximise convenience?			x	
	Are high-risk patients under 65 with co-morbidities targeted for vaccination, health checks, and antiviral access?			x	
	Are plans in place to support high-risk patients' urgent care needs at home or in the community whenever possible?			x	
Patient Safety & Clinical Pathways	Are plans in place to maintain patient safety for frail elderly, CYP, and mental health patients under pressure?			x	
	Has progress been made embedding national ED Mental Health Action Cards into escalation processes across providers?		x		Work ongoing with AQAA
	Are SDEC, frailty, streaming, and elective pathways resilient enough to sustain during peak winter pressures?		x		
Learning from Exercise Aegis & Assurance	Are processes in place to capture and act on learning from Aegis before finalising plans?		x		Check and challenge meeting will support this
	Overall, how confident is the organisation that the BAS can be completed affirmatively by 30 Sept, with evidence to support this?			x	

Warrington

Domain	Question	R	A	G	Commentary / Evidence
Governance & Oversight	Are governance and escalation arrangements clear, mature, and learning taken from Exercise Aegis?		x		Individual areas have good governance and escalation processes; however improvements could be made to create more joint up working and a cohesive approach to increase demand
	Is locality oversight in place to support winter planning, with a clear path to sign-off by end of Sept?			x	The executive oversight group meet weekly to signoff and monitor UEC and winter programmes
	Has a robust Quality and Equality Impact Assessment (QEIA) been completed and reviewed?		x		The draft QIA has been completed and will continue to be review as risks or alternation to the plans are identified.
	Have all relevant SRO roles been allocated for the locality?			x	SROs for the various programmes are in place from all system partners
	Are EPRR frameworks and leadership structures understood and consistently applied across teams?			x	the EPRR framework is embedded with all systems to deal with emerging contingencies
Planning, Risks & Mitigations	Are risks to quality identified with mitigations for base, moderate, and extreme pressures?			x	Escalation trigger tools in place across the system with clear roles and responsibilities for any incidents impacting on quality or patient safety
	Are mitigations for known risks sufficiently developed?		x		Mitigations are in place for all known risks, but they will not completely remove all risk
	What additional risks remain to be addressed before Board Assurance Statement (BAS) completion?		x		Gaps identified around cohesion and communication between partners to be able to respond to escalated risk in one area Place partners reviewing surge plans to allow faster response to predicable surge
Capacity & Flow	Is winter demand modelled across the system and shared between partners?			x	Anticipated winter demands, based on historic trends, are built into the systems planning, including bank holidays
	Are seven-day discharge profiles agreed with local authorities and social care (including P1 and P3 standards)?		x		Ongoing improvements for 7-day discharge profiles is withing the UEC programme

Domain	Question	R	A	G	Commentary / Evidence
	Has action been taken in response to the May 2025 Elective Care Demand Management letter, with monitoring in place?			x	The elective programme reflects the letter
	Are elective services protected through hubs, cold sites, or ring-fenced capacity?			x	Ring fenced elective capacity is provided on the Halton Hospital site.
Workforce & Wellbeing	Are staffing/surge plans robust and ready to be stress-tested?		x		
	Have concrete steps been taken to improve staff vaccination uptake (flu, covid)?			x	WHH have a robust vaccination programme
	Are staff wellbeing and resilience offers developed and in place for winter?			x	Health and wellbeing offers across the system, access to OH and other support services available
System Working & Partnerships	Were all relevant partners engaged in developing the plan (primary care, 111, community, acute, MH, ambulance, LA, social care)?			x	All partners are engaged in the UEC and winter planning
	Are local authority and social care partnerships sufficiently embedded in planning and escalation?			x	Social care partners have winter plans for increased demand
	Have Better Care Fund mechanisms, predictive analytics, and shared dashboards been incorporated?			x	Capacity and demand plans have been nationally approved
	Are VCSE, care homes, and community providers engaged to support escalation and discharge?		x		NHS community services are fully engaged in all aspects of the UEC and winter planning. Non-NHS providers are part of care capacity to support patients avoid admission and to be discharged. There is no winter funding to increase non-NHS capacity above planned levels.
Prevention & Vaccination	Are vaccination programmes (flu, covid, RSV, childhood) designed to reduce complacency, build confidence, and maximise convenience?			x	National programme with good local delivery
	Are high-risk patients under 65 with co-morbidities targeted for vaccination, health checks, and antiviral access?			x	Local providers are calling the appropriate patients

Domain	Question	R	A	G	Commentary / Evidence
	Are plans in place to support high-risk patients' urgent care needs at home or in the community whenever possible?			x	Urgent community response services are available to support patient needs in their own homes and is integrated with wider primary and community services
Patient Safety & Clinical Pathways	Are plans in place to maintain patient safety for frail elderly, CYP, and mental health patients under pressure?		x		The quality and safety of care has been reviewed within the risks and impact assessment
	Has progress been made embedding national ED Mental Health Action Cards into escalation processes across providers?		x		National MH action cards are not formally embedded but the principles are part of the trusts ED MH actions
	Are SDEC, frailty, streaming, and elective pathways resilient enough to sustain during peak winter pressures?		x		Within WHH a workstream focused on streaming and deflection is part of the transformation programme, this is monitored at executive level
Learning from Exercise Aegis & Assurance	Are processes in place to capture and act on learning from Aegis before finalising plans?			x	The areas identified at the event have been reviewed and assured
	Overall, how confident is the organisation that the BAS can be completed affirmatively by 30 Sept, with evidence to support this?			x	the winter plans will be assured through the system governance

Wirral

Domain	Question	R	A	G	Commentary / Evidence
Governance, Oversight & Assurance	Are governance and escalation arrangements clear, mature, and ready to test in Exercise Aegis?			x	Winter & business continuity/Opel Escalation plans in place. Wirral Team confirmed for Exercise Aegis.
	Are command structures and escalation triggers documented and understood by all teams so that decisions in surge conditions are made quickly and risks are not transferred to patients			x	Within Wirral Opel Escalation Framework. On call system in place across ICB and providers.
	Is Board oversight in place to support winter planning, with clear path to sign-off by end of Sept?			x	Board sign off still to be sought in September 25.
	Are EPRR frameworks and leadership structures understood and consistently applied across teams?		x		Subject to review/testing pre-Winter
Operational Grip & Escalation	Are OPEL processes set up for real-time visibility of pressures across all services?			x	All SHREWD parameters available have been populated with Wirral figures.
	Are escalation/de-escalation protocols clear and ready to demonstrate in the exercise?			x	All providers have BCPs in place with overall Wirral Opel Escalation Framework.
	Are operational teams prepared to coordinate across urgent & emergency pathways under pressure?			x	Use of WhatsApp, Daily SCC call and other UEC touchpoints e.g. Discharge Cells, Opel 4
Risk Management & Mitigations	Do draft winter plans include risk scores for all high-risk areas (workforce, discharge, MH ED waits)?			x	
	Are mitigations for known risks sufficiently developed to test in Aegis?		x		See risks outlined in presentation slide deck without full mitigation plans.
	Have additional risks already been identified that must be addressed before Board Assurance Statement completion?			x	
Workforce & Wellbeing	Are staffing/surge plans robust and ready to be stress-tested?		x		Successful recruitment key to addressing risk across RNs/CSWs
	Have concrete steps been taken to improve staff vaccination uptake?			x	See Winter Plan

Domain	Question	R	A	G	Commentary / Evidence
	Are wellbeing and resilience offers for staff well-developed for winter pressures?			x	See Winter Plan
System Working & Partnerships	Are local authority and social care partnerships sufficiently embedded in plans to test in Aegis?			x	
	Are systems able to flex capacity to support direct access of flu patients into community bedded capacity?			x	
	Have BCF, predictive analytics, and shared dashboards been incorporated into planning?			x	BCF Plans assigned off by national team. Reductions in key metrics such as Falls and ACS conditions.
	Are VCSE, care homes, and community providers ready to support escalation and discharge?			x	VCSE included in Discharge pathways and Executive Discharge Cell
Patient Safety & Clinical Pathways	Are plans in place to maintain patient safety for high-risk groups under winter scenarios?			x	New Neighborhood Frailty / HIU / VWs / ARI Hubs
	Has progress been made embedding national ED MH Action Cards into escalation processes?		X		Implementation plan developed by CWP.
	Are elective care, SDEC, frailty, and streaming pathways resilient enough to sustain under pressure?		X		Capacity limitations exist
Learning & Readiness for Assurance	Are processes in place to capture learning from Aegis and use it to strengthen final plans?			x	
	Overall, how confident is the trust/system that the Board Assurance Statement can be completed affirmatively by end Sept?		x		

Appendix 3:

Winter SRO Role Cards – OPEL Aligned

NHS
Cheshire and Merseyside

Responsibility Area	ICB Winter Exec	System Coordination Centre (SCC) SRO	Local Authority / Community SRO Need to be identified	Acute Hospital SRO	Locality Winter SRO
Responsibility 1	Overall accountable officer for winter resilience across the system.	Leads in day monitoring of system pressures across acute, community, mental health and ambulance.	Represents social care and community services in winter escalation.	Senior operational lead for acute trust during winter pressures.	Provides visible senior leadership across all providers in the locality.
Responsibility 2	Chairs system calls during system OPEL 4 escalation	Maintains oversight of OPEL triggers and thresholds for the ICS.	Chairs locality/community tactical calls during OPEL 2–3.	Chairs trust-level command meetings during OPEL 2–4.	Chairs daily locality operational calls during winter OPEL 2- 4 as identified on daily scc system calls
Responsibility 3	Authorised to trigger system-wide escalation and request mutual aid.	Provides daily situational reports to ICB Strategic Commander and NHSE regional team.	Leads discharge improvement actions and Home First implementation.	Accountable for ED flow, SDEC utilisation, discharge and site management.	Oversees whole-system flow: acute, community, mental health, social care, ambulance.
Responsibility 4	Provides assurance to NHSE and regional teams on winter delivery.	Coordinates locality escalation and mutual aid deployment.	Ensures community capacity (reablement, step-down, domiciliary care) is maximised.	Leads implementation of HO45 ambulance handover standard.	Monitors discharge performance and unblocks barriers in real time.
Responsibility 5	Directs cross-locality prioritisation of capacity and workforce.	Ensures data accuracy and timely reporting against national metrics.	Escalates risks in community delays and DTOCs to locality/system	Deploys surge beds and manages escalation of elective cancellations.	Triggers escalation actions in line with OPEL framework.
Responsibility 6	Signs off regional reporting and daily system SitReps.	Acts as tactical hub linking localities with regional/national command.	Supports mutual aid across Places for community beds and packages of care.	Reports directly to Locality Winter SRO and ICB SCC on trust pressures.	Acts as Gold Commander for locality during OPEL 4.

16.07.25 v.1.4

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 September 2025

Cheshire and Merseyside Work and Health Strategy and 'Get Britain Working' Plans

Agenda Item No: **ICB/09/25/18**

Responsible Director: Clare Watson
Assistant Chief Executive

Cheshire and Merseyside Work and Health Strategy and 'Get Britain Working' Plans

1. Purpose of the Report

1.1 The ICB along with its partners has a statutory duty to produce an Integrated Care strategy, which should include how assessed local needs such as those relating to work and health will be met. In addition to this Local Authorities are mandated to publish Get Britain Working (GBW) Plans. This paper provides the Board with an update on the Cheshire and Merseyside responses to these requirements.

2. Executive Summary

2.1 This report provides detail on the development of the Cheshire and Merseyside Work and Health Strategy (Appendix One).[1] The detail in the report also outlines the development of the two Cheshire and Merseyside Get Britain Working Plans these are based on the Liverpool City Region Combined authority and Cheshire and Warrington Footprints Appendix Two and Appendix Three)

2.2 NHS Cheshire and Merseyside Integrated Care Board (ICB), Liverpool City Region Combined Authority (LCR CA), and Enterprise Cheshire and Warrington have been collaborating with Local Authorities, NHS commissioners, the VCFSE sector, employers and providers on the development of a Cheshire and Merseyside work and health strategy. This work has multiple aims of improving the health of our population, the workforce and supporting economic growth.

2.3 The final strategy was formally launched on 09 September 2025 along with the inaugural meeting of the Cheshire and Merseyside Work and Health Partnership. Given the changing structural landscape across Cheshire and Merseyside, work is ongoing to consider the most appropriate governance route for the oversight of the implementation of the strategy and the two GBW Plans. The proposed routes for governance and oversight are described further in this report

3. Background

3.1 The aim of this work is to initiate and support the mobilisation of service integration on work and health across the ICS area, in line with identified population health need, to increase workforce participation for disabled people and people with health conditions who face health and social barriers to work.

[1] https://www.cheshireandmerseyside.nhs.uk/media/fh0lrgw2/cm-hw-strategy_final.pdf

This complements the fourth aim of ICSs, to help the NHS support broader social and economic development.

3.2 This work is nationally mandated and the developments to date have concentrated on four key workstreams:

- analysis of available data on work and health across the individual nine places and Cheshire and Merseyside as a whole
- service mapping across the nine places, documenting existing arrangements at a Place level on work and health
- development of an ICS Work and Health Partnership
- development of an Integrated Work and Health Strategy and Action Plan.

3.3 This work fully aligns with:

- All Together Fairer our Health and Care Partnership – work and health is one of the HCP's 6 Headline Ambitions
- the development of both the Liverpool City Region and Cheshire and Warrington GBW Plans (we are fully engaged with the two working groups)
- the HCP's focused work on Child and Family poverty and specifically the optimisation of the benefits workstream
- work around the Housing and Health Agenda
- our role as an NHS anchor institution. We recognise our role in driving social value by creating local NHS jobs and strengthening public trust in healthcare services. Recruiting from within local communities generates tangible benefits, improving wellbeing, increasing household income, and enhancing community resilience.
- the health and inclusion elements of the developing economic Growth and Sustainability plans
- our wider work on population health and segmentation of the population focuses on those cohorts that experience significant inequality.

3.4 The ICB received a national allocation of £89k (2024-25) via the Department for Health and Social Care to support leadership and capacity building. This was utilised to support a procurement exercise facilitated by the Liverpool City Region Combined Authority (LCRCA) in partnership with Cheshire and Warrington. Social Finance a not-for-profit social enterprise were successful in the tender – the work focusing on the four workstreams described above. It is worthy of note that there has been considerable support and engagement across the whole system – Social Finance and their associate company PPL have specifically remarked on how robust the collaboration has been.

3.5 We subsequently received an additional £89k (2025-26) in line with the strategy this has been used to support development work focusing on two specific interventions around supporting children and young people with mental health needs to remain in education and or training in the LCRCA this links with the Youth Guarantee Scheme.

3.6 In supporting elements of the plan, we are waiting for final confirmation on two applications to take part in national programmes namely:

- the development of Employment advisors in MSK services – this will focus on St Helens and Knowsley as a proof-of-concept piece of work.
- the Widening Access Demonstrator programme which aims to support individuals from deprived areas into entry level roles in the health and care sector.

3.7 Alongside this work, Local areas are mandated to produce GBW Plans. The two drafts are provided as appendices to this report. The ICB has been fully engaged in the development of these plans.

3.8 DWP and DHSC's Get Britain Working White Paper (published in November 2024) sets out the requirement for places to develop local Plans to address key issues in local labour markets. These span supporting people to enter and participate in local labour markets, ensure school leavers have access to quality further training and employment opportunities if not progressing into higher education, raise the bar on creating good quality jobs in local economies, fill shortage skill and labour vacancies, support women and people who have had caring responsibilities to progress in work, and address local inequalities in labour market outcomes.

3.9 In Cheshire and Merseyside, the GBW plans are being developed on the Liverpool City Region combined authority and Cheshire and Warrington footprints.

3.10 Two multi agency working groups have been established and national funding was made available to support the development of the plans. In both areas external support has been procured to facilitate the process.

3.11 The Get Cheshire & Warrington Working Plan (Appendix Two) brings together existing strategies into a practical, joined-up framework for delivery. It maps what provision exists, where the gaps are, and how different parts of the system interact - both for those delivering services and for the people navigating them. Moving beyond strategy into implementation, the Plan builds shared understanding, surfaces delivery challenges, and supports collective action. The plan focuses on 5 key priorities:

- Priority 1: Most deprived neighbourhoods
- Priority 2: Young people and NEETs
- Priority 3: Long-term sickness and early retirement
- Priority 4: Carers and parents facing challenges
- Priority 5: Connecting people to opportunities.

3.12 The Get Liverpool City Region Working Plan (GLCRWP) (Appendix Three) provides a high-level, strategic overview of the local labour market challenges, alongside a summary of the existing interventions in place to tackle them. The Plan builds upon the City Region's existing plans, strategies, assets, and good practice to place additional and urgent emphasis on increasing the volume of

our residents who can take advantage of the opportunities our local economy affords. The plan focuses on four key strands:

3.13 The proposed governance of oversight of the delivery of the Cheshire and Merseyside Work and Health Strategy will be via the two Get Britain Working Boards. This will ensure alignment across the three plans avoiding duplication and making best use of the available resources.. In addition, the draft plans have been shared for comment over a broad spectrum of stakeholder and comments included. This has also been discussed in corporate senior leaders' team and population health board in anticipation of Exec and Board sign off.

3.14 In addition to this there will be quarterly reporting to the Cheshire and Merseyside Population Health Board this will be via the established All Together Fairer Board as Work and Health is one of the headline priorities in All Together Fairer: Our Health and Care partnership plan.

3.15 Routing governance and oversight through the Population Health Board will provide a level of stability and focus as we work through devolution and the review of the current Health and Care Partnership.

3.16 To provide adequate monitoring of the key outcomes and metrics the plan is to develop a collaborative collective dashboard. This will help us to understand progress against our agreed outcomes.

4. Ask of the Board

4.1 The Board is asked to**:**

- **Acknowledge** the joint working on the development of both the Work and Health Strategy and the Get Britain Working Plans.

- **Endorse** the published Cheshire and Merseyside Work and Health Strategy and the approach adopted by the two draft Get Britain working plans on the understanding that the final documents will be circulated once complete.

- **Endorse** the proposed governance and oversight of the work and health strategy.

- **Acknowledge** that progressing the work will require Senior ICB leadership and representation at the two Get Britain Working Boards (or appropriate governance structure once established) and an ongoing resource to ensure delivery against plans.

5. Reasons for Recommendations

5.1 The three documents have been developed as the Cheshire and Merseyside responses to our statutory requirements and national mandates.

5.2 Cheshire and Merseyside has strong foundations for inclusive economic growth: a growing population, a diverse economy, and established partnerships across local government, health, education, and business. Regional strategies set out a shared direction to reduce economic inactivity, improve employment and health outcomes, and better align workforce development with economic growth. These strategies present a consistent view of labour market challenges.

5.3 The creation of the ICS Work and Health Partnership and strategy has seen full engagement with relevant leads from across the 9 Places including health, local authority, VCFSE sector, Job centre Plus network, Liverpool City Region Combined Authority, Enterprise Cheshire and Warrington / Cheshire and Warrington Joint Committee, Department for Work and Pensions (DWP) and employers.

5.4 Creation of the Work and Health Strategy for the Cheshire and Merseyside footprint pulls together the local strands of work at a C&M, subregion and a Place level to strengthen and articulate our vision for work and health, supported through our governance arrangements.

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

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

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

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

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

6.1 All of the above are core elements that are embedded in the Work and Health Strategy and the two Get Britain Working Plans – the plans fully align to All Together Fairer: Our Health and Care Partnership Plan.

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

7.1 Meets the areas outlined in the JFP/ADP in relation to the wider determinant's agenda - Work and Health being a headline priority in the overarching All Together Fairer: Our Health and Care Partnership Plan. The approach has also included a deep dive into the most impacted population health cohorts. Addressing inequality is a core stream with each of the strategies.

8. Link to meeting CQC ICS Themes and Quality Statements

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

7.1 The key themes of integration and system leadership are core to each of the three documents.

9. Risks

9.1 The programme management resources supporting this work are limited and will need consideration to assure delivery and ongoing assessment of priorities and use of resources by the Executive Team and Board

9.2 Delivery of the requested reduction in the running cost allocation may have a significant impact on the ICB's ability to deliver the Work and Health Strategy and senior leadership engagement in the two Get Britain Working Boards. This will become clearer as we begin to understand the details of the revised national and local operating models.

10. Finance

10.1 There is no direct impact on finances at this stage – although it needs to be noted that the current and ongoing financial constraints will limit potential investment required to deliver the work and health agenda

11. Communication and Engagement

11.1 Much of the content of the JFP and subsequently the NHS Delivery Plan has been developed through existing programmes, which have established mechanisms for engagement in developing the plans work and health is a core aspect outlined here.

11.2 A copy of the draft documents have been shared with stakeholders throughout the process, feedback received has been incorporated into the final versions. The plans have also been reviewed by the ICB corporate executive team and Place Directors.

12. Equality, Diversity and Inclusion

12.1 An overarching Equality Impact Assessment (EIA) has been completed for the previous JFP, NHS Delivery Plan and the Recovery Programme, the Work and Health strategy is an integral element of these plans - individual EIAs will be produced as required to assess the impact of the individual programmes and plans.

13. Climate Change / Sustainability

13.1 Climate change and sustainability are included as priorities in the ***All Together Fairer: Our Health and Care Partnership Plan*** and associated HCP delivery plan and as one of our headline ambitions – this cross references with the three documents.

14. Next Steps and Responsible Person to take forward

14.1 The ICB Strategy and Collaboration and Sustainability and Partnerships teams will:

- Support finalising the content of the two Get Britain Working Plans
- Finalise the detail in relation to the alignment of the Work and Health Strategy with the Get Britain Working plans.
- Circulate and socialise the Work and Health Strategy and the GBW plans - engaging with programme and enabler leads to fully complete - this will provide the detail of delivery plans containing agreed outcomes, measures metrics and milestones of key priorities.
- Support discussion around the development of a collective dashboard to support the Work and Health Strategy
- Ensure that the governance reflects the developments in both Liverpool City Region Combined Authority and Cheshire and Warrington sub regions and aligns fully with the plans regarding the future of the overarching Health and Care Partnership (HCP)
- Following the above agree a consistent approach across our revised sub-committee structures to capturing delivery of plans, and progress in impacting the agreed outcomes, measures and defined metrics noting this will require ongoing programme management office support.
- Work via the All together Fairer board to ensure quarterly reporting to the Population Health Board.

15. Officer contact details for more information

Stephen Woods, Head of Strategy
(stephen.woods@cheshireandmerseyside.nhs.net or 07813178150)

Dave Sweeney, Associate Director of Sustainability and Partnerships
(Dave.sweeney@cheshireandmerseyside.nhs.uk or 07921623720)

16. Appendices

CLICK HERE to view the consolidated appendices

Appendix One: Cheshire and Merseyside Health and Work Strategy

Appendix Two: Get Cheshire & Warrington Working Plan

Appendix Three: Get Liverpool City Region Working Plan (GLCRWP)

Cheshire and Merseyside
Health and Care Partnership

All Together in Health and Work – An integrated pathway to better outcomes in Cheshire & Merseyside

July 2025

Commissioned by Cheshire and Merseyside ICB and delivered by Social Finance & PPL. For enquiries, please email ankita.saxena@socialfinance.org.uk

Social Finance: Fergus Hamilton, Ankita Saxena, Nadine Smith, Patrick Troy

PPL: Pippa Quincey, David Segal

Towards a fairer future: Building an integrated approach to work and health

Aims of the work:

The aim of this work is to initiate and support the mobilisation of service integration on work and health across the Cheshire and Merseyside ICS area to increase workforce participation for disabled people and people with health conditions who face health and social barriers to work. This complements the 4th aim of ICSs, *to help the NHS support broader social and economic development*.

Social Finance and PPL have worked in partnership with Cheshire and Merseyside over the last four months to develop an integrated health and work strategy, and develop a Health and Work Partnership to oversee implementation of the strategy.

Principles of the work:

- **Prevention focused** – Early intervention to reduce health-related job loss and job-related health conditions.
- **Equity in access and outcomes** – Target support to the groups that are in most need of support.
- **Integration** – Deliver seamless, person-centred services across sectors.

In 2022, the All Together Fairer (ATF) report outlined how public, private, and third sector bodies could address health inequalities through actions at both Place and regional levels, focusing on social determinants of health, including employment.

Each local area has its own approach to tackling unemployment and health inequality, supported by a wider ICS-level programme on work and health. An opportunity exists for more alignment and resource and knowledge sharing between local areas and health across the ICS region.

This piece of work supports our delivery against the Marmot indicator on employment and the Cheshire and Merseyside priority of addressing child and family poverty. It underpins our work with employers and system partners, supporting them to create environments that support our population to start, stay and succeed in work.

[1] ONS Annual Population Survey
[2] NHS England – Fit note data
[3] ONS Annual Population Survey
[4] NHS England – Fit note data

Why it matters: Outcomes for work and health are intrinsically interlinked, and must be treated holistically

There were over 10,000 people with sickness absence in Cheshire and Merseyside in December 2024, and nearly 100,000 people are economically inactive due to poor health.

Actively employed (1.1 million)

In December 2024, there were 1.534 million people of working age (age 16-64) across the region. 74% of these were in paid employment.[1]

Sickness absence (11,500)

Around 3.3% of people were absent from work due to temporary sickness in December 2024 —a rise from 6,800 in December 2004.[2]

Unemployed (45,000)

The unemployment rate in Cheshire and Merseyside is 3.8%, slightly below the Great Britain average of 3.9%.[3]

Inactive – Sick* (97,000)

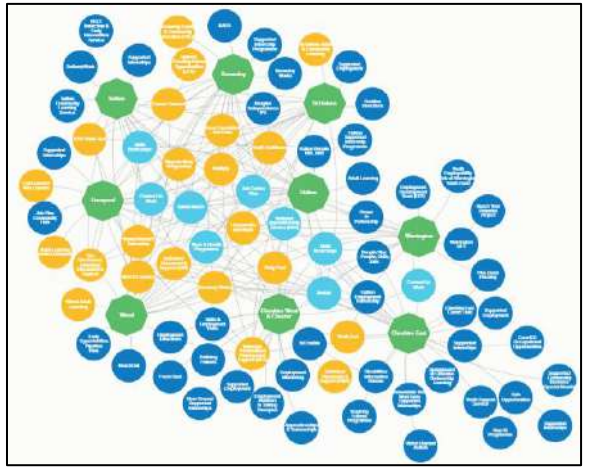
Fit note data shows that a combined 7% of people are off work with long-term and temporary sickness across Cheshire and Merseyside, compared with 5.1% nationally.[4]

*A further 352,100 people were economically inactive across the region without any known sickness.

A broad range of services already exist in the region, but system partners must strengthen how they work together to ensure that we reach those with complex needs

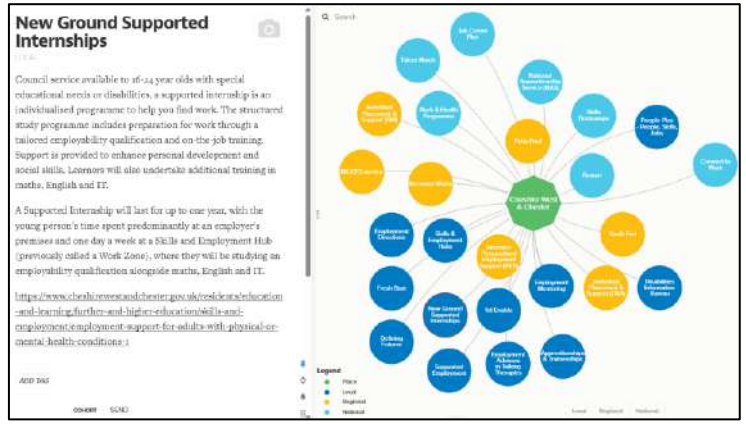
Summary of service mapping findings:

- **Service gaps and challenges with reaching people:** High-needs cohorts are falling through gaps in employment provision across the region. The depth of service provision is often not the issue here—greater challenges persist around better engaging people with health-related barriers to work at the right time and place.
- **Strategic commissioning:** Funding for employment programmes at regional and national levels is competitive, short-term and highly complex. Cohesive employment and skills provision would benefit from a more unified and simplified approach to funding and commissioning, supported by a robust needs analysis and a greater focus on outcomes.
- **Role of anchor institutions:** Anchor institutions have a key role to play in shaping health-promoting employment, but more could be done to scale examples of good practice and learning of what works at a regional level (e.g. Early Opportunities Pipeline in Wirral).
- **Greater support for employers:** Employers need additional incentives and support if they are to become partners in the system. Without this, they will struggle to create and maintain supportive roles for people with complex barriers to work in the current economic conditions.
- **VCFSE sector as a key enabler:** The VCFSE sector must be a key strategic partner across employment and health due to its ability to engage underserved communities. Partnerships with the VCFSE sector should be founded on commitments to sustainable funding and ensuring their voice is present in regional strategy decisions.



Health and Work service map: Region view

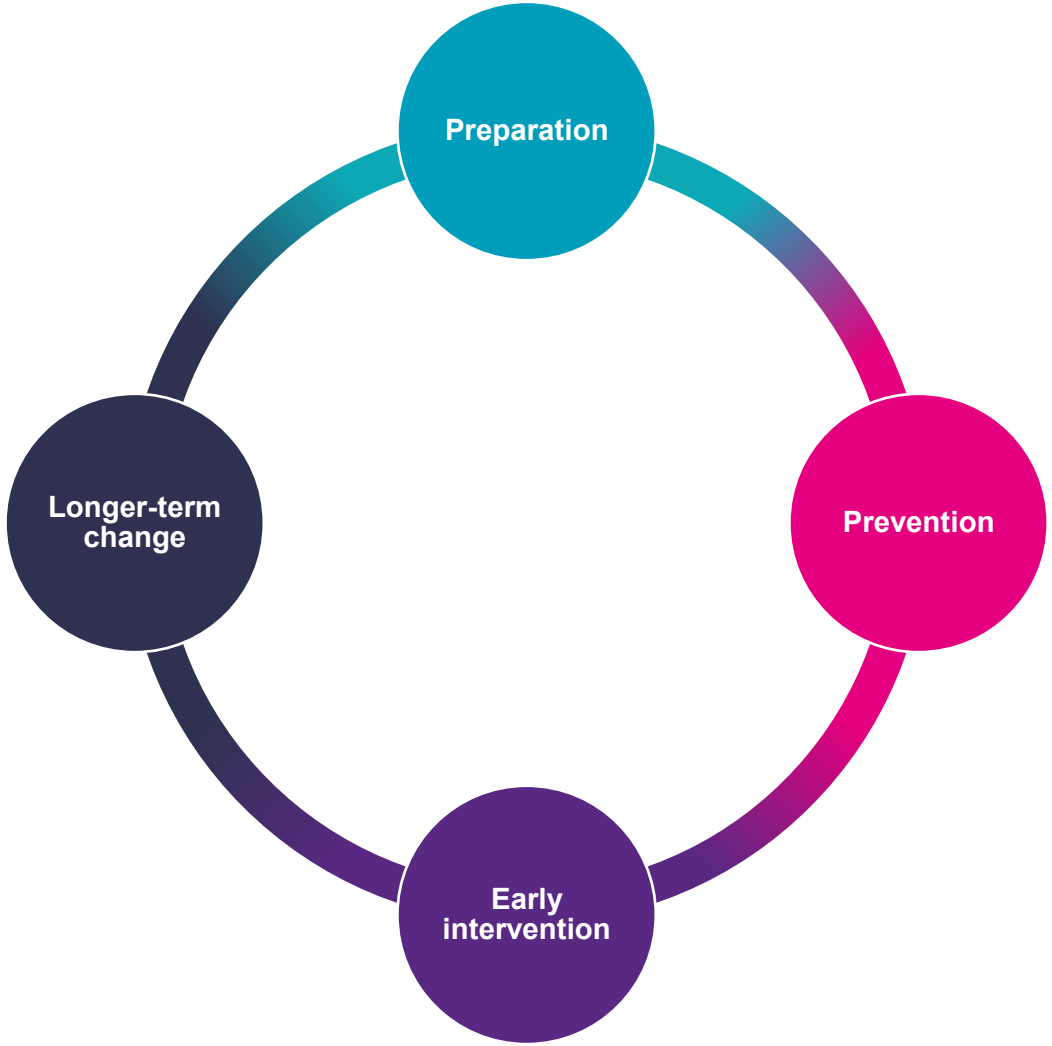
Health and work services map: Local view



Extracts from interactive Service/System Mapping

The Health and Work Strategy is underpinned by four key pillars

- **Preparation** to support young people and others not in employment, with the holistic health, wellbeing and skills support to enter employment.
- **Prevention** to ensure the 1.1 million people who are employed can sustain employment.
- **Early Intervention** to ensure the 11.5k people who are signed off on temporary sickness absence annually can re-integrate into the workforce effectively.
- **Longer-term change** to support the 45k people unemployed and 97k people economically inactive due to health barriers, to live independent and fulfilled lives.



*See Appendix 2 for a full list of recommendations against the strategy framework

Making it real: How to drive better health and work outcomes

Pillar	Key recommendations	Example ideas
Preparation	To prevent young people from becoming unemployed: • Improve **access to education pathways** for people with work-limiting health barriers such as young people with mental health barriers (e.g. through wrap-around support, better financing models). • Improve **quality of skills provision** to better match employer demand in the region.	• Mapping of adult education and transition pathways to better understand barriers to education and skills for people with health conditions. • Development of bespoke skills programmes, with smart financing options and an IPS-style model of wrap-around support for priority cohorts.
Prevention	To improve retention: • Support employers in at-risk sectors, such as the NHS. • Aim to give businesses the **right incentives**, information and tools to adapt roles, improve job design and strengthen workforce management and awareness of best practice.	• Stronger incentives for employers to take a preventative approach to ill health, with cross-sector sharing of what works. • Timely access to vocational rehabilitation and financial support within key anchor institutions, along with opportunities for work placements and retraining.
Early intervention	To reduce economic inactivity: • Improve **access to support for people with** work-limiting health barriers within healthcare services. • Improve **quality of employment support provision** to better match employer demand.	• Co-locate health and employment navigators in Primary Care networks in deprived neighbourhoods. • Build local caseworker models, ensuring culturally appropriate support for minoritised communities.
Longer-term change	To improve equity: • Create a **single front-door** for people experiencing health-related barriers to employment to access support and opportunities. • Make Cheshire and Merseyside an excellent **place to live and be healthy for women.**	• Create a new community covenant to rebalance relationship and commissioning to VCFSE. • Support and mandate local anchor institutions to report on employment practices for people with long-term conditions or disabilities. • Model to support women with long-term conditions/co-morbidity or those with pre-conception and post-conception and endocrine condition.

***See Appendix 2 for a full list of recommendations and outcomes**

Shaping a system-wide vision for health and work

This consultation employed a comprehensive, system-wide approach to shape an Integrated Health and Work Strategy for Cheshire and Merseyside. It lays the foundations for a joined-up, place-sensitive approach to improving employment outcomes for people with health-related barriers to work.

1. Stakeholder engagement

Engaged over **60 stakeholders** across the region, including health, local government, DWP, and VCFSE representatives, building on existing partnerships and ensuring wide input.

***See Appendix 4 for a list of 27 stakeholders interviewed**

2. Service mapping

Mapped **existing services and governance structures** to understand current activity, identify **integration opportunities**, and **highlight gaps** across the system.

***See Appendix 1 for detailed service mapping findings**

3. Data analysis

Analysed local data on economic inactivity, health conditions, and service access **using CIPHA and stakeholder insight** to inform a clear, targeted forward vision.

***See Appendix 3 for further data analysis on the state of health and work in the region**

4. Partnership building

Convened initial ICS-wide Health and Work Partnership sessions across the region, including over **35 representatives** from health, local government, DWP, and VCFSE representatives.

Co-developed a strategic framework and delivery plan anchored in prevention, equity, and integration, aligned to ICS population health priorities.

***See Appendix 2 for a full list of recommendations against the strategy framework**

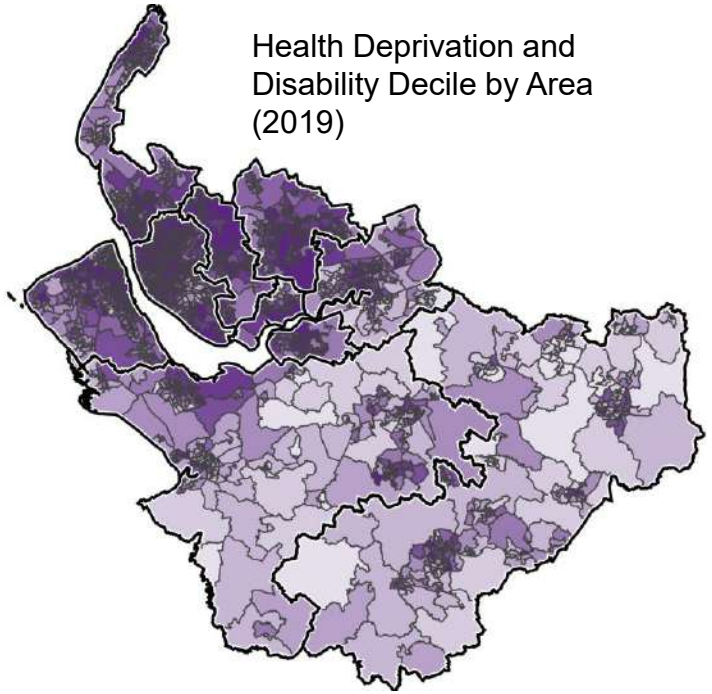
[1] Wirral Public Intelligence Team (2024)
[2] Index of Multiple Deprivation (IMD) (2019)

Health deprivation is prevalent across Cheshire and Merseyside, with significant geographic overlap with employment rates

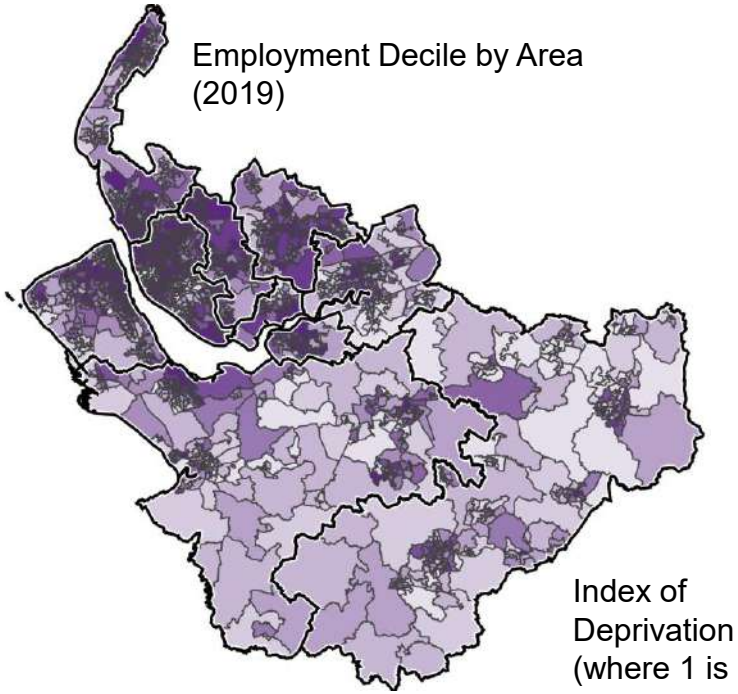
Life expectancy in the region's most deprived areas are 12 years fewer than in its least deprived areas. High rates of health inequality also exist within local authorities themselves – in Wirral, there is a difference in average life expectancy of nearly 12 years between the wards of Birkenhead & Tranmere and West Kirby & Thurstaston.[1]

A third of the population in Cheshire and Merseyside live in the most deprived 20% of neighbourhoods in England. The region's average Index of Multiple Deprivation (IMD) score is 28.6, significantly higher than the national average of 19.6,[2] contributing to high rates of health inequality.

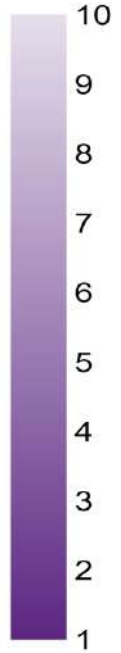
Considerable geographic overlap are observed between rates of health and economic deprivation, with areas of high health deprivation corresponding with areas of low employment. The interlinked nature of these indicators provides a compelling rationale for greater cross-sector alignment between health and employment partners.



Health Deprivation and Disability Decile by Area (2019)



Employment Decile by Area (2019)



Index of Deprivation (where 1 is most deprived)

*See Appendix 3 for additional data analysis on the state of health and work in the region

Despite the broad range of services, several cohorts are falling through gaps in provision

Several disadvantaged groups need greater support in accessing employment and developing the skills needed to secure work that promotes positive health outcomes. While some are already experiencing poor health, many are understood to be at heightened risk of developing physical and mental health conditions due to their exposure to multiple disadvantages across the social determinants of health.

Several underserved cohorts are falling through gaps in current employment and skills provision:

- Children and young people with mental health conditions
- Carers who are 'economically inactive'
- Young people with experience of the care system
- People with experience of the criminal justice system
- Refugees and asylum seekers
- Over 50s with skills gaps
- Adults experiencing social isolation
- Women facing barriers to employment

The Health and Work Partnership should **develop a strategic approach to engaging with these groups**. See Appendix 2 for examples of potential engagement methods and tailored support interventions that promote improved health and employment outcomes.

- While local authority Employment and Skills teams feel that **bespoke services** to support these cohorts **can be beneficial**, efforts to reach some of the more disadvantaged groups (e.g. care leavers and people with experience of the criminal justice system) with such services have seen variable success.
- Maintaining **local sovereignty** over employment and skills strategy and approach is important to ensure that programme fit the **needs of local populations**. **Flexibility in funding** for employment and skills programmes would provide **important innovation space to trial new approaches** that target those most in need of support.
- The Health and Work Partnership should **implement a data and outcomes-led approach** and capitalising on regional participation and buy-in to **disseminate knowledge and evidence of what works** for underserved cohorts.

Funding and commissioning for programmes at regional and national levels is complex and would benefit from simplification

‘An integrated health and work strategy needs to be quite brave and accept from the beginning that the way the current structure has been set up allows people to fall down various cracks and there's not very much that we can do to get them out. We need to understand how funding mechanisms and various service provisions rub together.’

Manager of Council Employment & Learning Service

‘We hope that what comes out of this work shows the need for greater simplification and clarity. Because if we’re confused, what does that say about our potential service users, who are either ending up with no assistance or in services that aren’t right for them.’

Head of Council Employment Service

- **Gaps in services for people with health-related barriers** to work are being driven by a fragmented and complex funding landscape for employment and skills programmes**.**
- **Short-term funding cycles and overlapping eligibility criteria** across national, regional, and local programmes are creating structural gaps, contributing to confusion among both service providers and users about who qualifies for what support.

- The **Health and Work Partnership** has a key role to play in tackling the challenges caused by a fragmented funding landscape.
- To support its role future strategic commissioning of services that align with the health and work needs of people in Cheshire and Merseyside, the Health and Work Partnership should undertake **a robust needs analysis at the Place level** to support improved regional funding alignment for employment support programmes.

Anchor institutions are perfectly placed to lead

Cheshire and Merseyside has a high proportion of public sector employment, with anchor institutions such as the NHS, local councils, emergency services, and education providers serving as major regional employers. These institutions hold significant influence over recruitment and employment practices, shaping local social and economic conditions in several key areas:

- Raising incomes for the lowest earners and increasing overall average income
- Reducing inequality, including the gender pay gap, disability employment gap, and ethnic minority employment gap
- Narrowing health inequalities, such as the life expectancy and healthy life expectancy gaps between local populations and national averages, for both women and men

The Health and Work Partnership should be guided by the five pillars set out in the Anchor Institution Charter (see right).

‘The NHS and local authorities are by far and away the biggest employer in any local authority area. And so that I think we need to challenge ourselves. I think many councils and NHS providers are not good with inclusive recruitment of those with complex barriers.’

Council Economic Lead

The Cheshire and Merseyside Anchor Institute has developed a set of priorities and principles that anchor organisations are asked to commit to delivering based on the 5 recognised anchor pillars:

The Five Anchor Institution Pillars

- Purchasing locally and for social benefit
- Using buildings for spaces to support communities
- Widening access to quality work
- Working more closely with local partners
- Reducing environmental impact

It is vital to work in partnership with employers to reduce the disability employment gap

Stakeholder engagement highlighted the extra support that employers will need if they are to become partners in the work and health agenda.

‘We can talk to employers about being a bit more flexible or a bit more open to working with different cohorts, but we can't dictate changing shift patterns and things like that. Some of them are brilliant with what they do, but at the end of the day, they have a 24-7 business to run. So, there's only so much we can ask—and we do—before they start to push back a little bit.’

Council Head of Inclusive Growth and Partnerships

‘Kickstart [DWP wage subsidy scheme] was really good. We are very supportive of that type of program and approach. The challenge for employers is taking a risk. And what a grants-based program like Kickstart gives them the ability to do is to reduce that risk.’

Head of Council Employment Service

- **Challenging economic conditions** in post-pandemic years have led employers to prioritise cost-cutting and efficiency, making them less likely to invest in training or support for individuals with complex barriers to work.
- **With limited resources and heightened competition**, businesses tend to view hiring such individuals as a greater risk, which presents additional challenges to employer engagement.

- **Local employers are expected to expand roles for people with complex health-related barriers to work**; however, without financial incentives and clearer guidance on how to create inclusive roles, the success of the Get Britain Working programme may be at risk.
- **De-risking inclusive recruitment** could include wage subsidies, tailored in-work support, and targeted employer engagement strategies which highlight the long-term social and economic benefits of supporting people with complex health-related barriers into work.

Better utilisation of the VCFSE sector will play a key role in success

- VCSFE organisations are deeply embedded within local communities and have built up trusting relationships with resident making them invaluable strategic partners for delivering employment and skills services to reach people who are unserved by statutory services. With over 120 full members, Voluntary Sector North West (VSNW) is the largest regional network and membership body, working to influence policy, drive system change, and strengthen the sector's voice in regional decision-making.
- The VCFSE sector faces challenges in places where its work is not viewed as part of the health system or is dismissed due to perceptions that it only delivers 'nice' or softer services. Additionally, structural and funding challenges—like short-term commissioning cycles, limited infrastructure and political attitudes—have led to underdevelopment in some areas.
- **The Health and Work Partnership should deepen collaboration with the VCFSE sector as a key partner at both strategic and service deliver levels.**

'VCFSE organisations are going through a really hard time at the moment. Shorter and shorter funding periods destabilise the local community and the people who work for and use the services. It's awful considering what they give back into our communities.'

Principal Public Health Officer, Council

Examples of effective partnerships between VCFSE organisations and local authorities across the region

Area	VCFSE assets
Liverpool	Liverpool CVS is well-developed, with over 100 years experience enabling VCSFE organisations in Liverpool. Currently manages wide range of grants and has funded employability services for people with health-related barriers to work.
Cheshire West & Chester	Cheshire West & Chester Council maintains strong local partnerships in the VCFSE sector. Youth Fed links to 150 youth groups in the area and delivers a range of programmes supporting young people with barriers to work.
Warrington	Warrington Youth Zone is supported by Warrington Council, hosting several programmes to support disadvantaged young people with training and work placements.
Wirral	Long-term partnership with Involve Northwest to deliver services to support people with employment and other issues. Recognised by Ofsted for effective VCFSE engagement.
Sefton	Sefton CVS is one of the biggest in the UK and works with the DWP and other partners to deliver services related to employment and health.

There are strong examples of partnership working, with a need to build on this to create a truly connected system

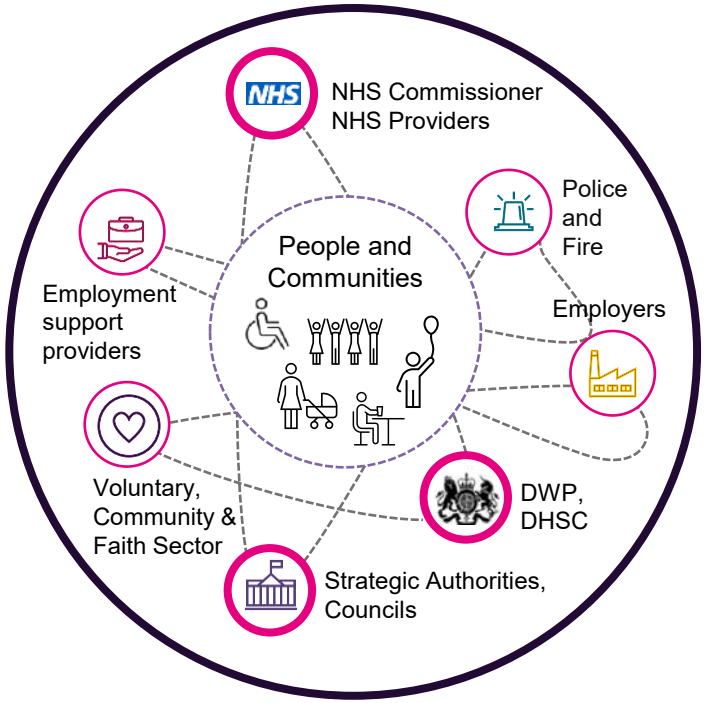
There is a long history of working in partnership across Cheshire and Merseyside, particularly in areas that require multiple partners to deliver on a shared vision. Partners have already been working on the Work and Health Agenda with an existing foundation to build on:

- **There are several active programmes already** in the geography that people we spoke to were working on: e.g. IPS, Devolution work, Trailblazers, Population Health Programme, Poverty Commission.
- **There is good collaboration taking place between national support programmes and the region**: e.g. DWP working with Enterprise Cheshire and Warrington on the 9,000 young people receiving benefits, anchor institutions work.
- **Positive collaboration is happening among partners in Cheshire and Merseyside:** e.g. targeted work on inequalities involving colleagues from across the ICB, Cheshire and Merseyside Public Health Collaborative (CHAMPS), and Liverpool City Region and Cheshire and Warrington.
- **There are a range of support pathways that are delivered through collaboration of key partners:** e.g. the Early Opportunities Pipeline Pilot in Wirral is delivered by Wirral Council in partnership with the borough's anchor institutions to remove barriers to work.
- **There are significant programmes of investment planned through devolution:** e.g. the Youth Trailblazer programme; WorkWell MSK programme; Widening Access Demonstrator.

- While there are some good connections already across different parts of the system, the opportunity to create a **connected system** is much greater. This will require greater clarity across Cheshire and Merseyside on the vision and everyone's roles and responsibilities to deliver that vision.
- **The opportunity here is to create the complementary links** between all the aspects we are working on: e.g. the opportunity in economic development to tackle poverty and the positive impact of better outcomes in enabling people to get into the workforce.
- **To do this we must broaden the understanding of each other's worlds,** and create those connections not just at the strategic level but also at the practical delivery points.
- **We must move from a series of targeted interventions** to a system focussed on delivering impact; including an ability to identify and measure outcomes, and an ability to learn form what does not work, and scale up the things that do, making best use of social impact investment opportunities.
- **Data will be critical**: There is a data richness across this area of work in Cheshire and Merseyside, but lots more can be done to create data insights that help focus and prioritisation. A crucial step will be to ensure all partners have access to standardised data that allow for human-centred insights into the state of health and work in the region.
- **Partnership with residents and communities** is key and an area that has not been consistently achieved – the Health and Work Partnership must have residents at the heart, with a shared mission to tackle inequalities as a primary focus.

To achieve our vision, we need a network of collaborators across a complex range of people and organisations

While the ICB and Local Authorities will provide a leading role in driving this work forward locally, they will do so as conveners and facilitators, of a much broader partnership that will develop and mature over time.



The partnership will work together across four fundamental areas :

- Strategic partnership to set out the vision; outcomes we are trying to achieve (and for whom); and how we will measure success
- Working together to design a model and pathways to tackle the health issues that are preventing people from work
- Implementing support and joining up services
- Defining what good looks like, tracking and measuring progress, and responding to this learning

And in ways that promote effective partnership and positive outcomes:

- Co-produce change with our communities, operating to a shared set of co-production principles
- Take action in an inclusive way that generates buy-in and ownership across the system
- Build from the foundations and assets that already exist, including community assets
- Ensure effective governance is in place and alignment to wider system priorities and values
- Be data and evidence driven, and establish an innovative agile approach to change through a test, learn and adapt approach
- Work to a shared set of long-term outcomes, tacking a whole system approach to delivering impact and value

By working in this way the partnership will:

- Focus on **prevention**, working with communities to understand needs and intervene early to maximise positive long-term impact on people's lives
- Tackle **inequalities,** targeting our support on people and communities who are seldom heard and would benefit most from our support
- Maximise our **impact,** by using our collective resources in a way that best meets the needs of the population

Partnership working will take place at multiple places across Cheshire and Merseyside

National

Cheshire & Merseyside

Liverpool City Region

Enterprise Cheshire and Warrington

Local Authority boundaries

Neighbour-hoods

Turning national policy into reality. This will see DWP collaborating at multiple levels dependent on programme outcomes and goals and which partners holds the levers and keys for that programme.

Defining a vision, target outcomes and priorities for C&M. Bringing together leaders from across the partnership; initially operating at C&M level but likely to transition to devolved areas.

Establishing and delivering plans
Each place will have a plan to deliver on the strategic outcomes for their local populations. Where there are benefits to work at scale, these elements will feed in to plans held by LCR & Enterprise C&W.

Co-production & delivering services
Providing tailored support and delivering services locally; *including services commissioned at scale – these must integrate and deliver at neighbourhood level.*

Learning and influence
All the learning from the work that happens on the ground with people, communities, and teams will flow back and influence not just local decision making but also national policy and focus.

To drive forward action during this period of significant change, a **Work and Health Partnership** will be established initially starting at C&M level, but likely to transition to align with the areas of Local Government reform as per the 10-year plan. This Partnership will own a joint **Prevention Strategy** guided by a **Joint Strategic Needs Assessment**.

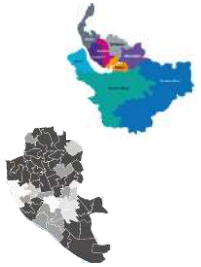
Tailored partnerships at each level will operate to a set of complementary roles and responsibilities

Who?

Strategic commissioning for work and health will happen at multiple levels stretching from national insights through to Strategic Local Authority area. To navigate this complexity a new group will be established at Cheshire and Merseyside level as a logical mid-point to convene partners.

Roles and responsibilities:

- Understand the specific needs of the population; both the whole population and variation within it, and to a neighbourhood level to understand specific demographics and needs hyper-locally.
- Develop strategic insights that will guide the utilisation of collective resources to better meet the needs of the work and health agenda.
- Own and communicate the collective vision for work and health across Cheshire and Merseyside
- Own the strategic approach to delivering on this vision, ensuring that this flows through the system and organisation effectively.
- Manage and distribute resources to ensure that they are aligned to the needs across the C&M population.



Who?

For the Health and Work Partnership to be successful, support must be provided locally and harness the breadth of assets of local neighbourhoods. Some services will be commissioned at a larger geography (e.g. across Cheshire and Merseyside or devolution areas), but they must commit to operating locally to ensure effective integration with all support and services as close to people and families as possible.

This will require partnership to be established at neighbourhood level, and at Place level to co-ordinate across and support neighbourhood delivery in community spaces, engaging with communities on their own ground.

Place roles and responsibilities:

- Develop and delivery of a shared plan.
- Deliver the plan through co-production, facilitating delivery at the neighbourhood level.
- Directing teams and organisational resources to deliver on the plan.
- Troubleshooting challenges and facilitating improvement and innovation.
- Create a learning and innovation environment where staff across statutory services, the voluntary and community sector and communities themselves are working together to deliver.

Neighbourhood roles and responsibilities:

- Analysing population health data to identify needs within the population and target resources
- Co-producing change to local support systems
- Helping people to navigate the local system and find the support they need through effective communication and guidance
- Co-designing and delivering support pathways that brings together partners to deliver integrated support that harnesses both statutory services and wider voluntary and community assets
- Operating to a ‘no wrong door’ approach, directing people to partner services as appropriate

Several immediate opportunities have been identified by partners from across the system

Co-production	Align priorities	Utilise momentum	Crack the data question	Share the learning
• The recommendations in this report are only the start of the journey, and partners are committed to co-producing the change with people and communities. • The partnership will become stronger as it develops a set of shared co-production principles to operate to as markers for success. • Any detailed plans will be built with these co-production principles at their heart.	• Reviews of existing organisational and partnership strategies and plans will enable the partnership to identify synergies, interdependencies and potential conflict. • Resolution of conflicts through open discussion and compromise at the start will help deliver change in the long term. • By aligning priorities against this shared vision now, partners will be able to build the outcomes and opportunities identified in this report into their individual organisation's priorities and plans.	• There are opportunities in existing projects and plans that can be used as a vehicle to move forward the agenda at pace as areas of test, learn and scale. • This will be supported by also identifying champions across the system who can embody the shared vision within and communicate it effectively to wider groups. • This champions must also come from the key communities who will benefit from this work and who can mobilise the strength of community assets to be part of co-producing the change.	• The partnership will take a pragmatic outcome focussed approach to improving data sharing and insight development, identifying the solutions that have the most impact (vs concentrating on all the risks and issues). • Over time the partnership will co-develop a data strategy and data improvement plan, including setting out any data sharing agreements that may be required in a mature system.	• The partnership will establish a simple infrastructure for sharing case studies and good practice. • This includes forums for staff to come together to share experiences, alongside service users, residents and charities. • It also includes processes and mechanisms to start small with innovative projects and changes, to then scale up the change if it works. • All supported by evidence shared through learning circles, ensuring feedback loops and two-way communication.

Change starts now

As a Marmot region, Cheshire and Merseyside has a golden opportunity to become a beacon of progress on work and health, both regionally and nationally. Guided by the strategy set out in this document and led by a cross-sector Health and Work Partnership, there is now undeniable momentum that must be capitalised upon to ensure that the wellbeing of the population and economic prosperity are advanced hand-in-hand. By embedding health into employment services and employment into health pathways, the region can reduce inequalities, boost productivity, and create a fairer, healthier future for all its residents.

Build on best practice

We see fantastic examples of best practice with regards to bespoke employment and skills programmes supporting underserved cohorts in the 9 Places. The Health and Work Partnership emerging from this work is an opportunity for shared learning of what works in the region and why, ensuring those services can support regional and hyper-local challenges and targeted public participation methods.

Drive inclusive growth

The NHS and local authorities have a strong opportunity to improve pathways to education, skills and employment for people with health barriers. Through leveraging their role as anchor institutions, building robust employer engagement programmes, and leveraging social impact investing to achieve outcomes–the region can improve its commitments to inclusive economic growth that leaves no one behind.

Focus on data and outcomes

An outcomes-based approach combining health, work, and skills will be needed to truly understand the long-term impact of delivery against strategic priorities. This will require the Health and Work Partnership to take a whole-system approach–one which focuses in on the interaction of work and health within the context of the wider social determinants of health.

Steward a complex system

The picture on health, work and skills—and how they relate to longer-term economic development and regeneration—is complex and can sometimes feel disjointed on the ground. While progress is being made, this remains a journey. There is now a clear opportunity for the Health and Work Partnership to play a central role in stewarding the next stage: strengthening regional integration and delivering better shared outcomes over time.

Glossary

ATF	All Together Fairer
C&M	Cheshire and Merseyside
C&W	Cheshire and Warrington
CHAMPS	Cheshire and Merseyside Public Health Collaborative
CIPHA	Combined Intelligence for Population Health Action
CVS	Council for Voluntary Service
DWP	Department for Work and Pensions
ICB	Integrated Care Board
ICS	Integrated Care System
IMD	Index of Multiple Deprivation
IPS	Individual Placement and Support
LCR	Liverpool City Region
MSK	Musculoskeletal
NHS	National Health Service
VCFSE	Voluntary, Community, Faith, Social Enterprise

Metro——Dynamics

Get Cheshire & Warrington Working Plan

Working Draft

September 2025

Contents

Executive summary

[placeholder]

Introduction and context

DWP and DHSC's Get Britain Working White Paper sets out the requirement for places to develop local Plans to address key issues in local labour markets. These span supporting people to enter and participate in local labour markets, ensure school leavers access quality further training and employment opportunities if not progressing into higher education, raise the bar on creating good quality jobs in local economies, fill shortage skill and labour vacancies, support women and people who have had caring responsibilities to progress in work, and address local inequalities in labour market outcomes.

The Get Cheshire & Warrington Working Plan brings together existing strategies into a practical, joined-up framework for delivery. It maps what provision exists, where the gaps are, and how different parts of the system interact - both for those delivering services and for the people navigating them. Moving beyond strategy into implementation, the Plan builds shared understanding, surfaces delivery challenges, and supports collective action.

There are near-term opportunities for the subregion which mean this Plan is timely:

- Devolution will give the subregion devolved Adult Skills Fund, which can be targeted at areas of need– if skills and confidence is a barrier for returning to work this could be a focus.
- Likely future ability to codesign future employment support could address economic inactivity (for example around health & work) and concentrations of unemployment in some parts of Cheshire and Warrington.
- Local Growth Plan development and future local growth funding succeeding UKSPF will connect labour market demand and growth opportunities with strategy around skills and local employment supply.
- MHLCG and the Cabinet Office are supporting place-based public service innovation efforts with test and learn approaches.
- The 10 year Health Plan sets out government reforms to neighbourhood health services and NHS management at the national and Integrated Care Board (ICB) level – moving to strategic commissioning more aligned with Mayoral Strategic Authorities.

Cheshire and Warrington has strong foundations for inclusive economic growth: a growing population, a diverse economy, and established partnerships across local government, health, education, and business. Regional strategies set out a shared direction to reduce economic inactivity, improve employment and health outcomes, and better align workforce development with economic growth. These strategies present a consistent view of labour market challenges.

Cheshire and Merseyside ICB's Work and Health strategy sets out the key health challenges in Cheshire and Warrington, linking to constraints on the labour market – this Plan draws on that data and analysis. The subregion's Sustainable and Inclusive Economic Strategy

(produced by Enterprise Cheshire and Warrington) sets bold ambitions to tackle key indicators of deprivation and combat place-based inequality, aiming for no communities in Cheshire and Warrington in the most 20% deprived nationally by 2045. To support this, the Fair Employment Charter, endorsed by the three local authorities, encourages local employers to offer secure jobs, training pathways, and diverse hiring practices that also benefit residents in disadvantaged areas.

Economic inactivity is rising, particularly among older people and individuals with long-term health conditions, and there is a need to reduce the 106,000 people currently inactive across Cheshire and Warrington. Place-based inequalities remain particularly pronounced in places such as Ellesmere Port and parts of Warrington, facing different barriers in each case.

The Local Skills Improvement Plan (LSIP) co-ordinated by South Cheshire Chamber of behalf of the subregion, identifies skills shortages in sectors including manufacturing, health and social care, digital and low carbon. Despite growth potential, skills provision is constrained by limited progression pathways, and misalignment between training infrastructure and employer need.

Programmes such as Multiply and Skills Bootcamps are widening access to adult learning, while the Health and Care Academy is developing clearer pathways into care roles. Local authorities are using UK Shared Prosperity Fund (UKSPF) allocations to commission locally tailored interventions that respond to community needs and align with LSIP priorities. The Integrated Care Strategy and Work and Health Strategy further reflect a shift towards more person-centred and preventative models of support, recognising the role of work in improving health outcomes and reducing inequalities.

Together, these strategies and programmes offer a strong foundation for action planning. In order to shift the dial on unemployment and economic inactivity, Cheshire and Warrington needs an approach going forward that will:

- Provide more flexibility to tailor services to local needs and enable partners to be more responsive and accountable to local communities
- Understand delivery at the best level for the individual to deliver better outcomes, preventing duplication of activity and administration
- Promote early intervention to build the social and institutional capacity enabling long term cost reduction.

This Plan sets out an analysis of the current labour market strengths and challenges, focusing in particular on patterns of economic inactivity and unemployment, maps current provision and gaps, and proposes actions to better integrate provision and employment support going forward under the first devolution agreement for Cheshire and Warrington. While the programmes and actions included here do not cover powers that are being devolved, it nevertheless supports a joined up strategic platform to go further on employment support, the priorities are intended to align with devolved powers across economic growth and skills, and partners want to work together on actions alongside devolution.

This Plan has been developed in engagement with partners across Cheshire and Warrington including the three local authorities, Cheshire and Merseyside ICB, DWP, skills providers, the voluntary and community sector, and employer representatives.

Labour market analysis

Overview of data

Using publicly available data largely from the Office for National Statistics and MHCLG Index of Multiple Deprivation, as well as bringing together insights from key strategies and policies, we have collated a separate detailed socioeconomic evidence base which is available to partners across the subregion. We have also drawn on existing strategies and policies, DWP data on Universal Credit claimants in Cheshire and Warrington, and engaged with stakeholder across the region to help target specific groups which are currently facing more barriers to entering employment.

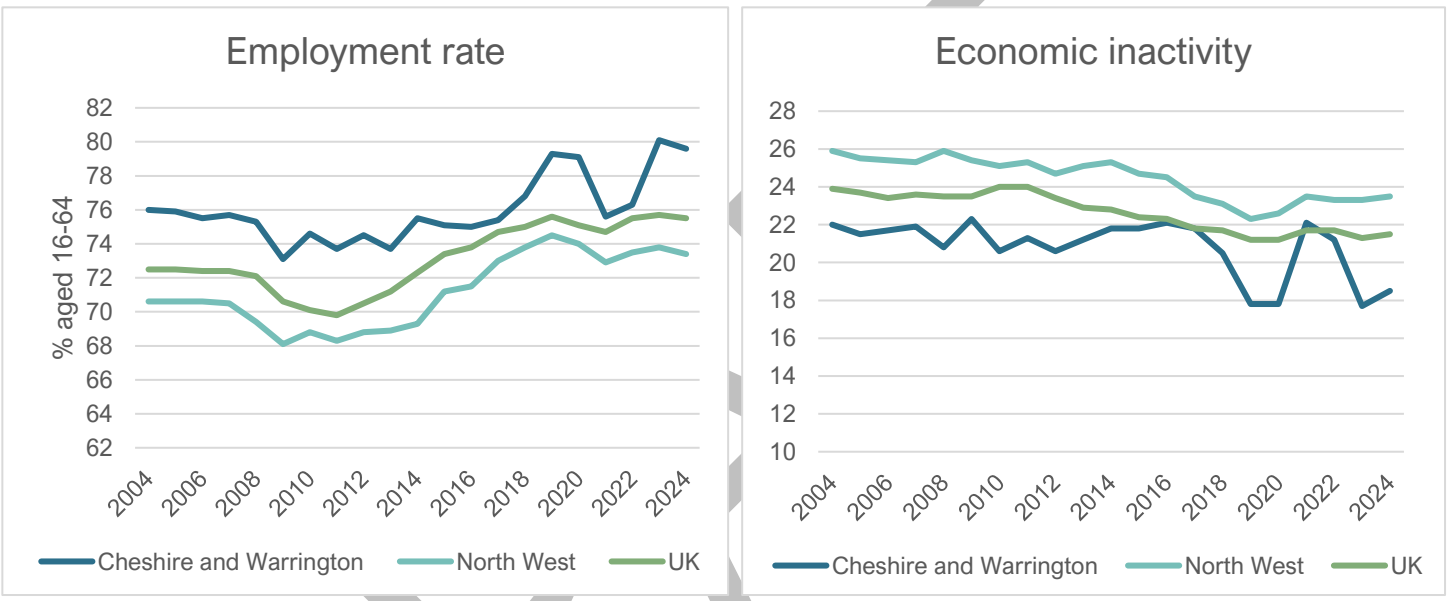
The labour market analysis in this Plan is based on the following data:

Local labour market	Current service provision
Labour market supply factors	
Levels of employment and inactivity – incl. older people, NEETs, ill-health	Existing services across the NHS, local government, JCP, and VCSE (coverage, levels of demand and delivery) supporting: • Inactivity and ill-health, disability • Unemployment and job matching • Skill and employability development • Poverty and multiple disadvantage Targeted initiatives and projects (coverage, levels of demand and delivery) such as UKSPF-funded employability programs; Supported Employment; health and work support for people with disabilities of substance misuse and targeted services for care leavers.
Unemployment – incl. long-term, older and young people	
Disadvantaged neighbourhoods	
Disadvantaged cohorts – multiple disadvantages incl. disability, homelessness, ex-offenders, care experienced, ethnicity	
Skill levels and educational attainment across places	
Labour market demand factors	
Earnings	Employer led / engaged activity and initiatives to support: • Employment and apprenticeship opportunities targeted for disadvantaged cohorts and neighbourhoods • Training and progression through high quality, skilled jobs with earnings progression • Specific in-demand skill development with colleges and skills providers
Vacancies in employment and apprenticeship/training opportunities across places and sectors	
Quality of jobs and local employer offer across places and sectors	
Skill requirements and shortage demand across sectors	

Employment and economic inactivity

The labour market in Cheshire and Warrington remains strong particularly when compared with the wider North West region. Employment is almost at the 80% target across Cheshire and Warrington, jobs growth has been strong and there is a relatively high number of job opportunities available compared to regionally and nationally. Economic inactivity despite a steep rise following the pandemic, has since fallen, following general downward trend over the last two decades and at 18.5% remains well below the 23.5% across the North West, indicating strong participation in the labour market in Cheshire and Warrington.

Figure 1. Employment rate (LHS) and economic inactivity (RHS) rate (2004-24)



Source: ONS Annual Population Survey (2025)

However, this masks the varying experiences felt by residents. Despite strong employment, long-term unemployment levels remain stubborn at around 100,000 including 65,500 Universal Credit (UC) claimants who have been unemployed for over 12 months. Within Cheshire and Warrington there is variation, where employment is lower and inactivity higher in Warrington compared to Cheshire.

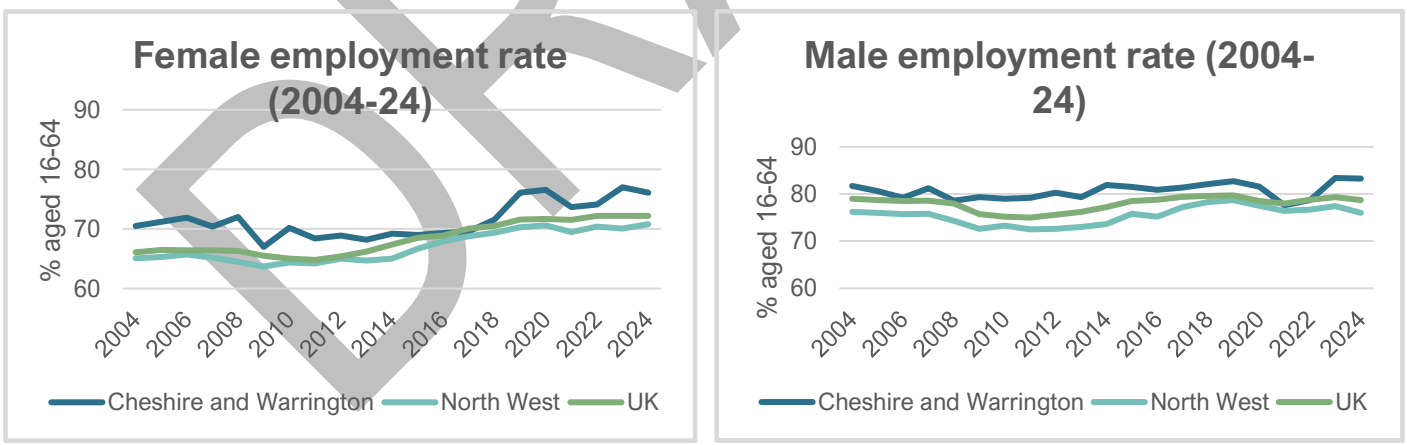
But jobs have been growing in Warrington more quickly than elsewhere in the subregion, and the number of jobs per working age resident (jobs density) is particularly strong in Warrington at 1.26, although all areas in Cheshire and Warrington have a high jobs density compared to 0.83 across the North West and 0.86 nationally.

Figure 2. Employment rate (LHS) and jobs growth (RHS)

Sources: ONS Annual Population Survey (2025); ONS Jobs Density (2025)

The employment rate for both men and women is high compared to regional and national averages, nonetheless, women in Cheshire and Warrington are more likely to be out-of-work than men, as shown by employment rates by sex which in 2024 stood at 83% for men but 76% for women. This follows through in terms of economic inactivity, although the female inactivity rate is lower than compared to regionally and nationally, the inactivity rate of 22.4% for women is above 18.8% for men in Cheshire and Warrington. In Cheshire and Warrington, women make up 60% of those who are economically inactive, slightly above 56% regionally and 58% nationally.

Figure 3. Employment rate 2004-24, female (LHS) and male (RHS)



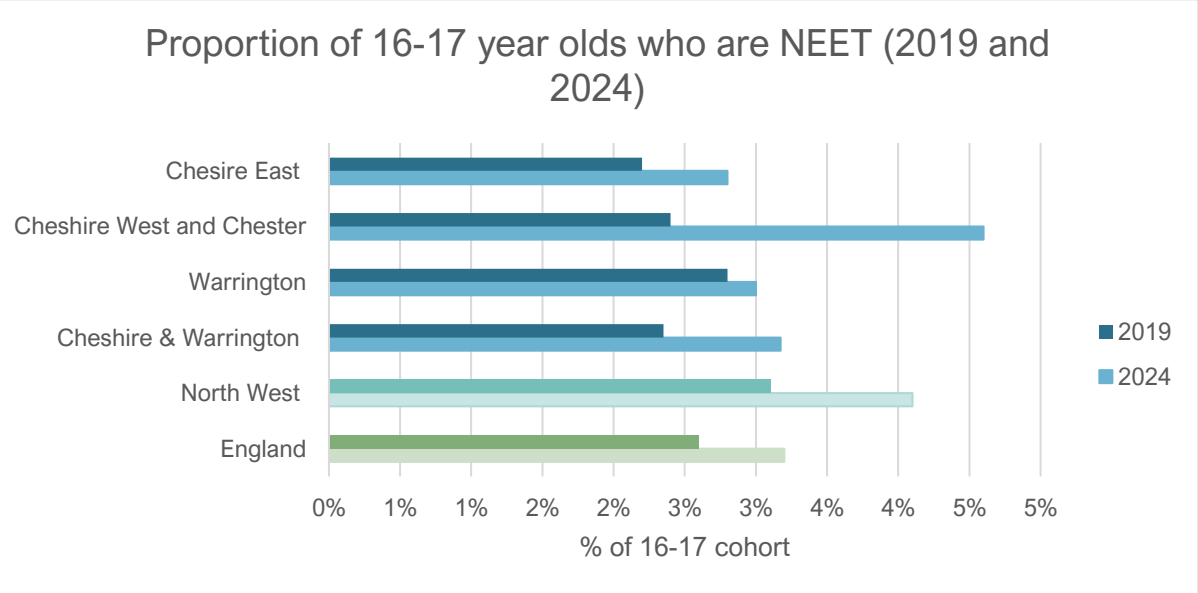
Source: ONS Annual Population Survey (2025)

Young people and NEETs

A key transition point is those leaving school and/or college ahead of potentially entering into the workforce. The risk for those leaving educational settings and not being in education, employment or training (NEET) has been steadily rising across Cheshire and Warrington over the last five years, with 528 16-17 years olds classed as NEET in 2024. Across Cheshire and Warrington the NEET rate has risen from 2.4% to 3.2% over the last 5 years. All areas in

Cheshire and Warrington have seen a rise in the NEET rate over this period, the most pronounced of which has been in Cheshire East where 4.5% of 16-17 year olds are NEET, Warrington and Cheshire West and Chester closer to 3% but nonetheless up from levels seen 5 years prior.

Figure 4. Proportion of 16-17 year olds who are NEET (2019 and 2024)

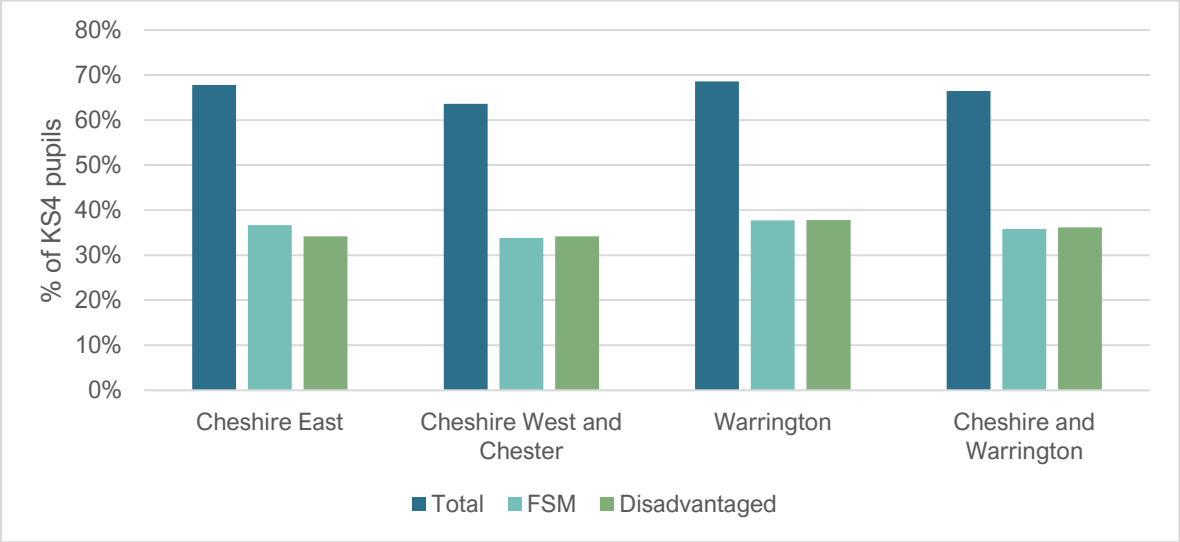


Source: DfE Participation in education, training and NEET age 16 to 17 by local authority (2023/24)

There are risk factors increasing the likelihood of young people in Cheshire and Warrington becoming NEET, including those eligible for Free School Meals (FSM) or classed as disadvantaged1 which includes those who have been in care. In the 2023/24 academic year, two thirds of pupils achieved grades 4 or above in English and Maths GCSEs across Cheshire and Warrington. However, attainment of young people eligible for free school meals or classed as disadvantaged is almost half overall GCSE attainment levels. Although attainment varies somewhat across Cheshire and Warrington, attainment in all three local authorities is far lower for those eligible for free school meals or classed as disadvantaged.

[1] Pupils are defined as disadvantaged if they are known to have been eligible for free school meals at any point in the past six years (from year 6 to year 11), if they are recorded as having been looked after for at least one day or if they are recorded as having been adopted from care.

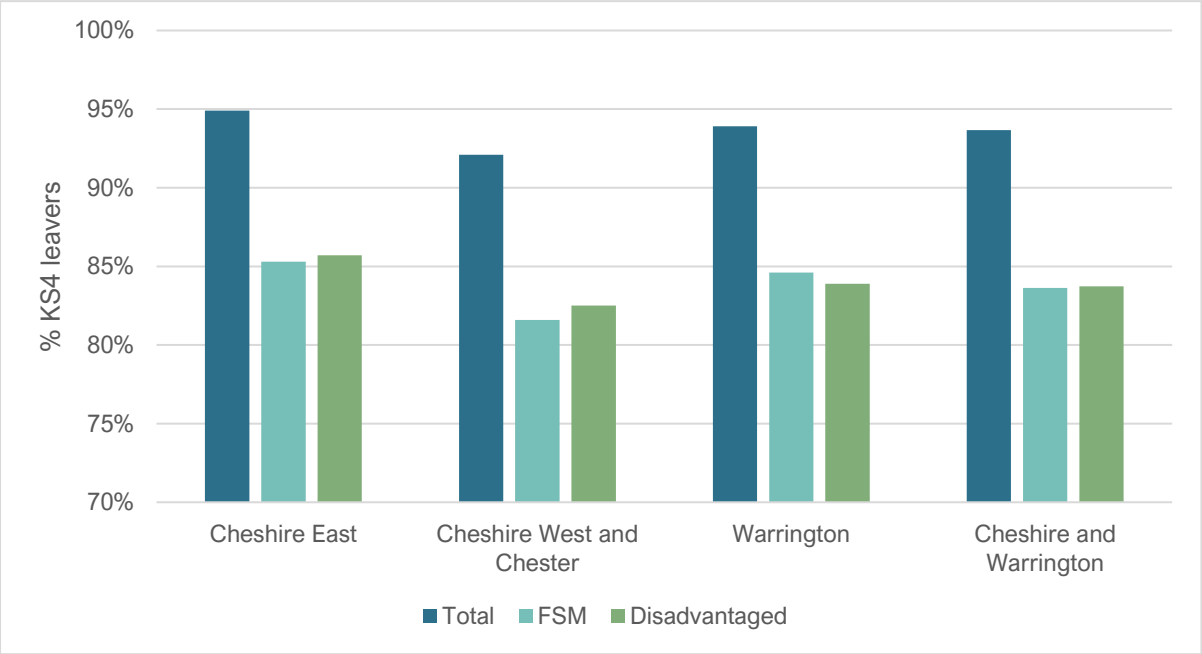
Figure 5. Percentage of pupils achieving grades 4 or above in English and maths GCSEs (2023/24)



Source: DfE Key stage 4 performance (2025)

This then has a knock-on impact on the ability to enter into further education, employment or some form of training. Across Cheshire and Warrington, 94% of KS4 leavers entered into some form of further education, employment or training in 2022/23, falling to 84% for those who are eligible for FSM or classed as disadvantaged, again a trend which is matched by the three authorities across Cheshire and Warrington. The attainment gap for those achieving Level 2 qualifications is around 25 percentage points for those eligible for FSM or classed as disadvantaged, opening up to 33 percentage points for Level 3 qualifications.

Figure 6. Percentage of KS4 leavers in sustained education, employment & apprenticeships (2022/23)



Source: DfE Key stage 4 destination measures (2025)

We have heard from stakeholders that there is a lack of consistent, sustainable re-engagement activity available across the subregion despite work trying to support more vulnerable school leavers including co-ordinated support between LA and college pastoral staff. Young people are now able to swap courses until November, and the opportunity to start college in January. But there is recognition for transition plans to be consistent across the subregion and then transferred/shared with the receiving institution.

More generally there is a lack of coordinated careers information, advice and guidance for young people and adults promoting the job opportunities available in Cheshire and Warrington. Engagement has found that work experience is very difficult to source and still relies on parents helping young people to find placements. From an employer's perspectives, there are a lack of incentives to take on younger more inexperienced people perhaps who have just left school or early into an apprenticeship, as they continue to grapple with an increase in minimum wages and National Insurance contributions, and higher energy costs. Mental health is another significant driver of rising NEET levels with a lack of access to mental health services a challenge nationally as well as in Cheshire and Warrington, with long waiting times to access services.

Long-term sickness and early retirement

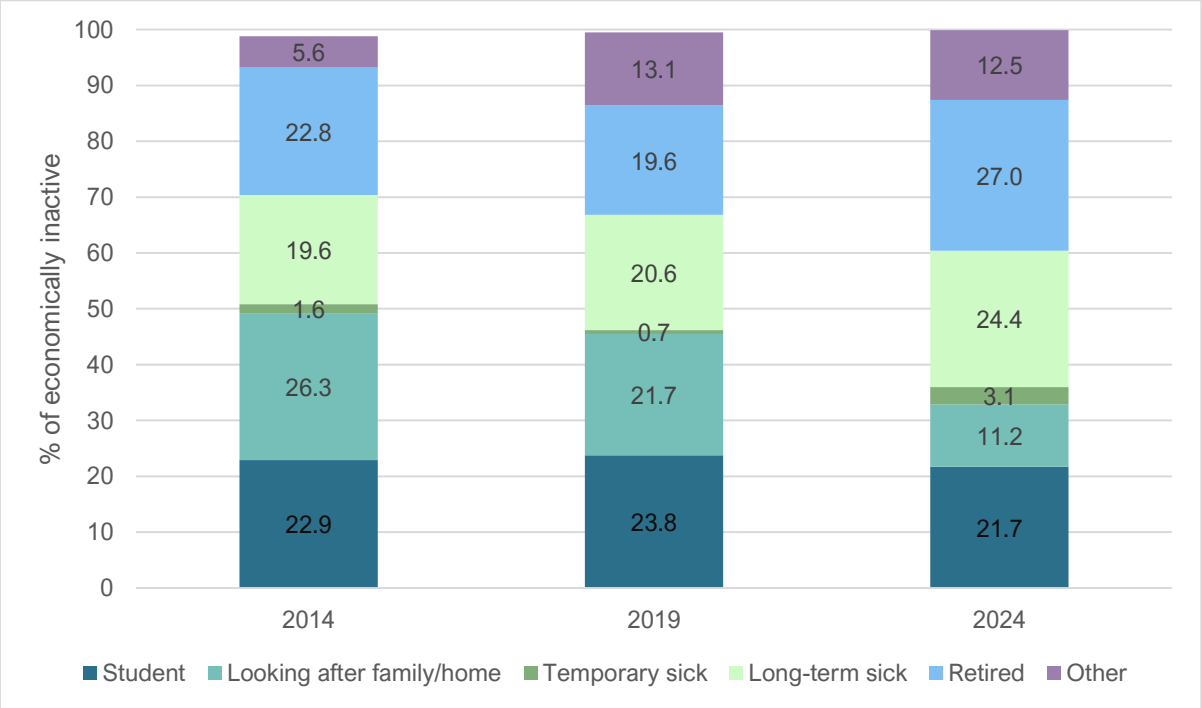
Between 2019 and 2024, there has been a slight rise in inactivity across Cheshire and Warrington, following wider trends since the Covid Pandemic where economic inactivity has risen. Although remaining well below the regional and national averages, inactivity has increased more steeply than compared to national trends. Within Cheshire and Warrington

there has been differing experiences. Economic inactivity is lowest in Cheshire West and Chester, where inactivity continued to decline over the last decade, including over the last 5 years to 15%, in contrast to trends seen elsewhere. Cheshire East has seen a slight increase in inactivity to 16.6% but again this is well below regional and national averages. Warrington has seen a significant rise in inactivity from 17% to 27% and has by far the highest rate of inactivity in Cheshire and Warrington, which is also above the regional rate.

There are two reasons which now account for more of the economically inactive population – these are long-term sickness and early retirement. Increasing long-term sickness is reflective of wider trends seen regionally and nationally. An increasing proportion who are retiring early in Cheshire and Warrington counters what has been seen regionally and nationally, with a slightly lower proportion of economic inactivity accounted for by retirement compared to a decade before.

Early retirement is the most likely reason for economic inactivity in Cheshire and Warrington, accounting for over a third of total economic inactivity in Cheshire West and Chester. The next highest reason for economic inactivity is long-term sickness. All three local authorities have seen long-term sickness increase as a reason for economic inactivity particularly so over the last 5 years in Cheshire West and Chester, and a continued rise over the last decade in Warrington, although long-term sickness accounts for a lower proportion of economic inactivity in Cheshire East.

Figure 7. Economic inactivity by reason in Cheshire and Warrington



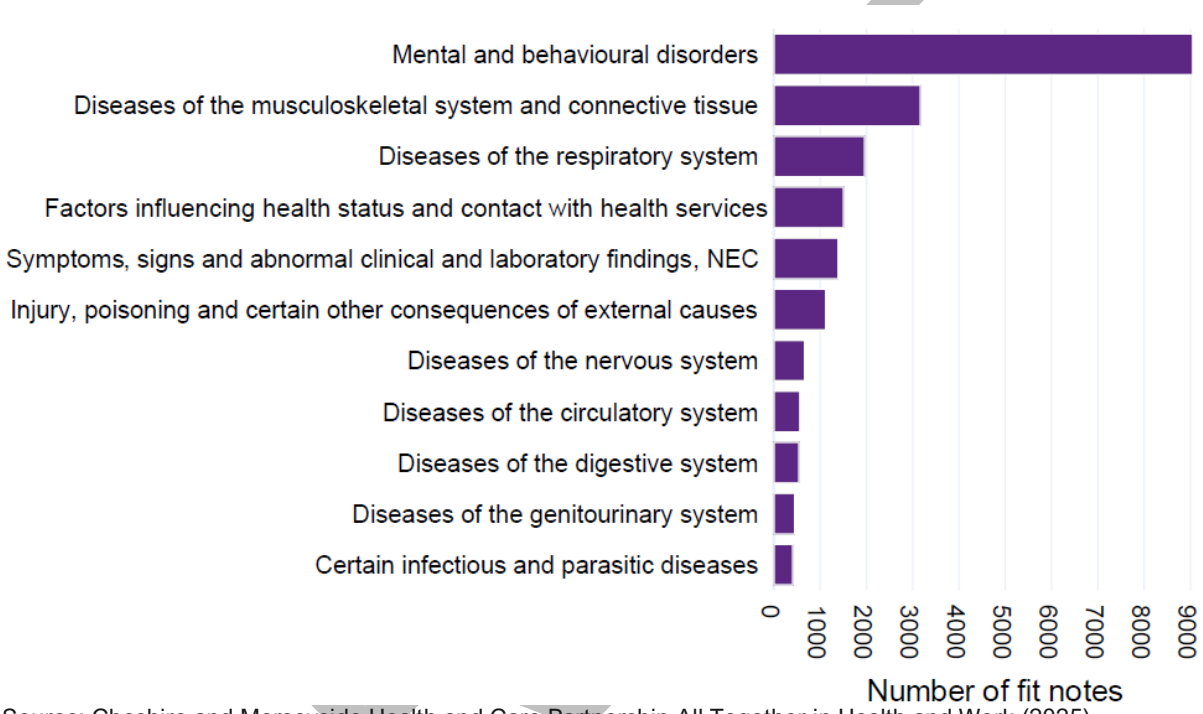
Source: ONS Annual Population Survey (2025)

In Cheshire and Merseyside in December 2024, 11,500 people were absent from work due to temporary sickness, compared to 6,800 in December 2004. This is a key group where

early intervention should focus to prevent progression to involuntary worklessness related to long-term sickness.

Fit note data shows that a combined 7% of people are off work with long-term and temporary sickness across Cheshire and Merseyside, compared with 5.1% nationally[2]. The largest drivers of worklessness are mental and behavioural orders, which made up around 40% of fit note reasons, followed by musculoskeletal and respiratory diseases.

Figure 8. Top 10 fit note reasons (Dec 2024) in Cheshire and Merseyside



Source: Cheshire and Merseyside Health and Care Partnership All Together in Health and Work (2025)

Fit notes owing to mental health and behavioural disorders have risen from around 6,000 per month in 2015 to 11,500 in 2024. Financial pressures, job strain and insecurity tend to be more prevalent for people with fewer qualifications or living in more deprived areas which is reflected in Cheshire and Warrington, with areas with greater deprivation exhibiting higher incidence of mental health fit notes.

Around a fifth - 21% - of the population in Cheshire and Merseyside report a long-term Musculoskeletal (MSK) condition, compared to the England 17.6% average[3]. MSK conditions affect people of all ages but are more common with advancing age and are more prevalent in area's with greater deprivation. Fit notes for musculoskeletal issues have risen from around 3,000 per month in 2015 to 4,300 in 2024 across Cheshire and Merseyside. Cheshire and Merseyside counters trends seen more widely where work-related musculoskeletal

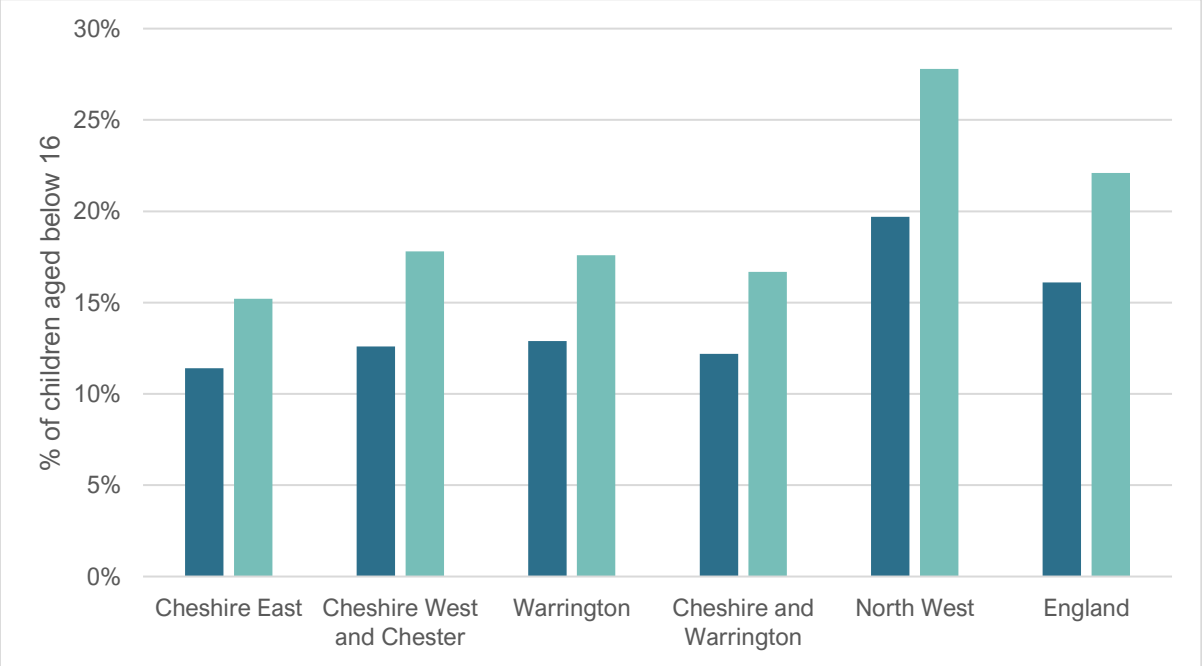
[2] Cheshire and Merseyside Health and Care Partnership All Together in Health and Work (2025)
[3] Cheshire and Merseyside ICB

disorders have decreased over time[4], highlighting a potential gap for employment support services specifically aimed at those with musculoskeletal conditions.

Carers and parents facing challenges

Although the number of children living in poverty is comparatively low, especially within the North West region, there has been a rise in the number of children living in poverty across the three local authorities. The three authorities rank amongst the six districts with the lowest levels of relative child poverty[5] across the North West. Latest estimates across Cheshire and Warrington estimate that just over 29,000 children aged below 16 are living in relative poverty, around 17% of children across Cheshire and Warrington, however this is up from 12% in 2014/15, a rise of 9,000 children.

Figure 9. Percentage of children aged below 16 living in relative poverty



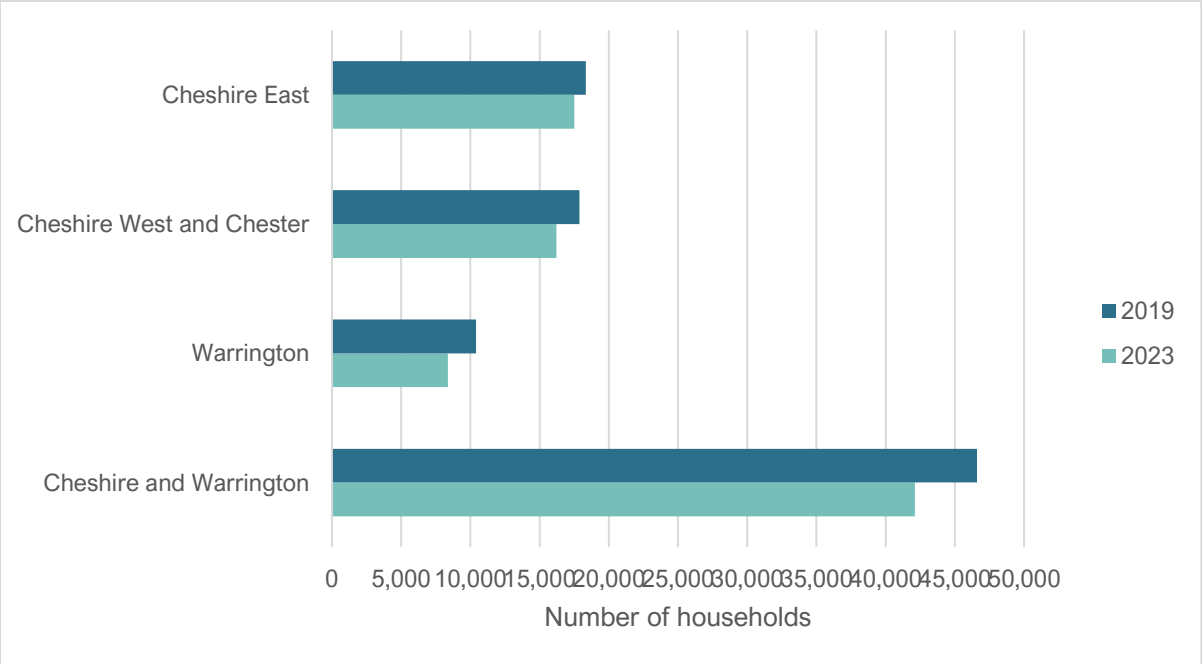
Source: Children in low income families: local area statistics, financial year ending 2024

This reiterates that there are an increasing number of families who are living on low incomes and therefore may face more barriers to sustaining employment. Some barriers for parents from low income families to return/enter into employment include childcare, transport and housing costs. On housing costs, this includes the cost of heating and general maintenance. Although the percentage of households who are in fuel poverty[6] has fallen over recent years,

[4] The Health Foundation Commission for Healthier Working Lives
[5] Relative poverty refers to people living in households with income below 60% of the median in that year.
[6] A household is considered to be fuel poor if they are living in a property with a fuel poverty energy efficiency rating of band D or below

there remains over 42,000 (10% of households) households across Cheshire and Warrington who are experiencing fuel poverty. This can make it more expensive to heat homes, and also increases the risk of developing health related issues by living in cold homes, again posing another barrier to employment, especially those who are also living with low incomes.

Figure 10. Number of households in fuel poverty



Department for Energy Security and Net Zero Fuel Poverty Subregional fuel poverty data (2025)

Unpaid carers and single parents are falling through gaps in current employment and skills provision and therefore facing significant barriers to workforce participation. Research conducted by the Jospeh Rowntree Foundation[7] projects that by 2035 there will be an extra 400,000 people in the UK caring for the elderly, sick and disabled for 10 or more hours per week. Although the government has recently put in place additional child care support measures of up to 30 hours of free childcare for working parents, Joseph Rowntree Foundation research emphasised that there is significantly less support for people caring for elderly, sick or disabled people, beyond voluntary compassionate leave from employers and a new entitlement to 5 days of unpaid care leave, placing additional barriers for those with caring commitments to work.

[7] Joseph Rowntree Foundation: The future of care needs: a whole systems approach

Earnings and quality of work

Median pay in Cheshire and Warrington closely matches UK levels, with modest variation across local areas in May 2025. Median pay for employees living in Cheshire & Warrington is highest in Cheshire East, and lowest in Cheshire West & Chester, although median monthly pay of £2,525 across Cheshire and Warrington is £100 above the regional average[8].

The varied nature of the economy in Cheshire and Warrington as displayed by the make-up of sector employment is evident in the occupation residents are employed in with both higher and lower skilled employment present, not massively different to the make-up of regional and national employment, although there is a slightly higher base of employment in high skilled occupations with a relatively high share of workers in managerial roles, well above regional and national averages. But there is variation across Cheshire and Warrington with higher shares employed as managers and in professional occupations in Cheshire West & Chester whereas Warrington has a higher share of residents employed in lower skilled occupations as process, plant and machine operatives and in elementary occupations.

In Cheshire East and Cheshire West and Chester, residents' earnings are higher than workplace earnings suggesting many commute to higher-paid, high skill jobs likely as managers or in professional occupations outside the area. In contrast, workplace earnings in Warrington are higher than resident earnings, indicating an inflow of higher-paid workers and potential skills mismatches among the local population, where residents are more likely to work in lower skilled occupations.

Figure 11. Employment by occupation (2024)

Sources: ONS Annual Population Survey (2025)

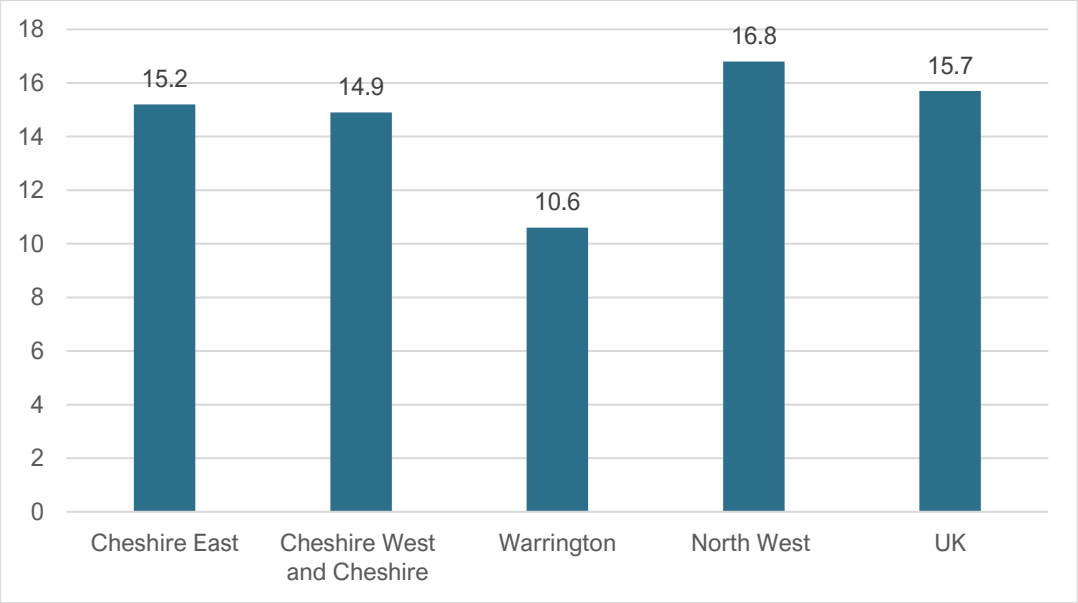
[8] ONS PAYE Real Time Information (2025)

All areas have seen a decline in the number of employees earnings below the living wage, and all have a lower proportion compared to 16.8% of employees regionally, especially in Warrington. Coupled with a strong employment rate, high earnings in relation to the regional averages, a high number of jobs per working age resident, and a high proportion in high skilled occupations points to a strong labour market featuring high quality job opportunities.

However, this is not felt by all in Cheshire and Warrington. It is estimated that 64,000 people earn below the living wage, around 14% of the working age population in Cheshire and Warrington, so there remain challenges for many residents in low-paid or insecure work with limited progression routes.

Despite the low proportion of employees earnings below the living wage in Warrington, we have seen that qualifications attainment tends to be lower than in other areas, creating a potential barrier to accessing good quality work, meaning that residents may be stuck in lower skills occupations rather than some of the higher paid roles in sectors such as professional, scientific and technical services where Warrington is particularly strong.

Figure 12. Percentage of employees earning below the Living Wage (2024)



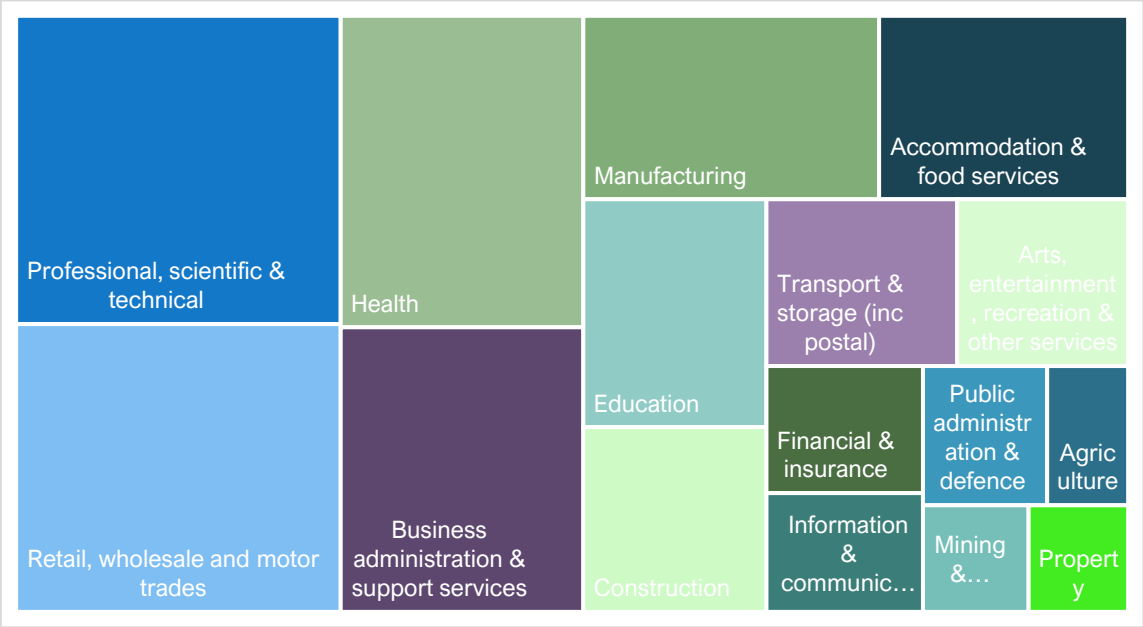
Source: ONS Number and proportion of employee jobs with hourly pay below the living wage (2024)

Sectors and occupations

Professional, scientific and technical services is the highest employing sector in Cheshire and Warrington, with employment growing strongly in the sector particularly between 2022 and 2023. The sector makes up 15% of total employment, well above 9.5%-10% regional and national averages. This tends to be a high value sector, covering areas such as life sciences (one of five priority sectors identified in their LSIP) and are core components of the growth sectors identified by the government as part of their Industrial Strategy.

Manufacturing remains an important sector (another priority sector) at over 8% of total employment, with employment growing by 1% a year on average since 2015, whereas nationally employment has declined somewhat. Business admin & support is also a relatively big employer in Cheshire and Warrington at over 10% of total employment. But overall there are few major differences in sector employment to the overall national economy, although IT is relatively small compared to nationally, along with health although this is still a significant employer regionally at 11% and another of sector priorities. Public admin & defence has a low proportion of employment compared to nationally, as does education which may point towards having to travel outside the region for certain courses/training options.

Figure 13. Breakdown of employment by sector in Cheshire and Warrington (2023)



Source: ONS Business Register and Employment Survey (2025)

All areas have a strong base of employment in professional, scientific and technical services with Warrington as the centre of employment, making up a fifth of local employment. Warrington is also the hub for business administration and wider logistics employment across the subregion, along with construction and utilities.

Cheshire East is the centre of manufacturing employment and although a relatively small employer, the base for agricultural employment in the subregion. Cheshire West and Chester is the base for employment in the financial & insurance sectors, along with education, and creative and hospitality sectors.

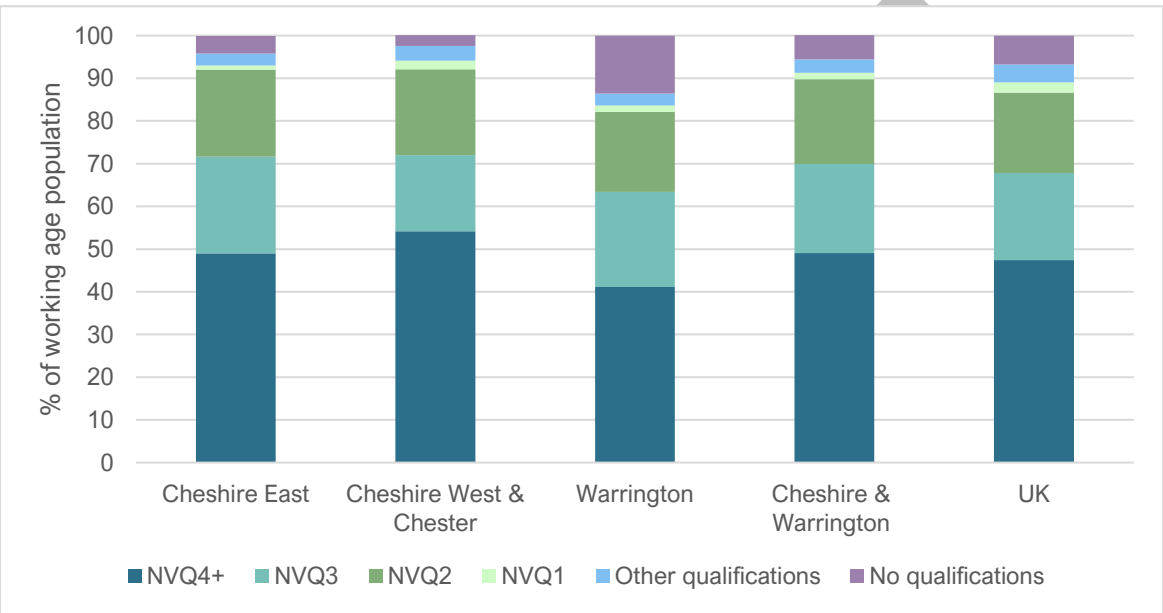
Skills

While there are strong top end skills across the region, gaps remain in foundational attainment, particularly in Warrington. Overall, qualification levels in Cheshire and Warrington are slightly above the UK average: 49.1% of working-age adults (16–64) hold NVQ4+ qualifications, compared to 47.4% nationally. Cheshire East and Cheshire West & Chester

have relatively high proportions of residents qualified to NVQ3 and NVQ4+. In contrast, Warrington has a significantly higher share of adults with no qualifications, at 13.6% - more than double the UK average of 6.8%, and well above neighbouring areas.

This suggests challenges in progression for some groups and points to uneven education outcomes across the subregion that may limit access to higher-skilled employment. There has been a rise in the number of 16-17 years olds are not in education, employment or training (NEET) to over 500. Previous reports and engagement have raised concerns over insufficient progression pathways for residents from Level 2 upwards.

Figure 14. Highest qualification attainment aged 16-64 (2024)

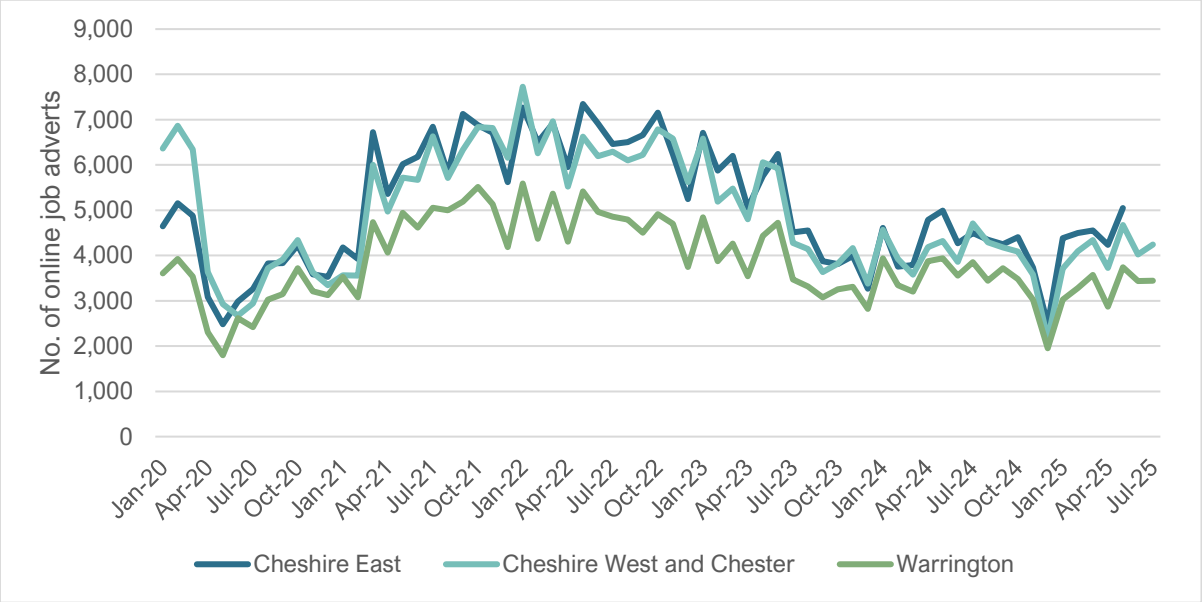


Source: Annual Population Survey (2025)

Employment demand

Vacancies fell significantly at the start of the Pandemic before slowly picking up until early 2023 before again falling until late 2024 Over the last year or so vacancies have started to pick-up again across all three local authorities. Job vacancies are focused in health and social care, construction, advanced manufacturing (including opportunities associated with low carbon) and the visitor economy, with some of the occupations most in demand being engineers, nurses and social care workers, and managers.

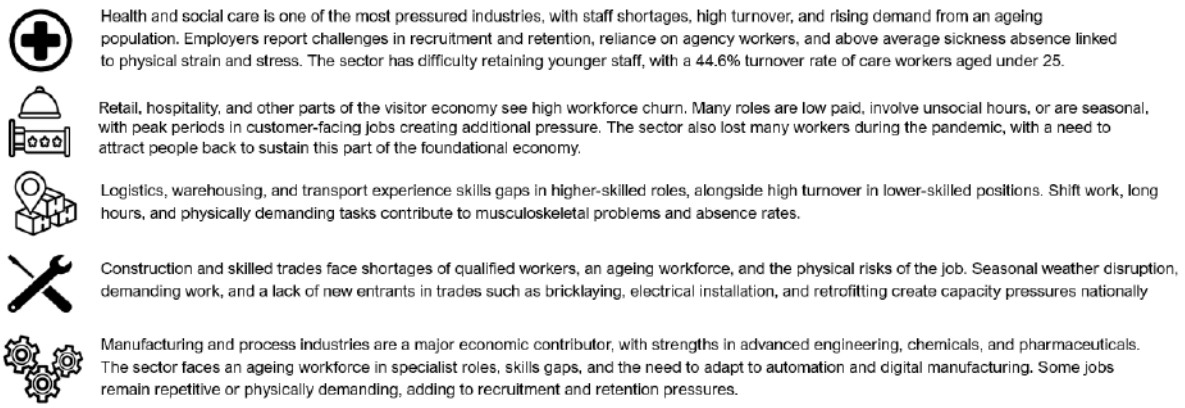
Figure 15. Online job adverts (2020-25)



Source: ONS Labour demand volumes by Standard Occupation Classification (SOC 2020), UK

Evidence from the Local Skills Improvement Plan and health and wellbeing strategies, alongside national trends and workforce challenges highlight health and social care, retail and hospitality, logistics, construction and manufacturing as industries where work related problems are most acute. These challenges typically stem from a combination of skills shortages, recruitment and retention issues, workplace health concerns and structural pressures in the business environment.

Figure 16. Sectors facing a high level of work-related problems



But it is not a case where vacancies can simply be filled by those currently out of work as there are skills mismatches across the patch. Previous reports and engagement have also raised concerns over insufficient progression pathways for residents from qualification of Level 2 upwards, an obvious barrier to enter into many of the sector highlighted, including professional, scientific and skills services, the largest employing sector across Cheshire and Warrington. Areas such as life sciences where Cheshire and Warrington displays a strong

specialism, are difficult for some residents to enter, particularly in Warrington where the share of adults with no formal qualifications is more than double the national average. And despite the need for more workers to enter into skilled trades, we have heard that apprentices have struggled to secure placements, with employers more focused on current delivery while operating in a high cost environment, opting to try and hire more experienced workers rather than on helping to train the next generation.

Employers need to take an active role in the skills and training landscape to help train staff to fill vacancies in the local economy and allow them to progress throughout their career. However from the latest Employer Skills Survey where data is available at a LEP level, Cheshire and Warrington ranks in the bottom half of LEP areas by the proportion of establishments who have funded or arranged training for staff over the last year (59%).Less than half of establishments funded or arranged on-the-job training (46%), the fourth lowest proportion across LEP areas.

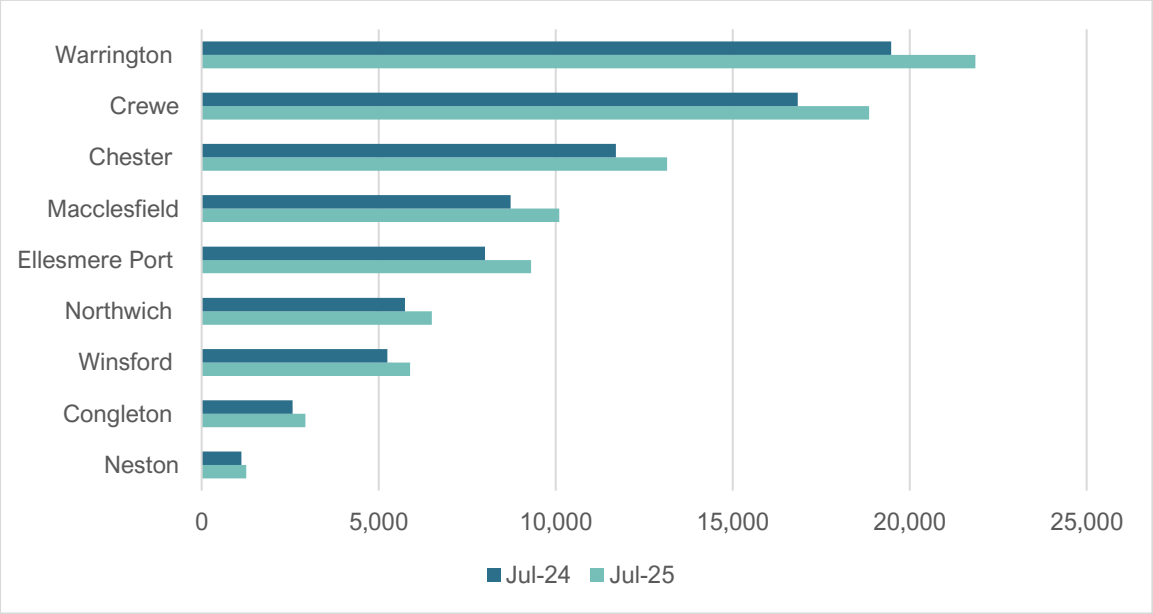
The proportion of employers investing in skills and training varies across the sub-region, where over 60% of establishments invested in training in Cheshire West and Chester and Warrington, falling to 55% in Cheshire East. This highlights the need for employers to invest in their workforce and potential employees if we are to help provide residents with the skills they need to fill vacancies and help to grow the local economy.

Universal Credit and unemployment

Between July 2024 and July 2025 total Universal Credit (UC) claimants have risen by over 10,000 from 79,400 to 89,850 across Cheshire and Warrington. The rise in UC claimants is partly explained by UC replacing six legacy in-work and out-of-work benefits (income-related Employment and Support Allowance, income-based Jobseeker's Allowance, Housing Benefit, Income Support, Working Tax Credit, and Child Tax Credit). To put into context, the 13% rise in UC claimants across Cheshire and Warrington is slightly below the 16% seen regionally and nationally.

Warrington continues to make up around a quarter of total claimants followed by just over one in five from Crewe – combined Warrington and Crewe make up nearly half of total claimants. All areas (as shown in the chart below using Jobcentre Plus) within Cheshire and Warrington have seen a rise of at least 12% in total claimants over the last year, the highest rises being in Ellesmere Port and Macclesfield of 16%. Ellesmere Port and Macclesfield combined made up a quarter of the total rise in claimants across C&W over the last year.

Figure 17. Total UC claimants (Jul 2024 and Jul 2025) by Jobcentre plus area

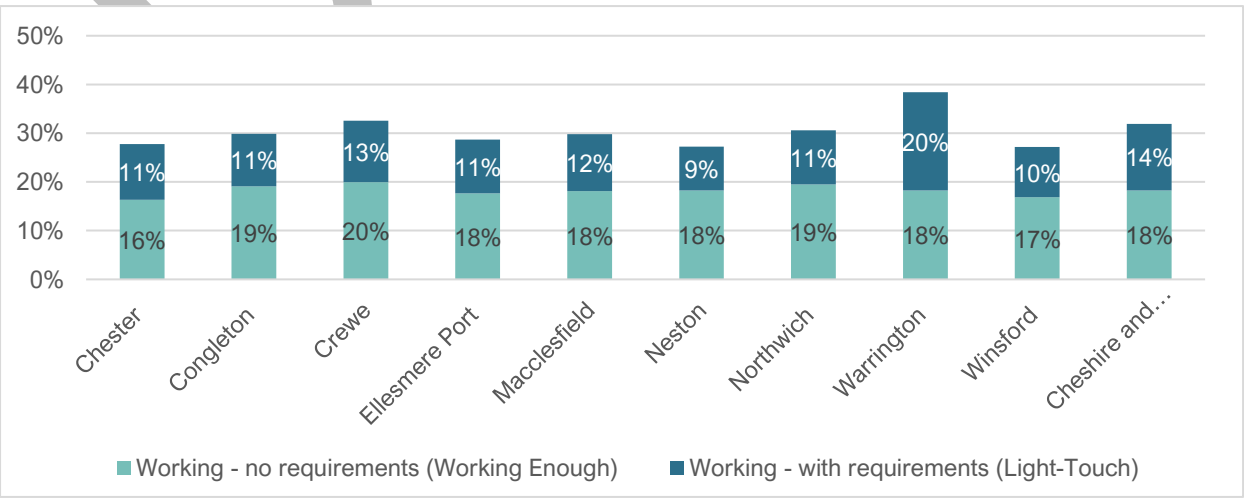


Source: Department for Work and Pensions (2025)

There has been a rise in the number of UC claimants with no work requirements to 45,600 across Cheshire and Warrington, making up over half of total UC claimants. Warrington and Crewe make up nearly half of total UC claimants with no work requirements, Warrington around quarter of UC claimants with no work requirements and Crewe a fifth of claimants.

Across Cheshire and Warrington, 32% of UC claimants are working with or without requirements. This varies with Warrington the highest at 38% of claimants with a high number of UC claimants working with requirements, to 30% or below in Winsford, Neston, Chester, Congelton and Ellesmere Port. Therefore most of UC claimants are not working – 58,700 UC claimants across Cheshire and Warrington are not working with over two thirds of these with no work requirements.

Figure 18. Percentage of total UC claimants working *[either working with or without requirements]* (Mar 2025)

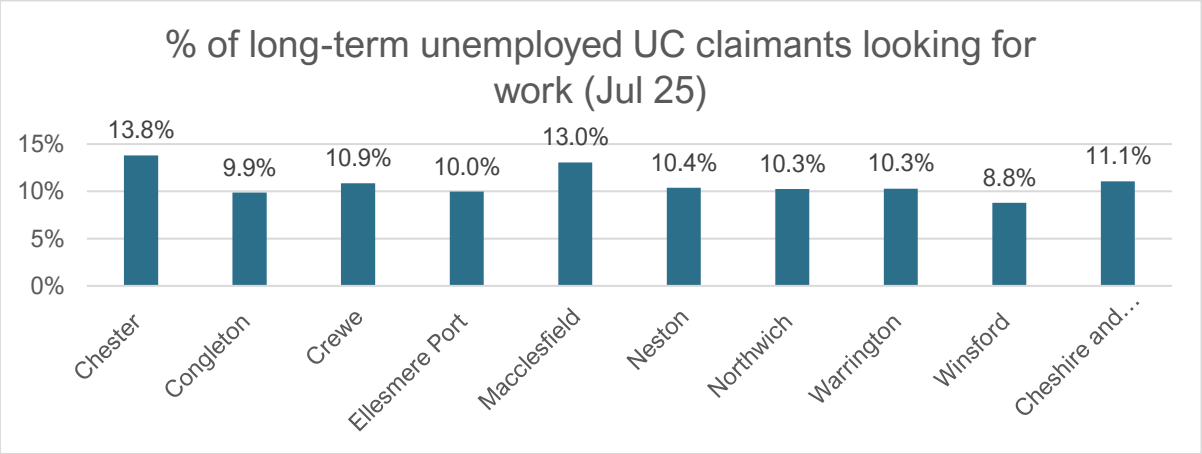


Source: Department for Work and Pensions (2025)

There has been an increase of over 7,000 UC claimants who are long-term unemployed to 65,400 across Cheshire and Warrington. This refers to people claiming UC who have been unemployed for more than 12 months across all regimes. Warrington makes up around a quarter of total of long-term unemployed UC claimants, a fifth from Crewe, Chester and Macclesfield combined another quarter of claimants.

Women make up 62% of long-term unemployed claimants across Cheshire and Warrington and this is fairly consistent across Jobcentre plus areas, slightly higher in Winsford and Crewe. Across all areas most of those who are long-term unemployed are not looking for work. Only 11% of UC claimants who are long-term unemployed are looking for work, the highest is in Chester and Macclesfield with 13-14% of UC claimants who are long-term unemployed looking for work but 10% or lower in Winsford, Congelton, Ellesmere Port, Warrington, Northwich and Neston.

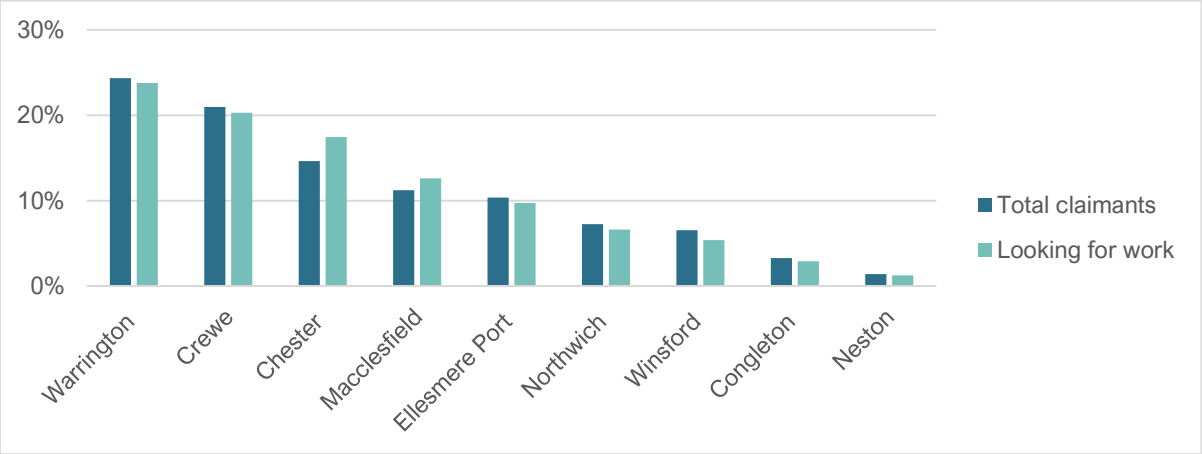
Figure 19. Percentage of long-term unemployed UC claimants looking for work (Jul 2025)



Source: Department for Work and Pensions (2025)

Between July 2024 and July 2025 total claimants looking for work has fallen by 6% from 14,450 to 13,635, with all areas within Cheshire and Warrington seeing a fall, although this has been more subdued in Winsford, Chester and Warrington. Those claiming UC and looking for work only make up 15% of total UC claimants. Although the overall split of UC claimants is not dissimilar to total UC claimants share across Cheshire and Warrington, Macclesfield and Chester make up a higher proportion of claimants looking for work than total UC claimants.

Figure 20. Share of total UC claimants and looking for work by Jobcentre plus area



Source: Department for Work and Pensions (2025)

Women make up 58% of total claimants with this being fairly consistent across Jobcentre plus area, while men make up 58% of UC claimants who are looking for work. Overall the fall in UC claimants looking for work appears to be from a fall in the number of female UC claimants looking for work, which have fallen by 12% over the last year whereas there has been little overall change in male UC claimants looking for work across Cheshire and Warrington.

Key transition points

Key transition points increase the risk of inactivity. They require sufficient, joined-up support to prevent disengagement and support groups most at risk. Below we have summarised three key transition points of leaving education and becoming NEET; falling out of work due to health; and leavers from institutional system in the Cheshire and Warrington context, along with a high level summary of existing support in place.

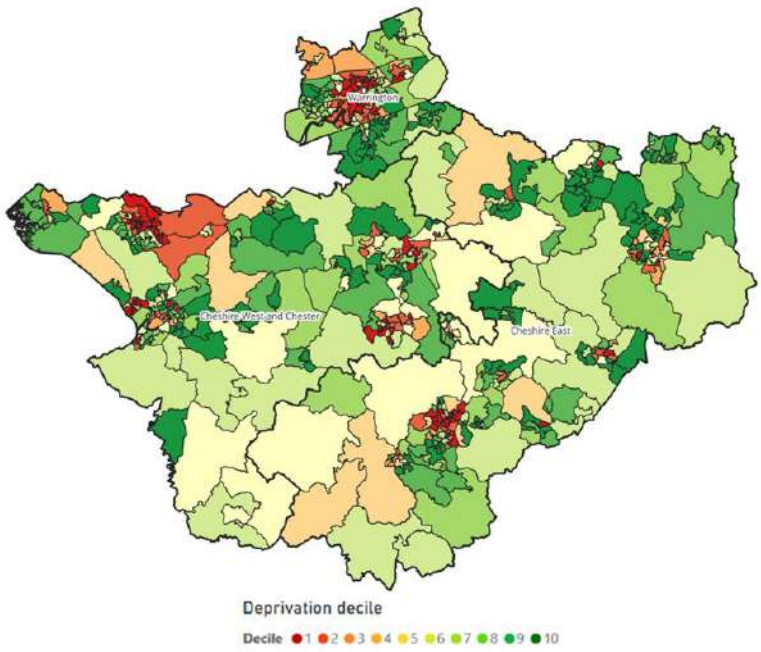
Figure 21. Key transition points – Cheshire and Warrington

Transition point	The need for intervention	Existing support
Leaving education becoming NEET	• Over 500 16-17 year olds in Cheshire & Warrington are NEET, equal to 3.2% of this age group, matching the national average. • Risk factors include poverty, SEND, care leavers and rural isolation • There are a lack of reengagement routes or sustained outreach in some areas	• Pledge Partnership Careers Hub • Fresh Start • Total people
Falling out of work due to health	• Rising long-term sickness is a key driver of inactivity • Includes mental health, MSK and other chronic illness	• Mid-Life MOT • Restart • IPS Severe Mental Health
Leavers from institutional systems (e.g. prison, military)	• High risk of disengagement after structured institutional life • Complex needs, including housing, mental health, addition and stigma • Limited integration with integration services and low levels of employer engagement in targeted hiring	• Breaking the Cycle: Tempus Novo support for ex-offenders • The Armed Forces community support hub

Deprived neighbourhoods

On the whole deprivation is low at the Cheshire and Warrington level, with almost two thirds of neighbourhoods living in the 50% least deprived neighbourhoods nationally, and over a third of neighbourhoods in the least 20% deprived nationally. However there are pockets of deprivation across the subregion particularly in urban centres of Crewe, Winsford, Warrington, Northwich, Macclesfield and Ellesmere Port. This includes some neighbourhoods towards the most deprived in the country including Crewe North East, Lache, Hebden Green, Poplars and Hulme, Central Warrington and Wharton.

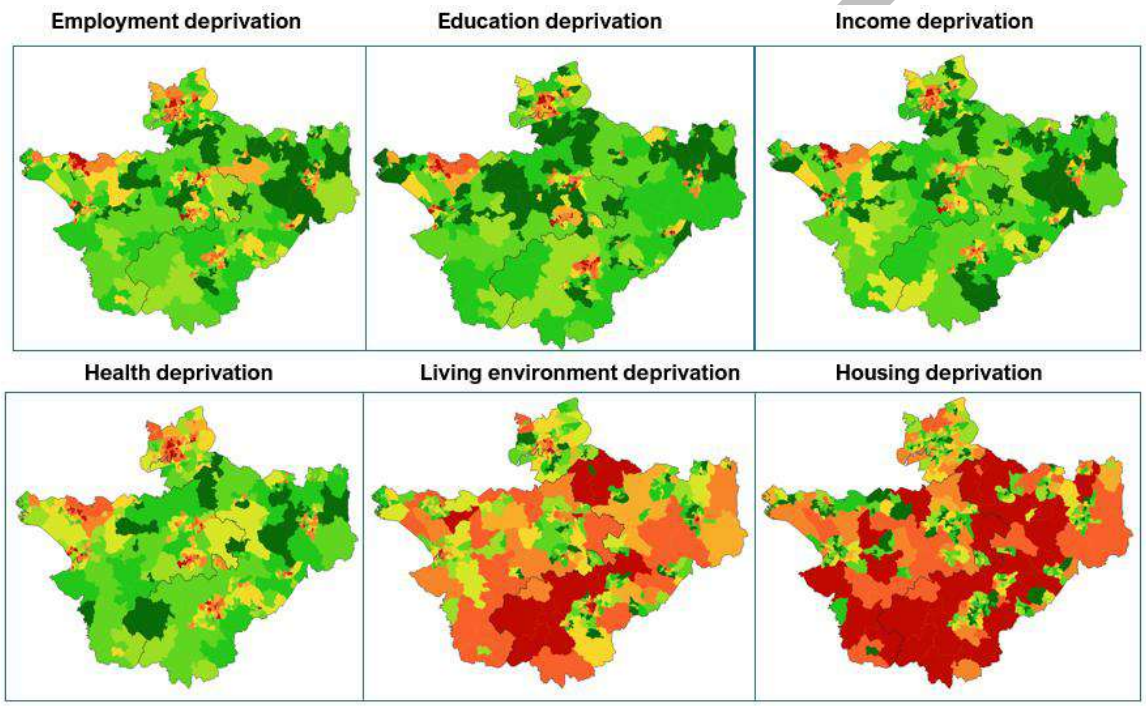
Figure 22. Index of Multiple Deprivation



Source: MHCLG English indices of deprivation (2019)

Focusing on different domains which make up the overall Index of Multiple Deprivation again points to relatively low levels of deprivation across Cheshire and Warrington across the domains of employment; education, skills and training, whilst highlighting pockets of deprivation concentrated in Crewe North East, Hebden Green, Northwich, Dallam, Ellesmere Port, Central Warrington and Blacon. However, we have heard that the Index of Multiple Deprivation may mask some of the inequality felt in more rural areas, where transport accessibility and housing affordability are potentially significant barriers to entering and sustaining employment. This can be seen in the living environment and particularly access to housing and services domains, where many of Cheshire and Warrington's rural communities rank more towards the most deprived nationally.

Figure 23. Domains of the Index of Multiple Deprivation[9]



Source: MHCLG English indices of deprivation (2019)

Social mobility is likely to be impacted for those living in more deprived neighbourhoods in Crewe, Winsford, Warrington, Northwich, Macclesfield and Ellesmere Port, and potentially reinforcing barriers people face to enter into employment after leaving school. But what may be considered less deprived areas, generally in more rural communities, there remains significant barriers to employment in the form of reliable and accessible transport, and in be able to afford housing given higher costs especially when compared to other areas in the North West.

[9] There are seven domains which make up the overall Index of Multiple Deprivation. The only domain not included in this figure is crime.

Current system and offer

This section maps the current service provision across Cheshire and Warrington, spanning local government, DWP, NHS, the education sector, and the voluntary sector. It provides an overview of local services and programmes, highlighting what support is available, who delivers it, and how far it reaches. It also summarises provision for each priority group and identifies key gaps in provision.

Cheshire and Warrington hosts a diverse network of employment and skills support. The three local authorities each run programmes for residents, complemented by national schemes through Jobcentre Plus, health related initiatives via the NHS, college and careers services by the education sector, and numerous voluntary sector projects. This array of skills provision and employment support assists inactive cohorts and those most at risk of disengaging from the labour market across the geography of the subregion. We have drawn on insights from engagement with councils, employers, service providers and as well as the developing Cheshire and Merseyside Health and Work Strategy, to inform a comprehensive understanding of the support landscape.

The below table summarises an overview of what support and provision is currently delivered across Cheshire and Warrington by partners.

Services are delivered at a range of locations, including JCP locations, Skills and employment hubs in Cheshire West and Chester, Springboard Work Hubs and Youth Hubs in Cheshire East, Warrington Youth Zone, various community settings, at local schools and colleges, and via online support. Programmes have been collated through desk-based research and stakeholder consultation. This is not a comprehensive list of all support offered across the subregion, but rather a brief overview of work and health support commissioned programmes.

Key:
- Sub-region wide
- Cheshire West and Chester
- Cheshire East
- Warrington

Figure 24. Matrix of support

Type of Support	Commissioned				VSCE delivery partners
	DWP	DfE	ICB	LA	
Job Matching	Restart			RAST redundancy support	Springboard Youth Fed
Skills Progression	Sector-based Work Academy Programmes Seetec Work and Health Programme (Cheshire)	Skills Bootcamps			Springboard Youth Fed YMCA Cheshire Total People
SEND	Employment Directions Supported Internships schemes		Mersey Care	Site Smart New Ground, Fresh Start Defining Futures Inspiring Futures Supported Employment	Fedcap Petty Pool Warrington Mencap Walton Lea Partnership Creating Adventures
Young people and NEET	Access to Work	The Careers Hub	CAMHs	The Pledge Partnership Venture with Confidence Youth Support Service Fresh Start	The King's Trust Youth Fed
Mental Health	EA in talking therapies (Cheshire)		EA in talking therapies IPS Drugs and Alcohol CAMHs IPS Veterans in Mind		
CIAG		The Careers Hub		Warrington LiFE Skills Employment hubs Work Hubs	
Adult and mid life		Adult Learning		Defining Futures	YMCA
Digital skills	Essential Digital Skills			Digital drop-in Microsoft Suite training	Springboard, Youth Fed Learn My Way

Local government

Local authorities provide a mix of employment and skills support for residents of all ages, within their own boundaries and programmes. Councils work closely with voluntary sector providers, colleges, and businesses to deliver targeted support for young people, NEETs, employers, and adults seeking to retrain or upskill.

The three councils deliver subregion-wide initiatives. Support facilitated through Enterprise Cheshire and Warrington – a Council owned partnership vehicle and the successor to the Local Enterprise Partnership – includes the Opportunities Portal, a digital platform promoting apprenticeships, training, and job vacancies across the subregion; Careers Hub link schools, colleges, and employers to raise aspirations and embed careers education; and a programme of Skills Bootcamps. Adult training initiatives that provide tailored, industry specific upskilling to adults is available through Sector Based Work Academy Programmes (SWAPs). Many programmes of support align local provision with employer demand and priority sectors outlined in the LSIP to respond to skills gaps and workforce needs. Each local authority has a specialised local offer for care leavers, and offers support and guidance to employers and training providers on providing opportunities.

Further independent, council-led services form part of the wider system of support and are summarised below.

Cheshire East

- Cheshire East Council hosts the welfare-to-work partnership, maintaining a directory of provision and referral routes, with outcomes delivered through commissioned programmes. Delivery is commissioned through various providers across the local authority
- Cheshire East Council works with Total People, who deliver apprenticeships, vocational programmes, and short courses to help residents gain skills and qualifications.
- The Venture with Confidence programme provides tailored support for young people who are NEET, helping them to re-engage with training and employment.
- The council works with YMCA and local housing associations to provide outreach and mentoring for residents experiencing homelessness or multiple barriers to work
- The Youth Support Service provides statutory open access support for 13–19 year olds (up to 25 with SEND), outdoor education focused support for NEET, support to young people who have an Education Healthcare Plan (EHC) , and transitional planning for targeted young people preparing for adulthood.
- Inspiring Futures, delivered by Fedcap on behalf of Cheshire East Council, offers personalised support for people with disabilities and health conditions into employment
- Supported internships are commissioned to help young people and adults with learning difficulties or additional needs move into sustainable employment.
- Supported Employment team supports residents with disabilities or complex needs into the work environment.

Cheshire West and Chester

- Cheshire West and Chester operates four Skills and Employment Hubs in Chester, Ellesmere Port, Winsford and Northwich, providing free one-to-one advice, guidance, qualifications, and confidence-building support for residents aged 19+. This is also where the employment support programmes are delivered.
- Site Smart, delivered by Procure Plus aims to break down barriers for care-experienced and NEET young people who are interested in entering the construction industry, offering local on-site experience at Ellesmere Port. This is currently funded by UKSPF
- Together Around the Family, an early intervention service that helps families identify strengths and needs, offering support and advice, and bringing together involved agencies.
- UKSPF funding supports programmes such as Fresh Start, for 16–19-year-olds disengaged from education, and Defining Futures, supporting adults with disabilities, those at risk of homelessness, over-50s, and residents in rural communities. Both have helped participants gain skills and qualifications, and progress into work, though UKSPF funding is due to end in March 2026.
- Designed to support those with poor grades or unwilling to remain in school or college, offering an alternative to repeated GCSE exams through practical, community-based learning, Fresh Start provides functional skills training through this approach.
- Defining Futures helps residents in rural areas who live a long way from job opportunities; however, the vast rurality of the region and varying degrees of transport connectivity mean that many rural communities are likely to experience less accessible support due to limited neighbourhood outreach.
- Integrated employment support models, such as Employment Advisers in Talking Therapies, and IPS programmes in primary care and drug and alcohol services, are delivered locally to embed employment support within health pathways. EA in talking therapies has seen success across the Cheshire region, with 62% of the 7,054 participants engaged successfully moving into, returning to, or remaining in work.
- Other targeted initiatives include independent travel training to help people build the skills and confidence to use public transport.

Warrington

- Warrington's Employment Development Team offers a wide range of support, including tailored employment coaching, CV and interview preparation, Digital Drop-Ins, and RAST redundancy support, alongside ESOL and digital skills programmes. The team works closely with both residents and local businesses to support progression into work.
- Warrington LiFE is the careers, education, information, advice and guidance servie provided by Warrington Borough Council. It works with schools, colleges and academies to deliver tailored support for young people, providing careers information, advice and guidance services.
- community-based support like Youth in Mind at Warrington Youth Zone.
- The council commissions a range of voluntary sector organisations to deliver specialist provision. This includes Warrington Mencap, Walton Lea Partnership, and Creating Adventures, which provide supported work experience, job coaching, and life skills development for adults and young people with learning disabilities. Support for veterans

is also delivered through voluntary and community-led services such as the Armed Forces Community Support Hub and Veterans in Mind.

DWP and JobcentrePlus

DWP provides personalised employment support through its JobcentrePlus network and work coaches, consisting of 9 JCPs and 200 staff working across the subregion, supporting Universal Credit claimants.

Several nationally commissioned schemes operate locally:

- Work and Health Programme: supports people of all ages with health conditions or disabilities, to see themselves ready for work within a 12-month period.
- Restart: Aimed at Universal Credit claimants who have been out of work for more than 9 months, providing up to a year of intensive help. Delivered locally across all boroughs, by FedCap in Cheshire East and Seetec Pluss in Cheshire West and Warrington.
- Individual Placement and Support in Primary Care: Cheshire West and Chester council places employment specialists in GP practices to help patients who are accessing primary health services to return to or remain in work. Since 2023 this program has engaged over 1,000 people in Cheshire West and Chester, with 33% of participants experiencing positive outcomes.
- Local Supported Employment: Cheshire West and Chester council support adults with learning disabilities and autism into paid employment. Supported Employment staff work long-term with clients and employers to find suitable roles and assist with in work adaptation.

In Autumn 2025, the Connect to Work programme launched by the government as part of the Get Britain Working White Paper is due to launch across Cheshire and Warrington. This will integrate IPS, Supported Employment, into a single, voluntary work and health support offer. This five-year scheme will provide holistic, person-centred support for economically inactive individuals facing barriers to employment. This will be managed initially by Cheshire West and Chester Council, but will operate across the whole of the sub-region.

NHS Integrated Care System and Board

The ICS operates across the footprint of Cheshire and Merseyside, working closely with local stakeholders to integrate health and employment support and encourage stable, and sustainable outcomes.

As a designated Marmot region, Cheshire and Warrington are committed to tackling the wider social determinants of health, including education and employment. Programmes include:

- Employment Advisors in talking therapies: Funded by DWP and NHS England and delivered across Cheshire, Employment Advisors in Talking Therapies work alongside therapists to address the emotional challenges related to work through integrated psychological treatment and employment support.

- Child and Adolescent Mental Health provision, delivered through the NHS across Cheshire.
- IPS in drugs and alcohol in Cheshire West and Chester: supports people accessing substance misuse services (VIA provision) who want to move into paid employment. The program provides advice about health and wellbeing, regular sessions with personal keyworker, support groups, and guidance on next steps, including education, training and employment support.

The ICB Works with councils on the Work and Health Strategy, aligning primary care, housing, and employment support to address long-term sickness and the main drivers of inactivity including MSK and mental health conditions.

Further education

In Cheshire and Warrington, further education colleges are central to delivering skills and training opportunities for both young people and adults. Higher education providers complement this delivery, and provide support linked directly to local economic and sectoral priorities outlined in the Local Skills Improvement Plan. Key areas of provision include:

- Sector-specific pre-employment programmes in areas such as health and social care, logistics, digital, and construction, alongside core English, Maths and IT skills.
- Supported Internships, available to SEND young people, aged 16 to 24, with an education and health care plan.
- Programmes to tackle wider barriers to work, including ESOL provision, digital skills support, and volunteering opportunities that act as a stepping stone into sustained employment.
- College pastoral staff and local authorities have co-ordinated to support vulnerable school leavers and those at greater risk of becoming NEET. Cheshire College South and West has worked closely with local authorities to smooth transitions and reduce disengagement across the academic year. Young people are able to start college in January, and opportunities are available to swap courses until November.

Universities and colleges collaborate through the Cheshire and Warrington careers hubs, helping to align careers advice, apprenticeships and employer engagement with local labour market opportunities. Specialist training centres such as the new Cheshire and Warrington Institute of Technology the Health and Social Care Academy and the Advanced Construction and Civil Engineering Centre, launched at Warrington and Vale Royal College, provide facilities to train students and upskill adults in high-demand fields.

Voluntary and community sector

The voluntary and community sector provides a range of commissioned and delivered services that support residents across Cheshire and Warrington to access work, build skills and manage complex barriers to work. The sector works closely with local authorities and the ICB to reach residents who may be less likely to engage with statutory provision.

Some examples of VSCE providers and services include:

- Petty Pool: offers supported internships for young people with special educational needs, helping them transition into employment or further learning.
- Youth Fed: supports a network of around 150 youth groups, providing mentoring, skills development and progression support for young people.
- Springboard: provides employability and confidence-building support for adults aged 18+. Springboard run Work Hubs in Cheshire East in Alsager, Congleton, Crewe and Macclesfield, as well as training for SEND student.
- Via (drug and alcohol service): delivers an Individual Placement and Support service within treatment pathways, supporting participants in recovery into employment.
- Targeted training provision exists to support residents into entry-level work – for example, the Greenhouse Training Centre, which delivers hospitality training, including a six-week barista course which has proven popular amongst residence. The centre offers a range of hospitality courses designed for both newcomers and experienced professionals, providing practical, hands-on training for individuals seeking to develop basic skills without undertaking formal qualifications.
- The King's Trust Team Personal Development Programmes offer 12 week programmes, delivered by CFRS staff across several Cheshire locations in Chester, Crewe, Macclesfield, Halton and Winsford. This programme supports NEET young people aged 16-25 years to develop confidence, self-esteem, teamwork and employability skills.

Chambers of Commerce

The South Cheshire Chamber of Commerce delivers the Cheshire and Warrington Local Skills Improvement Plan, coordinating on behalf of the subregion, and working to tailor support to meet local sectoral needs. There is a rich network of Chambers of Commerce across the subregion representing different communities and economic centres, and engaging deeply with employers. Their engagement feeds local intelligence around the local labour market, opportunities for growth and investment, and challenges that businesses are facing, whether in labour and skills or more broadly in local infrastructure, land and connectivity.

Priorities

Priority 1: Most deprived neighbourhoods

Cheshire and Warrington generally experiences low levels of deprivation, but there are high levels of deprivation in some of our urban centres and rural communities including Crewe, Winsford, Warrington, Northwich, Macclesfield and Ellesmere Port. Deprivation has been concentrated in these areas for a number of years, impacting the social mobility for these communities, which for example can be seen in lower education attainment in Warrington. This may create a cycle whereby residents feel they have to move from these communities in order to access more training/employment opportunities.

The Index of Multiple Deprivation also masks some of the challenges felt by those in some of our more rural communities which may on the surface appear to be more affluent, but where significant barriers remain to accessing training or employment in the form of reliable and accessible transport, and higher than average housing costs.

Despite coverage across major towns in the subregion, stakeholders noted ongoing challenges in reaching all who need support, with engagement, not capacity being the biggest constraint. Deprived neighbourhoods lack consistent outreach and visible access points, underlining the need for a stronger visible presence within communities.

Partners expressed during engagement on this Plan a need for more local access points, particularly in areas in Cheshire East and Warrington, outside of employment hubs. These are needed in people's communities to be able to better support people in deprived neighbourhoods who may be further from the labour market. There are also issues with some pockets of rural deprivation and the reach of services.

Priority 2: Young people and NEETs

On the whole, Cheshire and Warrington has a skilled labour market with almost half of residents qualified to degree level or above. However, there are uneven education outcomes across the subregion that may limit access to higher-skilled employment.

NEET levels have slowly been rising across Cheshire and Warrington to 3.2%, and as high as 4.6% in Cheshire West and Chester – although these figures fluctuate through the school year. There are further barriers to enter into employment for young people who are eligible for Free School Meals (FSM) or classed as disadvantaged, where the proportion attaining grades 4 or above in English and Maths GCSEs is almost half of total Key Stage 4 cohort. This has a knock-on impact on ability to access future opportunities with those eligible for FSM or who are disadvantages less likely to be in some form further education, employment or training, and thus increasing the chance of becoming economically inactive, reinforced by insights from stakeholders of a lack of consistent, sustainable re-engagement activity.

Support for young people, including those not in education, employment or training is provided through a layered system of careers guidance, youth services, and targeted

programmes. Raising young people's aspirations and developing employability skills help to support young people through key transition points and into employment and training.

Transitions out of education can be a critical point for disengagement, stakeholders recognised impactful support for young people in the area moving from education to employment, offering apprenticeship opportunities and specialised training to support sustainable career pathways. Despite this, apprenticeship opportunities for younger entrants have declined, with opportunities being taken by older and more experienced workers. For young people already disengaged from education, specialised re-engagement programmes provide alternative, employment-focused provision outside of traditional progression routes.

Mental health is a significant driver of rising NEET levels. Locally available services are not at levels to fully meet demand. Long waiting times exist (which are replicated nationally) and this limits the impact of support.

Provision is not consistent across the subregion, meaning that the level of support a young person receives depends heavily on where they live. In Macclesfield, for example, the removal of the King's Trust provision has left a gap, with little alternative provision available locally. Cheshire West also lacks the presence of a dedicated local youth hub. DWP only supports those 19+, missing an opportunity for earlier preventative support.

Support for young care leavers is fragmented. Specialised approaches that are trauma informed are not embedded across all programmes, and stakeholders recognised the need for more structured stepping-stone opportunities to help those most disadvantages to move gradually into education, training or employment. Despite efforts with colleges to support more vulnerable school leavers, there is recognition that transition plans need to be consistent across the subregion and shared from education to receiving institutions to best prepare staff and maintain support.

Engagement revealed that apprenticeship opportunities for young people are being limited by a reduction in employer willingness to offer places. Engagement shows that in sectors such as construction, employers are increasingly reluctant to commit to long-term training. Rising costs including increases to the minimum wage, National Insurance contributions and energy bills, are compound pressures, reducing incentives to take on younger and less experienced entrants. Similarly, engagement has found that work experience is difficult to source and still relies on parents helping young people to secure placements

Priority 3: Long-term sickness and early retirement

Over recent years health related issues have risen across Cheshire and Warrington. We have seen this in the form of an increasing proportion of economic inactivity made up by long-term sickness, as well as a rise in people off work due to temporary sickness. Fit note data shows that a combined 7% of people are off work with long-term and temporary sickness across Cheshire and Merseyside, compared with 5.1% nationally.

Mental health and musculoskeletal conditions are the most significant health drivers of inactivity and lock term sickness. The largest drivers of health related worklessness are mental and behavioural orders which make up around 40% of reasons for fit notes across

Cheshire and Merseyside, exacerbated by financial pressures, job strain and insecurity, and therefore more acutely felt in some of our more deprived communities. Musculoskeletal and respiratory diseases are the next most likely reason given in fit notes, where 21% of the population in Cheshire and Merseyside report a long-term musculoskeletal condition, compared to the England 17.6% average.

There has been a rise in sickness absence from work and people reporting being economically inactive both due to temporary and long-term sickness. It will therefore be increasingly important to support early intervention to prevent people being absent from work becoming long-term sick or leaving employment.

Early retirement is the most common reason for economic inactivity in Cheshire and Warrington, accounting for over a third of total inactivity in Cheshire West and Chester. With an increasingly ageing population, this is a key group to target to ensure there are suitable job opportunities for those who may be looking to return early, which can help fill the growing number of vacancies in the subregion, and continues to contribute to the local economy whilst helping to develop the future skills pipeline by passing on the skills and knowledge they have developed through their careers.

While JobcentrePlus can provide support for those who are out of work and seeking employment, and the Opportunities Portal provides signposting to job opportunities for people over 50, there are a lack of tailored programmes designed to prevent early retirement or actively seek to re-engage those who have already left the workforce.

Over recent years, employment services have shifted to digital platforms, with job opportunities posted online, and support often offered through portals and website signposting. With technology moving at pace that can be overwhelming for adults returning to work, digital exclusion acts as a barrier to job searching and training for older residents. For older residents with limited experience with modern, digitised recruitment practices, these systems can be challenging to use, further limiting access to job opportunities.

Priority 4: Carers and parents facing challenges

There has been a rise in the number of children living in poverty across the three local authorities. The three authorities rank amongst the six districts with the lowest levels of relative child poverty[10] across the North West. Latest estimates across Cheshire and Warrington estimate that just over 29,000 children aged below 16 are living in relative poverty, around 17% of children across Cheshire and Warrington, however this is up from 12% in 2014/15, a rise of 9,000 children.

Support for those balancing work with caring or parenting responsibilities, particularly lone parents and low-income families, is primarily embedded within broader programmes rather than offered through tailored provision. Access to support is typically through channels such

[10] Relative poverty refers to people living in households with income below 60% of the median in that year.

as Jobcentre Plus work coaches or general skills and employment services, but these offers are usually generalised, and not specific to the circumstances of carers or single parents.

Unpaid carers and single parents are falling through gaps in current employment and skills provision and therefore facing significant barriers to workforce participation.

These services can direct carers to training or employment support when appropriate, but dedicated employment support is limited, with wellbeing remaining the central emphasis.

Childcare affordability and inflexible employment practices can be core barriers to entering employment, and employers are not consistently supported to offer adjusted hours or specialised support to fit commitments.

Cheshire and Warrington's carer support service offer education, training, and employment advice to carers across the subregion. Council commissioned services such as the Carers Trust Cheshire and Warrington, Better Together in Cheshire West and Chester, Cheshire East Carers Hub and Warrington Carers Hub offer support to carers. However, the majority of this is general support and advice, covering financial support and social engagement.

But partners identified a rising issue among communities in specialist services for carers as a significant service gap. Many in this cohort may not actively come forward for employment support because their immediate circumstances make working difficult. There is a lack of focused outreach to identify and engage carers or struggling parents specifically.

Priority 5: Connecting people to opportunities

There are stark contrasts across the subregion in adult skill levels - Cheshire East and Cheshire West & Chester have relatively high proportions of residents qualified to NVQ3 and NVQ4+. In contrast, 14% of residents in Warrington hold no formal qualifications, a clear barrier to entering into certain sectors/roles.

Across Cheshire and Warrington it is estimated that around 100,000 people have been unemployed for over a year, with almost two thirds of these claiming Universal Credit. Tailored support will be needed to help encourage some of those people back to work, along with working with employers to see what adjustments can be made to ensure a phased return for those who may never of had a job or those returning to the workplace.

A lack of sufficient entry level jobs in the business base act as a barrier to lower-qualified residents without accessible routes into good employment. This can exclude people from the labour market despite a desire to work. The number of vacancies has started to pick up again following a decline post-pandemic. There are a number of issues which may be preventing residents who are currently out of work from filling these roles.

Local Supported Employment services provide job matching services to connect residents with vacancies, helping to match existing skills with employer demand. Careers Hubs and the Pledge Partnership engage with the local employer base to raise awareness of local opportunities and provide brokerage between residents and businesses and fill local vacancies. But engagement has found that a loss of local training providers has reduced options for entry-level and vocational training, leaving fewer accessible pathways into work.

Employers are not consistently providing intermediate labour market opportunities or tailored entry-level roles for people with barriers to work, such as low skills or limited work history.

Actions

In order to shift the dial on unemployment and economic inactivity across the five priorities identified through the data, current provision mapping, and partner engagement, Cheshire and Warrington needs an approach going forward to:

- Provide more flexibility to tailor services to local needs and enable partners to be more responsive and accountable to local communities
- Understand delivery at the best level for the individual to deliver better outcomes, preventing duplication of activity and administration
- Promote early intervention to build the social and institutional capacity enabling long term cost reduction.

The below actions are developed and proposed based on the analysis in this Plan and the current and evolving operating environment in Cheshire and Warrington. They are to be further developed and detailed with partners.

We will also explore engagement over the coming months with people with lived experience of disadvantage to ensure the implementation of the Plan reflects all barriers to work and support needs. We will do this through survey work, working through community partners (e.g. VCSE organisations, housing associations, unions and the Probation and Prison Service), and direct engagement with communities through targeted events in local areas, drop-in sessions at common meeting places and listening groups.

Evolving a strategic employment support service for Cheshire and Warrington

Cheshire and Warrington starts from a position of strength with employment already almost at the 80% target rate set out in the GBW White Paper, and strong growth potential centred on professional, scientific and technical services including life sciences, advanced manufacturing and energy sectors. This plan provides an opportunity for Cheshire and Warrington to continue to unlock growth by targeting key cohorts into employment who we know face more barriers.

Cheshire and Warrington can play a key role in converting the Government's ambition to get two million more people into work. By building on provision already in place and adopting a joint-up, targeted approach, we can help provide a route back into employment for 17,000

who are inactive[11] but are seeking to return to work and some of the 100,000 who have been long-term unemployed, including 65,500 Universal Credit (UC) claimants who have been unemployed for over 12 months.

Building on the effective targeted provision that exists in communities in Cheshire and Warrington, with the development of the Strategic Authority over the next year, there is an opportunity to draw together good practice in the programmes that are running in different places through different partners into one developing strategic employment service. Initially, this will offer better coordination and connection with devolved powers and funding, as well as deeper collaboration with partners.

Over time, as devolution evolves in Cheshire and Warrington, this strategic capacity will be used to develop more integrated future service design. Government has indicated a direction towards devolving employment support, and the English Devolution Bill sets out the process through which Strategic Authorities can become Established SAs with Integrated Settlement funding across seven competences including skills and employment support, and health, wellbeing and public service reform. The Bill also allows for an annual right to request further powers and funding by Mayors to Ministers.

This will therefore be a strategic function for Cheshire and Warrington that develops over time, starting with coordinating and aligning existing delivery service insights, develop new approaches based on best practice and fill provision gaps over the medium term, and developing longer term into designing integrated services across Cheshire and Warrington with future funding and devolved powers.

The focus of the strategic service should be to design a system that addresses people at risk and preventing people from falling out of the labour market – that is strategic, consistent, and long term to help the cohorts of people who will become inactive through a similar range of barriers – health, skills, transport, culture, caring, and quality of jobs. This should provide a standing portfolio of responsive interventions that is always there for people, and also sets up a delivery model for prevention.

This will require development of core functions:

Building on provision that is working well

- While a range of local support is available, residents in deprived areas who face multiple barriers to employment, such as homelessness or substance misuse are often supported through community organisations. We will work with partners to connect services more closely to mainstream employment support, leaving gaps in pathways into work, building on current local good practice, for example:
  - IPS approaches that are developing into the new Connect to Work programme, being designed for implementation in Cheshire and Warrington, building on understanding of what has worked locally.

[11] We have taken a 5-year average of the proportion of the economically inactive population across Cheshire and Warrington who want a job and multiply this by the economically inactive population.

- Using functional skills and practical learning design in adult training programmes for people to gain the certifications they need to progress into apprenticeships and employment, moving away from mandated approaches to GCSEs and classroom learning that doesn't work for everyone. This will be used to inform the developing devolved Skills Priorities Plan.
  - Testing pilot WorkWell services and embedding employment advisers in musculoskeletal pathways, which would strengthen preventative support for those whose health issues may lead to long-term sickness.
- We will develop ongoing a new approaches that build on good practice tested in Cheshire and Warrington (and wider afield), using a overarching strategic service to retain knowledge and intelligence from programmes, and use engagement with service users to understand lived experience and how programmes work and could be improved in future.

Data and evidence development

- Through the capacity of the new Strategic Authority, we will continue to build and retain a local evidence base from programme intelligence and analysis of what is happening in the labour market, combining publicly available data and local service data to understand population level changes in employment and health over time.
- We will also build an understanding of beneficiaries' journeys in different circumstances and places in Cheshire and Warrington to inform future programme design and retain an up-to-date understanding of barriers people face.
- This will require enhanced data sharing and transferability between services – bringing together evidence from across local authority services, DWP and JobcentrePlus, NHS trusts and providers, and the VCSE sector.
- Setting up shared data analysis and digital tools will enable a more joined up view of where provision is delivered, scale up approaches that work well, streamline areas of duplication, and monitor programme outcomes to iterate as they are delivered.

Partnership collaboration

- Partnerships have been established in Cheshire and Warrington, with several active programmes including IPS, devolution, Pledge Partnership, the Population Health Programme, and Poverty Commission.
- We will build on these to develop lasting collaboration mechanisms and provide more tailored support to those with health issues, to help bring down barriers preventing people from entering and sustaining employment.
- We will develop opportunities to share capacity and capabilities among public service and VCSE organisations across frontline service delivery, data analysis, and programme design and management.

[placeholder – governance diagram]

We will focus on specific support across the five priorities identified in this Plan:

Priority 1: Most deprived neighbourhoods

- There is a need to be more proactive in creating inclusive environments and providing opportunities and sufficient support for disadvantaged cohorts, to both enter and remain in employment.
- We will support expanding community led approaches that are in development in some areas, and should be developed and expanded to enable local solutions to employment barriers in development but not yet embedded, so that we have fuller coverage of support across Cheshire and Warrington.
- We will develop and coordinate access points in deprived neighbourhoods to support people in their communities who are further from the labour market, face complex barriers, and live in areas with barriers to services and employment centres. These will provide wraparound support in existing communities spaces, for example, at foodbanks or housing association premises, to target those most in need.
- Access points will provide a gateway into formal support – working with VCSE organisations to deliver a neighbourhood service setup for support triage, preparation for individuals to access further services, and provide a journey to JobcentrePlus, college or other learning environment, volunteering, or with an employer.

Outcome: a reduction in economic inactivity in our more deprived communities over the with support initially looking to encourage those who are economically inactive to want to work, with more people going on to access employment related support.

Priority 2: Young people and NEETs

- We will develop a regional approach to skills, careers, and employment support that delivers early intervention and prevention of young people falling out of education, training, or employment at key transition points.
- This will require greater partnership working and collaboration between schools, colleges, skills providers, local support services and employers to better match skills supply and demand tailored to younger people entering the workforce, gaining work experience, and understanding their own potential and training routes.
- We will collaborate on designing local apprenticeship schemes that can be more flexibly delivered to meet the needs of employers, and to engage with young people closer to where they live, and in community environments that work for them – not requiring everyone to come to a formal learning environment to understand careers options and guidance.
- We will work with schools to implement early intervention more comprehensively for young people such as care experienced to prevent NEET status and offer alternative progression routes from formal education.

Outcome: a reduction in the number of young people who are NEET across Cheshire and Warrington by working to develop consistent and sustained engagement activity.

Priority 3: Long-term sickness and early retirement

- While varied health related employment support exists, the system lacks consistency in linking health and employment services at scale across Cheshire and Warrington.
- We will join up innovative services that are currently operating in specific areas to shift more comprehensively to support for people who are inactive and long-term sick and to prevention for people at risk of dropping out of the labour market.
- We will work with partners to develop more consistent front door support across the area to provide in every part of Cheshire and Warrington access to employment support professional services with other services where individuals' front doors are primary or secondary healthcare, housing and homelessness support or temporary accommodation, JobcentrePlus and welfare, financial or debt advice, and other voluntary organisation services.
- Support will include retraining and employability interventions targeting older workers including working with employers and anchor networks to support return to work, age-inclusive employment support, and more flexible employment options.
- We will work with employers and employer representatives to better connect support for people who are off sick temporarily to prevent absences becoming people leaving the workforce.

Outcome: a reduction in the number of people who are economically inactive due to long-term sickness. This will also see a reduction in the 7% of people who are off work with long-term and temporary sickness across Cheshire and Merseyside.

Priority 4: Carers and parents facing challenges

- The rising numbers of children living in low-income households and in poverty, and inactivity linked to caring requires more joined up support for parents and those with caring responsibilities.
- We will focus on early years and family support across communities to provide more consistent family hub style support for early years education, healthcare and childcare, combined with access and guidance for parents on services they require e.g. financial, welfare or housing support, and employment support and learning opportunities, to support parents with multiple barriers to participating in the labour market and support early intervention for improved childhood health and development outcomes.

Outcome: more people engaging in targeted early years and childcare support. An increase in the number of young people who are disadvantaged engaging in further education, employment or training opportunities.

Priority 5: Connecting people to opportunities

- Training and employment support services alone are insufficient to connect disadvantaged residents to sustained employment. Provision to engage this group therefore needs to be matched by demand-side measures that encourage the creation of accessible, good-quality jobs at the lower end of the labour market.
- Support is needed to ensure residents are not prevented from accessing local job opportunities by providing tailored support and training which can help to fill local vacancies, including those from more disadvantaged backgrounds who may have been prevented from achieving their potential in an educational setting.
- We will work with employers and trade bodies on understanding skills and labour needs, link up hiring pathways with individual support service pathways, and codesign participation in employment support and skills programmes, for example, T Level and apprenticeship placements, supported internships and employment, and targeted programmes for specific cohorts, so that employers are prepared to better support individuals and develop quality job and progression opportunities.

Outcome: an increase in the number of employers who are investing in skills and training, and an increase in the number of supported internships and employment. More young people and adults accessing local training opportunities.

Maximising the impact of a new Strategic Authority

As the Cheshire and Warrington Strategic Authority is established and developed, we will ensure that the devolved powers and funding that are immediately devolved align with the priorities in this Plan, and can help to deliver the operating environment that will improve employment outcomes, through:

- Devolved Adult Skills Fund via the Skills Priorities Plan (to be agreed with the DfE)– prioritising allocations and working with providers to ensure funding is targeted at our skills, labour market and employment priorities, building on the collective work of the Local Skills Improvement Plan.
- Local Growth Plan – identifying employment and business growth opportunities through engagement with employers, and connecting specific sector, occupation, major project and skills needs with employment support and skills provision to inform connecting individuals with training and employment that supports local growth.

- Future local growth funding – using employment and skills priorities to inform future local growth funding (including the successor to UKSPF), and designing local interventions to support the Local Growth Plan and employment support priorities.
- Tools to alleviate barriers to participating in the labour market – employment priorities informing strategic roles of the SA in strategy, funding and delivery of transport, infrastructure, housing, employment land and spatial planning, to connect people to opportunities.
- Developing institutional roles – working to integrate employment support and health at the strategic commissioning level between the Mayor and ICB, aligned with the ambitions of the 10 year Health Plan.

Get Liverpool City Region Working Plan

[Final]

16 September 2025

Contents

Executive Summary

The Liverpool City Region (LCR) is committed to supporting the national ambition of achieving an 80% employment rate by 2035.

This challenge demands a coordinated whole system response including the Liverpool City Region Combined Authority (LCRCA), Local Authorities, the Department for Work and Pensions (DWP), the NHS, education and training providers, the Voluntary, Community Faith and Social Enterprise sector (VCFSE), employers and individuals with lived experience.

The Get Liverpool City Working Plan (GLCRWP) serves as a high-level strategic framework that draws on evidence and partnership engagement. It builds on existing strengths that have been established within LCR's employment and skills eco-system anchored over a number of years by programmes such as Ways to Work and Households into Work while recognising the urgent need to address deep rooted spatial inequalities, overlapping deprivation and persistent barriers to employment.

Labour market: Key challenges.

- **Employment rate:** At 71%, the LCR employment rate lags significantly behind the national average and the Get Britain Working Plan aspiration. Economic inactivity stands at 25%, well above the UK average, driven by a range of factors including long-term sickness, skills gaps, caring responsibilities and spatial disadvantage.
- **Disproportionate impact:** Women, young people, ethnic minorities, disabled residents and those without qualifications are more likely to experience worklessness and insecure employment. Childcare barriers and health related inactivity are particularly acute, with high levels of benefits dependency and persistent income deprivation in many parts of the City Region.
- **Systemic inequalities:** All local districts face elevated deprivation, low pay and uneven job density. Lower self-employment rates and business density, slower job growth and sectoral skills shortages intensify these issues.

Collaboration and system change.

The GLCRWP is grounded in partnership aligning with overarching local strategies including the Plan for Prosperity and the Liverpool City Region Growth Plan 2025-2035. It emphasises the integration of health, employment and skills systems taking inspiration from All Together Fairer and All Together in Health and Work, which focus on reducing inequalities through prevention, integrated services and targeted employment support interventions for disadvantaged groups.

The plan advocates for sustained multi-agency action through a Collaboration Agreement enabling information sharing, policy innovation and the testing of coordinated service delivery. Key future actions include targeted skills provision, improved data sharing via the LCR Office for Public Service Innovation (OPSI) and leveraging devolution opportunities to drive inclusive growth.

Immediate priorities and action strands.

Four strands underpin the GLCRWP's approach:

- **System change:** Developing integrated governance and partnership arrangements, commissioning a review of employment support and testing community facing hub models.
- **Work:** Promoting workplace health and wellbeing, incentivising inclusive employer practices and supporting groups with structural barriers to work. Promoting "fair employment" and supporting local economic development in ways that advance social value and opportunities for all.
- **Skills:** Refreshing the Local Skills Improvement Plan, deepening the local talent pool and launching flexible local programmes to boost skills among economically inactive residents, influenced by best practice models of delivery.
- **Health:** Embedding the "Health in All Policies" duty, whilst expanding health and growth accelerators, further testing of prevention demonstrator projects and developing innovative mental health support in collaboration with partners.

Building for the future.

With the scheduled conclusion of the UK Shared Prosperity Fund (UKSPF) in March 2026, the plan stresses the need for replacement funding and additional resources, system simplification and stable long-term investment to support inclusive employment.

This plan is the starting point for a strengthened, coherent approach; it will be iteratively updated, guided by a Partnership Board, with input from others including the LCRCA Equality Panels, to ensure delivery remains responsive to local spatial need and grounded in lived experience.

Political oversight of the plan will be undertaken through the existing Education, Employment and Skills Cabinet Board. In addition, LCRCA will draw on existing governance and assurance processes including the Overview and Scrutiny Committee.

Chapter 1: Overview

The Liverpool City Region (LCR) is committed to supporting the government's ambition of an 80% employment rate by 2035. Currently, the Liverpool City Region's employment rate is 70.9%, therefore achieving this stretching target requires supporting an additional 90,000 working age people into work over the next 10 years. This will only be possible through enhanced partnership working locally and stronger engagement with central government – developing a shared understanding of our local priorities and challenges which in turn drive collective action.

This Get Liverpool City Region Working Plan (GLCRWP) provides a high-level, strategic overview of the local labour market challenges, alongside a summary of the existing interventions in place to tackle them. The Plan builds upon our City Region's existing plans, strategies, assets, and good practice to place additional and urgent emphasis on increasing the volume of our residents who can take advantage of the opportunities our local economy affords.

Our GLCRWP takes a whole-system approach and has been co-developed with stakeholders recognising and valuing their experience, contribution, and input. The Plan brings together a range of partners - the Liverpool City Region Combined Authority, Local Authorities, NHS Cheshire and Merseyside Integrated Care Board, Department for Work and Pensions, employers and business representatives, skills and training providers, the VCFSE sector and anchor institutions - on a shared mission to support our residents into good quality work, reduce barriers to employment and strengthen the local system, making it work better together.

The Plan sets out the immediate priority actions that we will take over the next 12-24 months, which will act as a catalyst to enhanced partnership working and further long-term systemic change. The GLCRWP will evolve over time through an iterative process and will be underpinned by the development of a Collaboration Agreement between LCRCA including our constituent authorities, DWP and the NHS to work collectively to prevent and address the multi-dimensional issues leading to worklessness and economic inactivity, demonstrating a shared intent for this to be the start of a more targeted and longer-term approach.

The City Region has a well-developed employment and skills eco-system including the delivery of locally focussed employment support through the established Ways to Work programme delivered through local authorities and targeted community-based support funded through Households into Work, alongside a range of other initiatives delivered by the local VCFSE sector.

However, the City Region faces persistent challenges regarding unemployment and economic inactivity, driven by deep rooted spatial inequalities and overlapping deprivation in many neighbourhoods, highlighting the need for sustained and highly targeted / concentrated interventions to support a cohort of individuals facing significant challenges into the workforce.

The challenge of moving towards an 80% employment rate across the Liverpool City Region is a significant ask given our baseline, current skill levels, employment and

economic inactivity rates and our current economy, it can only be delivered in partnership and through the additional national focus placed upon these issues by the national Get Britain Working Plan.

With the UK Shared Prosperity Fund (UKSPF) scheduled to conclude in its current form at the end of March 2026 there is considerable uncertainty within the City Region regarding funding for local employment support services, outside of mainstream DWP support and the new Connect to Work programme.

It must be stressed that additional resources will be required to address our significant spatial issues, and we will, as a City Region, continue to press government regarding replacement funding for UKSPF alongside access to and inclusion in associated national initiatives and programmes such as:

- Economic Inactivity Trailblazers.
- Health and Growth Accelerators.
- Jobs and Careers Pathfinders.

The advent of the English Devolution and Community Empowerment Bill and the confirmation of LCRCA as an Established Mayoral Strategic Authority provides an opportunity for the LCR to drive forward the integration of the work, skills and health agenda through enhanced partnership working, increased collaboration and improved data sharing to maximise the opportunities afforded through greater devolution.

There is an overarching need for system change, alongside simplification, stability and the strengthening of operational partnerships to address the key challenges and barriers identified:

- Improving the availability of accessible, relevant and long-term funded education, skills and employment support services targeted at communities and individuals with the greatest needs.
- Enhancing health prevention interventions, in particular mental health and wellbeing support.
- Raising awareness, availability and access to good employment opportunities for residents and employers.

Chapter 2: Introduction

The Get Britain Working White Paper (November 2024) outlines the government's approach to reforming employment, health and skills support to tackle economic inactivity and support people into good work. It seeks to address significant challenges in the UK labour market, including:

- High levels of economic inactivity, with over 2.8 million people out of work due to long-term sickness or a disability and nearly 1 million young people not in employment, education or training (NEET).
- Employment rates in the UK have not returned to pre-pandemic levels, and the country lags other G7 nations in this regard.

- Millions of people are in low-paid, insecure jobs, while many employers report unfilled vacancies and skills shortages.

The White Paper is seen as essential for economic growth, reducing benefit expenditure, improving public finances, raising living standards, and offering everyone the opportunity to participate in and benefit from work. The White Paper aims to raise the national employment rate to 80%, which would mean over two million more people in work bringing social, economic, and fiscal benefits.

The Government challenged local areas to publish their own strategies, and this GLCRWP is our local response; convened by the LCRCA, this plan has been developed through the work of a task and finish group featuring a wide range of stakeholders and partner organisations.

Existing plans and strategies

This GLCRWP has been developed within the context of a wide range of existing interconnected plans and strategies published by both LCRCA and other local partners including the Cheshire and Merseyside Health and Care Partnership. Care has been taken to ensure alignment and complementarity across LCRCA and partner plans, recognising their importance in guiding respective and collective action.

The Plan for Prosperity remains the overarching, first principles strategy. In the "No-one Left Behind" thread of the plan it is recognised that the strategy for "Levelling Up People" fails if significant numbers of residents cannot participate in an improved economy.

The **Liverpool City Region Growth Plan 2025-2035** provides a bold, ambitious roadmap to unlock the City Region's potential, drive up productivity, and build an economy that works for everyone. As part of the Growth Plan's development, designated high level Shared Priority Challenges were agreed with HMG in several areas including:

- **Employment, skills and health** where we will work together in developing a fully integrated approach which works for our residents, supports inclusive growth and increases productivity.

The Growth Plan highlights a number "people" focused outcomes, including:

- Attraction, development and retention of talent.
- Enhanced performance across the skills spectrum.
- Increased labour market participation.
- Improving health equity and wellbeing.

The **LCR Long Term Skills Plan** sets out the strategic vision for transforming and better integrating post-16 employment and skills provision across the region. Developed collaboratively by the Combined Authority alongside local authorities and stakeholders, the plan responds to persistent skills issues.

The City Region's Chambers of Commerce (co-ordinated by Liverpool Chamber of Commerce) are working together to give businesses across the region a voice and strengthen the relationship between employers and training providers through the **Local Skills Improvement Plan** (LSIP). The plan identifies and aims to address the skills need of the City Region, bridging the gap between employers, education providers and key stakeholders by driving collaboration to prioritise and implement actionable strategies tailored to local skills demands.

LCRCA's Corporate Plan 2024-2028, **Innovating for Growth,** reiterates the commitment to address long-term structural challenges and inequalities that impact too many of our residents and communities. Talent is widespread, but opportunity is not yet available to all, and too many people have horizons that are affected by inequalities linked to the postcode in which they live.

The **LCR Social Value Policy and Framework** highlights the importance of "continued delivery of effective services that support the most vulnerable and disadvantaged residents across the Liverpool City Region: and ensuring that services are designed to consider and support those residents located in the most disadvantaged areas (based on Indices of Deprivation) who may need tailored support to overcome barriers to social, digital and economic inclusion".

Statutory health improvement and health inequalities duty

The English Devolution and Community Empowerment Bill includes a provision for a new statutory health improvement and health inequalities duty to be conferred on Mayoral Strategic Authorities in England. This new duty will require Strategic Authorities to have regard to improving population health and reducing health inequalities when exercising any of their functions.

Specifically, they must consider how their policies and actions impact the health of people in their area and work to minimise negative health effects and reduce inequalities. Health inequalities are broadly defined, covering differences in life expectancy and general health that result from factors such as housing, employment, transport, access to services, and personal behaviours.

This responsibility applies across all strategic authority functions, not just in traditional health or care roles, promoting a "health in all policies" approach. The duty is intended to formalise and strengthen the leadership role of mayors and Strategic Authorities in improving health outcomes, shifting focus towards prevention and health equity.

In practice, this means Strategic Authorities must actively design their work, investments, and partnerships to support healthier, fairer communities and report on their impact. As an Established Mayoral Strategic Authority there is huge potential for going further with broader and deeper powers to allow the City Region to maximise its opportunities.

With the right powers and investment, the City Region can become one of the most dynamic, forward-looking economies in the country, over the next decade adding billions to economic output, creating tens of thousands of new jobs and closing long-

standing productivity gaps by scaling and promoting our strengths and investing in our people.

This isn't something any one organisation can deliver on its own, and we need to continue to collaborate and follow a shared mission forged in genuine partnership.

All Together Fairer

"All Together Fairer" the Cheshire and Merseyside's Health and Care Partnership (HCP) Plan was published in 2024 and focusses on four core strategic objectives:

1. Tackling health inequalities in outcomes, experiences and access. (Eight Marmot principles).
2. Improving outcomes in population health and healthcare.
3. Enhancing productivity and value for money.
4. Helping to support broader social and economic development.

The strategy emphasises working together to shift investment towards prevention and equity, tackle poverty, ensure fair employment, and embed health equity into services and policies.

The eight Marmot principles include:

- Giving every child the best start in life.
- Enabling all children, young people, and adults to maximise their capabilities and have control over their lives.
- Creating fair employment and good work for all.
- Ensuring a healthy standard of living for all.
- Creating and developing healthy and sustainable places and communities.
- Strengthening the role and impact of ill health prevention.
- Tackling racism, discrimination, and their outcomes.
- Pursuing environmental sustainability and health equity together.

Population health emphasises the many factors that influence health outcomes, including social, economic, environmental, and behavioural factors not just health care or biological aspects. The goal is to improve health for entire populations and to reduce health inequalities by addressing these wider determinants through partnerships, data-driven interventions, and policy change.

In practice, population health strategies seek to:

- Improve overall health outcomes for defined groups (e.g., by age, location, or risk factor)
- Identify and reduce health disparities and inequalities between groups
- Address the root social, economic, and environmental causes of poor health

- Engage various sectors (health, local government, industry, community organizations) to improve conditions that impact health.

This approach is central to current NHS and public health initiatives, helping to guide decisions that promote fairer, healthier communities.

All Together in Health and Work

The 'All Together in Health and Work' strategy, published in September 2025 by the Cheshire and Merseyside Health and Care Partnership, aims to initiate and support service integration on work and health to increase workforce participation for disabled people and those with health conditions who face health and social barriers to work, adopting the following principles:

- Prevention focused – early intervention to reduce health-related job loss and job-related health conditions.
- Equity in access and outcomes – target support to the groups that are in most need of support.
- Integration – deliver seamless, person centred services across sectors.

The strategy is underpinned by four key pillars:

- **Preparation** to support people with the holistic health, wellbeing and skills support to enter employment.
- **Prevention** to ensure those in employment can sustain employment.
- **Early intervention** to ensure those who are signed off on temporary sickness absence can re-integrate into the workforce effectively.
- **Longer term change** to support those unemployed and economically inactive due to health barriers to live independent and fulfilled lives.

The strategy highlights that whilst there is a broad range of services available some cohorts are still too often falling through gaps in employment and skills provision.

- Children and young people with mental health conditions.
- Carers who are economically inactive.
- Young people with experience of the care system.
- People with experience of the criminal justice system.
- Refugees and asylum seekers.
- Over 50's with skills gaps.
- Adults experiencing social isolation.
- Women facing barriers to employment.

Chapter 3: Labour market analysis.

This GLCRWP has been informed by an extensive evidence base produced by the LCRCA Evidence, Research and Intelligence team.

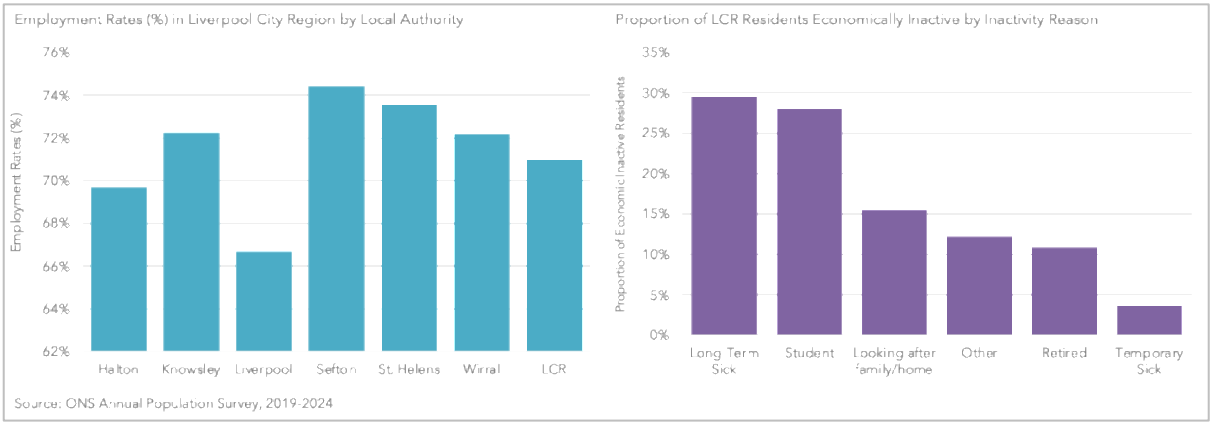
Overview

The Liverpool City Region labour market is characterised by strong recent growth in jobs, improving skills levels and dynamic key sectors, but faces significant challenges including persistently high economic inactivity, health related barriers to work, and a lower employment rate than regional and national averages.

Addressing these challenges, particularly health, skills and economic inactivity can unlock substantial local economic growth and help LCR close output gaps with the rest of the UK.

The LCR has a 71% employment rate, compared to the national average of 76% and the government aspiration of 80%. To achieve this 80% target, we will need an additional 90,000 residents to move into employment. This equates to 9.4% of the current working age population in comparison to national rates requiring 4.4% of working age residents to move into work to reach aspirations.

Figure 1: To reach the employment rate target for Get Britain Working, the City Region has significantly further to go than nationally.



Economic inactivity presents an ongoing and complex challenge for the Liverpool City Region (LCR), which comprises the six local authorities of Halton, Knowsley, Liverpool, Sefton, St Helens and the Wirral.

Despite recent improvements, the region continues to exhibit higher rates of economic inactivity (25%) compared to both national (21%) and regional averages (23%). High inactivity rates depress regional economic output and reduce the tax base, increasing pressure on public services. There is a strong correlation between economic inactivity and broader social issues such as health inequalities, intergenerational disadvantage and reduced social mobility.

All six districts have lower than average employment rates and higher rates of economic inactivity, with long term sickness (30%), studying (28%) and looking after family / home (16%) the biggest recorded contributing factors to this inactivity.

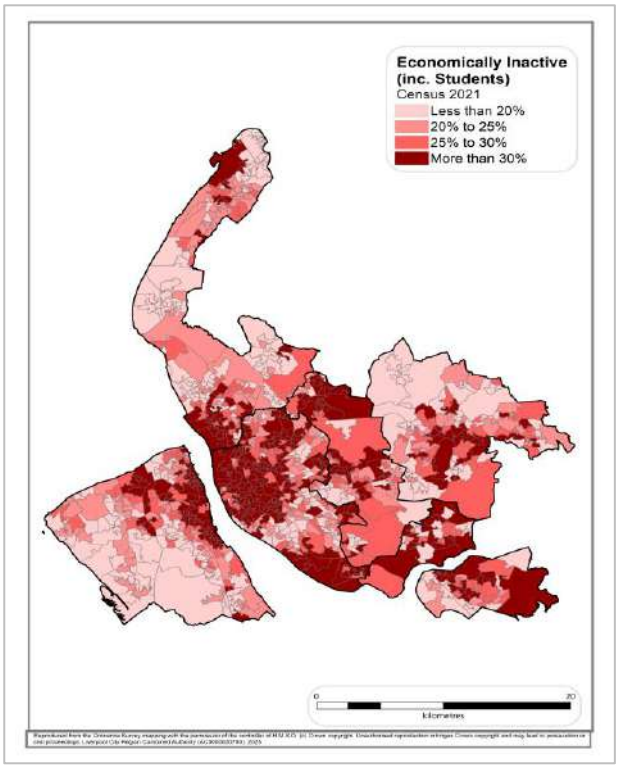
Disproportionately affected groups in LCR include women, young people, ethnic minorities, and disabled residents, compounding the regions inclusive growth challenges.

Key Issues.

The causes of inactivity and its causes are many and complex, encompassing a wide range of socio-economic factors.

- **Economic Inactivity and Low Employment Rate:** LCR has one of the highest inactivity rates (24%) and lowest employment rates (71%) in the UK, with progress in reverse since the pandemic.
- **Health Related Barriers:** Poor health and high prevalence of health deprivation in many neighbourhoods contribute to large numbers of workless households and health related inactivity.
- **Skills Gaps:** Despite improvements, educational attainment and formal qualifications remain below regional and national levels, with a higher proportion of residents lacking any qualifications and fewer holding higher-level qualifications.
- **Spatial and Social Inequalities:** Deep-rooted deprivation is widespread and persists in many areas across the City Region, leading to concentrated disadvantages and high claimant rates for out of work benefits. All six boroughs across the City Region are affected by elevated deprivation compared to wider national trends, with Knowsley and Liverpool consistently rated within the top three most deprived local authorities nationally.
- The legacy of the **COVID-19 pandemic** has deepened structural inequalities across the LCR particularly for those already furthest from the labour market.
- Unemployment rates across the six boroughs remain consistently above the UK average, highlighting pronounced spatial labour market inequalities and specific hotspot areas. As of September 2025, the LCR model-based unemployment rate is 5.3%, notably higher than the latest UK average of 4.7%. Liverpool itself registers the highest local unemployment at 7.0% with marked increases year-on-year and persistent concentrations in deprived central wards and north of the city districts.
- LCR is categorised by stark employment disparities, with some neighbourhoods recording some of the highest employment rates in the North West, whilst others experience severe and persistent unemployment and economic inactivity.

Figure 2: Economic inactivity across the LCR is widespread and significantly above national average.



This fragmented landscape means that large pockets of disadvantage and worklessness exist alongside areas with strong labour market performance and relative economic prosperity, making the overall employment profile highly disparate and uneven across the City Region.

Addressing this challenge is a central aim of this GLCRWP, alongside the need to tackle localised barriers ensuring inclusivity.

Contributing factors.

Opportunities to participate in the labour market, alongside worklessness and economic inactivity are influenced by a wide range of individual, familial, social, demographic and economic factors including but not limited to:

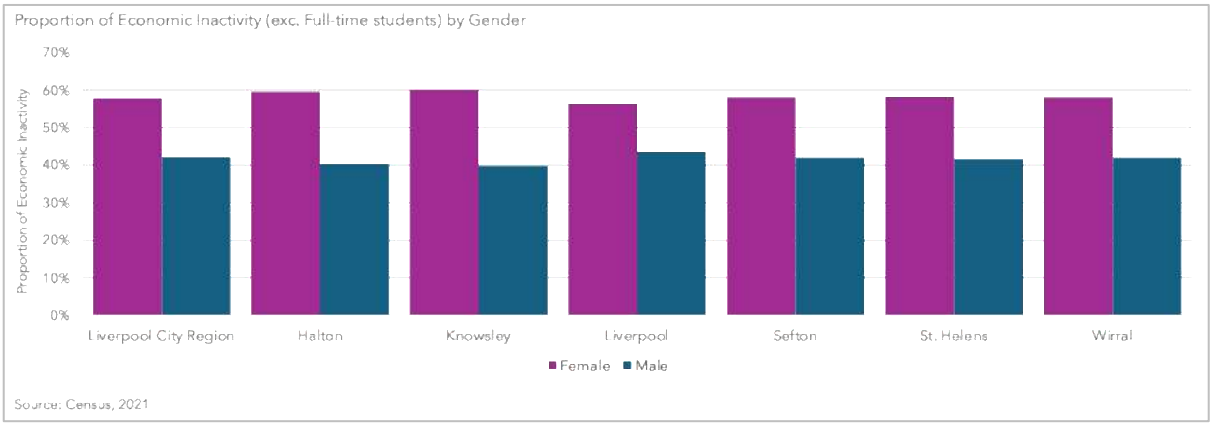
- Gender.
- Sex.
- Age.
- Ethnicity.
- Education / qualifications / skills.
- Health and wellbeing.
- Disability.
- Deprivation / place.

- Background and life experiences. (Including those with experience of the care or criminal justice systems).

Higher levels of female economic inactivity

Across all local authorities in the City Region, economic inactivity is higher for working age females (excluding full-time students) than for the same population of males. Knowsley (60.1%) has the highest proportion of female economic inactivity in the City Region, over 13,000 female residents in Knowsley are economically inactive accounting for 13.3% of the working age population, opposed to 8.8% for males.

Figure 3: There is a slightly higher proportion of females in Liverpool City Region, and a higher rate of female economic inactivity.



Women are 1.8 times more likely than men to be in severely insecure work, this includes temporary, part-time, low-paid and contractually uncertain jobs, leading to underemployment or fluctuating status between employment and inactivity.

The COVID-19 pandemic worsened labour market outcomes for women, reversing progress in employment rate parity and increasing the prevalence of inactivity linked to caring roles, health, or mental health challenges.

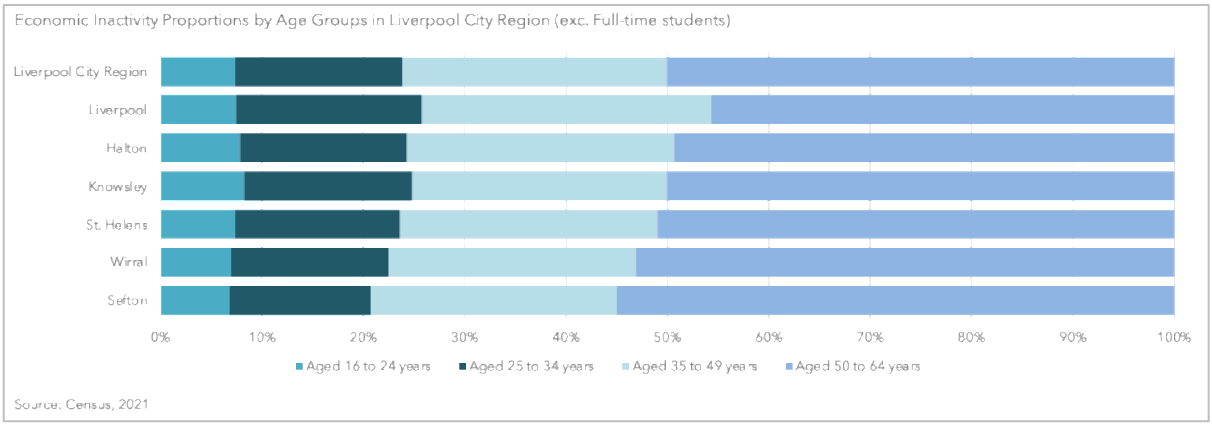
Difficulties with childcare are a major driver of economic inactivity, with women disproportionately affected due to caring roles. Nationally, 1.5 million mothers would work more hours if better childcare were available, this is especially acute in LCR due to high levels of deprivation and limited childcare infrastructure in some geographic areas. Childcare barriers exacerbate existing inequalities, locking families in cycles of poverty and reducing the pool of available labour, impacting employers, productivity and local economic prosperity.

50-64-year-olds are most likely to be economically inactivity

In LCR there are nearly 980,000 residents who are “working age”, aged 16-64 years old, accounting for 76.7% of the population (aged 16 and over). Within the working age population in the City Region, 50-64 is the largest age group accounting for 32.2%, a pattern that can also be observed across the local authorities.

For the working age population in the City Region (excluding Full-time students), over 202,000 residents are economically inactive, the age group with the highest proportion of economic inactivity in the City Region is 50–64-year-olds. Inactivity within this age group is due to long-term sickness, caring responsibilities and early retirement. This pattern is observed across all local authorities; however, Sefton has the highest proportion of economic inactivity for 50–64-year-olds (54.9%), accounting for over half of economic inactivity within the local working age population.

Figure 4: Those aged 50-to-64-years-old are the working-age band most likely to be economically inactive in Liverpool City Region.

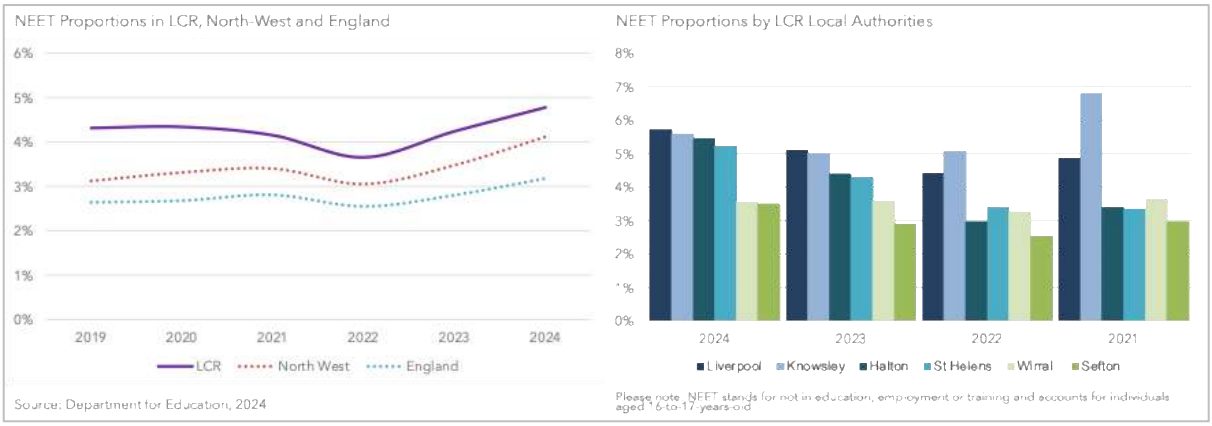


Young people are more likely to be NEET

The level of youth economic inactivity is increasing across LCR, as illustrated by above average levels of young people Not in Education, Employment or Training (NEET). Since 2022 proportions of NEET in LCR have increased (+1.13 percentage points) and at 4.79% are significantly higher than regional (4.12%) and national rates (3.19%).

Liverpool has the highest proportion of NEET of the six local authorities in LCR at 5.72%, whilst Sefton at 3.50% has the lowest rate, which however is still above the national average.

Figure 5: Youth economic inactivity is increasing in LCR as illustrated by above average NEET rates in the City Region.



Black, Asian Minority Ethnic residents more likely to be economically inactive

Liverpool City Region is less ethnically diverse than regional and national levels, however over the last 10 years the city region has become more diverse at a faster rate than the national average.

Across LCR 1.4 million residents (84%) identify as white (2021) compared to 95% in 2011. With 124,000 residents identifying as Black, Asian and Minority Ethnic (16%), there has been an 154% increase in the population identifying as Black between 2011 and 2021.

The LCRCA – Race Equality Declaration of Intent highlights that the City Region's population is increasingly diverse and multicultural, yet institutional racism is affecting the outcomes for Black, Asian and Minority Ethnic residents. Among other indicators, Black, Asian and Minority Ethnic residents are

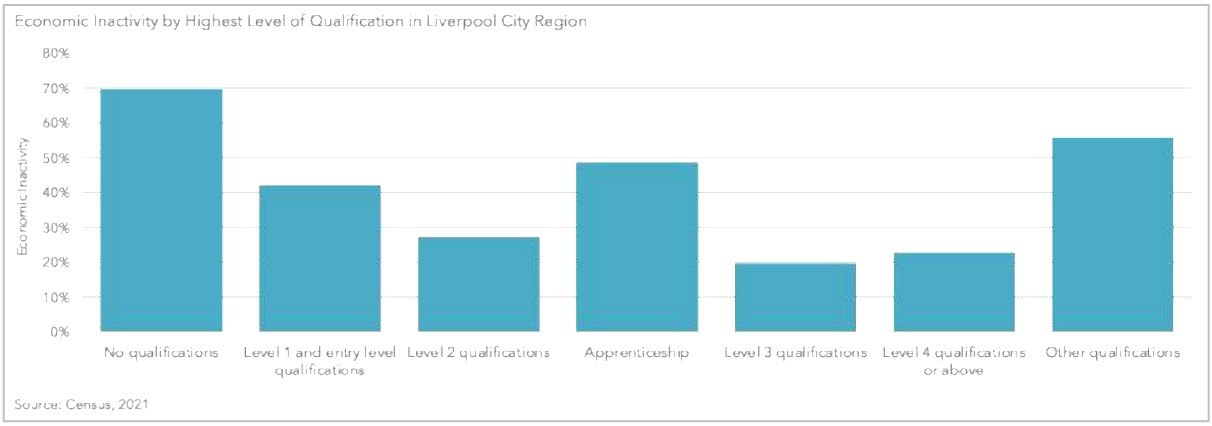
- Facing higher employment gaps.
- More likely to be economically inactive.
- Paid less on average than white residents.
- 1.3 times more likely to experience severely insecure work compared to white workers locally.
- More likely to live in poverty.
- Less likely to own their own home.

Analysis shows that women, disabled people and younger workers from ethnic minority backgrounds are more likely to experience insecure work and periods of economic inactivity.

High levels of inactivity amongst those with "no qualifications".

In LCR 21.1% of residents have "no qualifications" of which 69.7% are economically inactive (excluding full-time students) compared to only 22.9% of economic inactivity amongst those whose highest level of qualification is "Level 4 or above". Across LCR the group with lowest level of inactivity are those with qualifications at Level 3.

Figure 6: Liverpool City Region residents with no qualifications are more likely to be economically inactive.

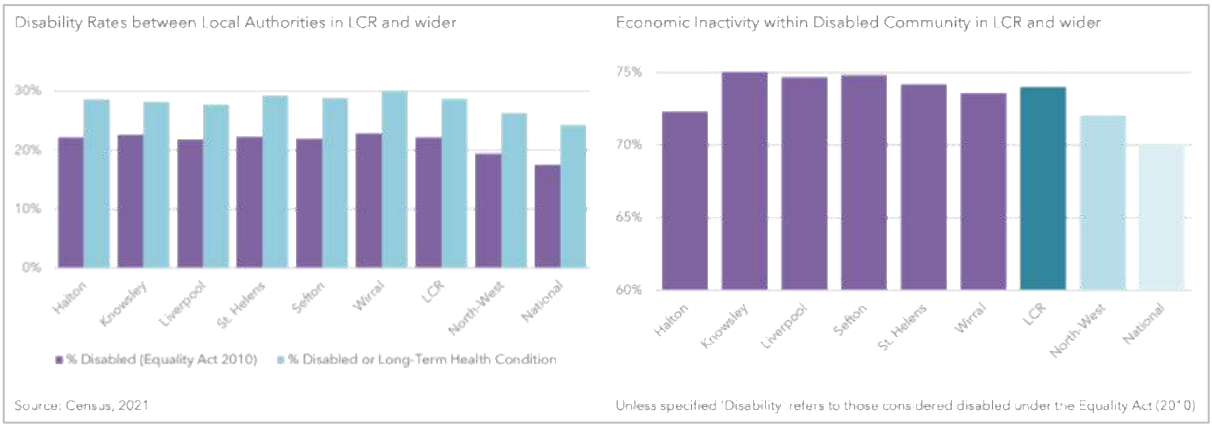


The City Region has a high proportion of residents with a disability.

The LCR has a higher proportion of residents with a disability, 22.2% of LCR residents are considered disabled under the Equality Act (2010) compared to 19.4% regionally and 17.5% nationally.

A greater proportion of residents with a disability in LCR report that their disability is limiting day to day activities. Within LCR those with disabilities face above average rates of economic inactivity (74% compared to 72% regionally and 70% nationally).

Figure 7: Above average rates of disability limiting residents with day-to-day activities contributes to increased economic inactivity in LCR



Many neighbourhoods face significant levels of deprivation

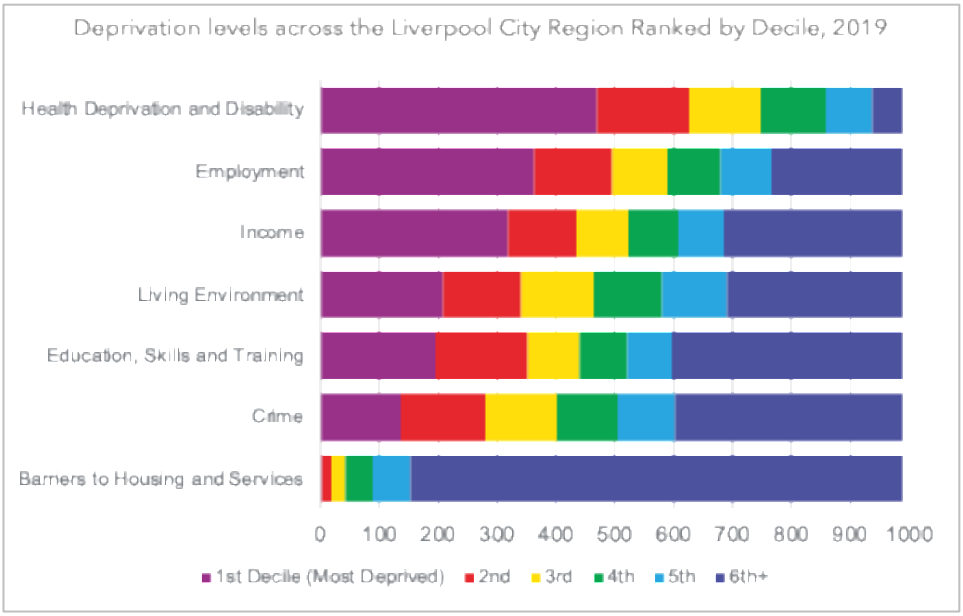
There are pronounced economic differences across the LCR, with each local authority area displaying unique strengths and persistent challenges. The economy is both diverse and uneven, containing pockets of wealth and high productivity alongside areas facing deep deprivation.

Many neighbourhoods across the LCR are characterised by significant levels of multiple deprivation with one third of all lower super output areas in the most deprived decile in the UK.

The City Region has a greater prevalence of deprivation than the national average across a wide range of domains, which act to reduce opportunities for LCR residents to fulfil their potential and present barriers which others outside of the region may not face.

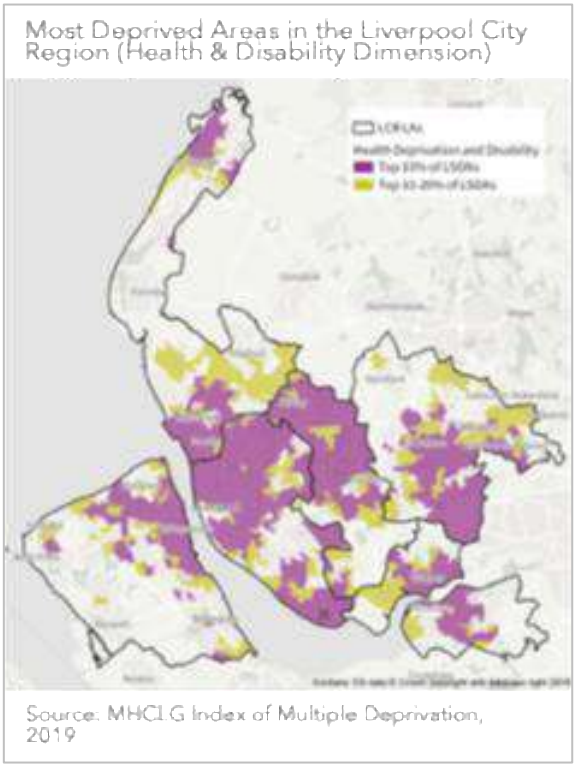
It should be recognised that COVID-19 has intensified pre-existing economic challenges the City Region saw a larger increase in Universal Credit claims. Local authorities faced increased service demands and additional financial pressures exacerbating the existing socioeconomic disadvantages of the area with recovery from these challenges notably slower than in less deprived areas.

Figure 8: Liverpool City Region has a greater prevalence of deprivation across most domains than the national average.



There are particularly high levels of deprivation in terms of health / disability and employment and income deprivation which underpin the overall index of multiple deprivation scores. The local authorities of Knowsley and Liverpool have particularly high rates of deprivation across many of the domains.

Figure 9: Health Deprivation is particularly widespread across the City Region.



Higher than average unemployment and lower than average pay.

There are high levels of unemployment and income deprivation amongst residents in the City Region, reflected in the high prevalence of worklessness and people requiring benefits support. Around one third of LSOAs are in the 10% most deprived nationally in terms of both employment and income.

Despite remaining above both regional and national levels, the number of City Region residents claiming unemployment benefits has stabilised in recent years. In December 2024, 4.7% of the working age population claimed unemployment benefits compared to regional (4.5%) and national rate (4.3%) meaning the gap is closing slightly.

Figure 10: Many communities in the City Region face challenges around employment.

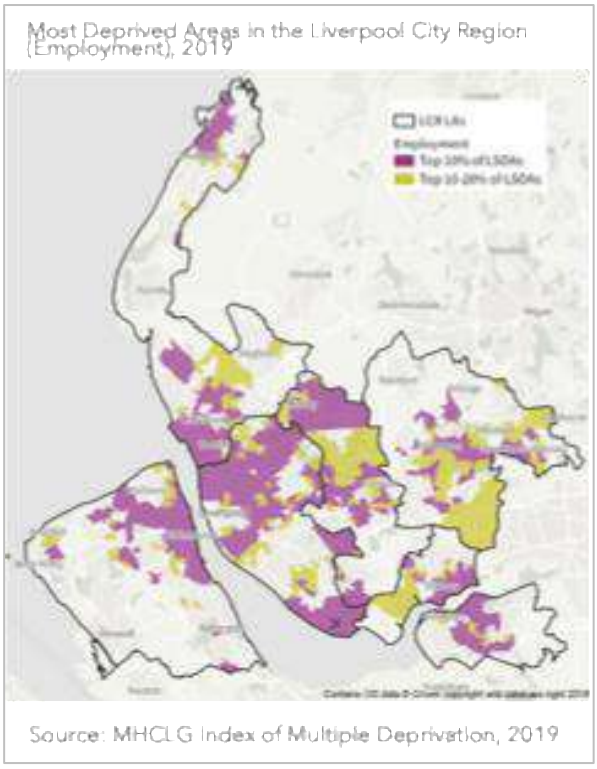
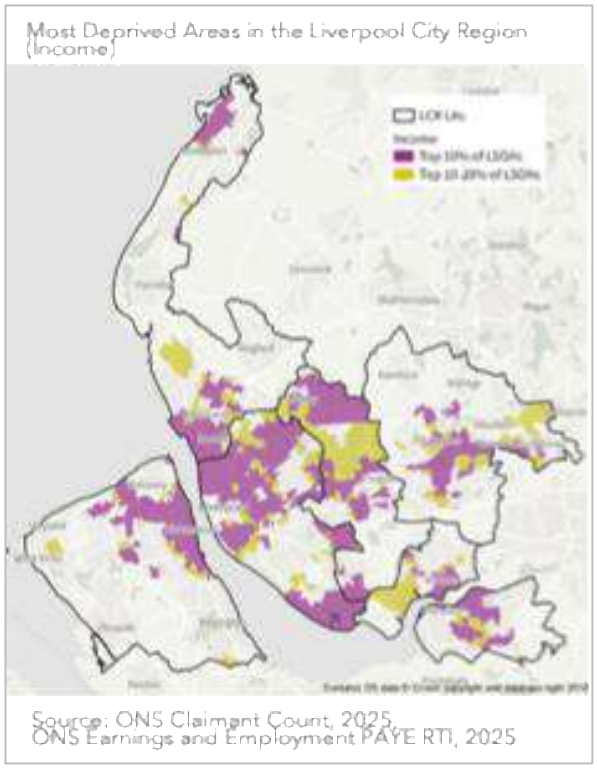


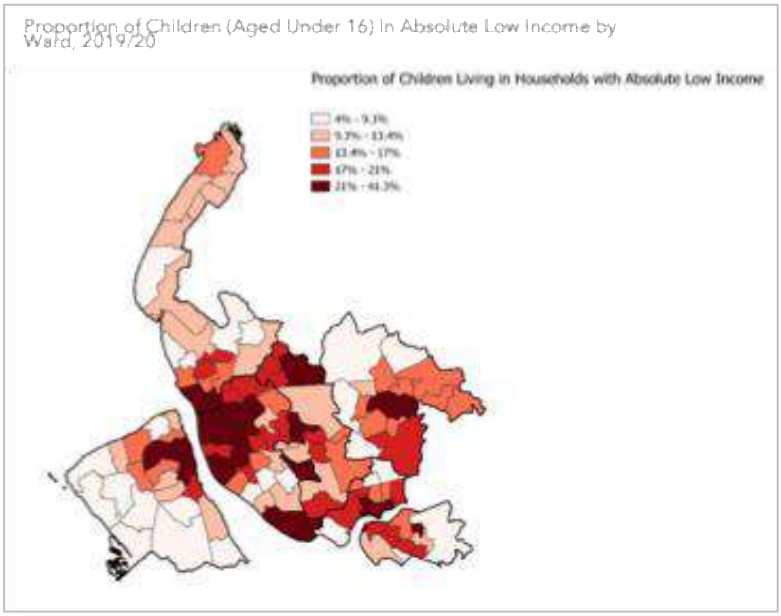
Figure 11: Many communities in the City Region face challenges around income.



The City Region faces persistent challenges regarding unemployment and economic inactivity, driven by deep rooted spatial inequalities and overlapping deprivation in many neighbourhoods, highlighting the need for sustained highly targeted / concentrated interventions.

Children living in the City Region are more likely to be negatively impacted by income deprivation. Within some wards in LCR, four in 10 children live in households with absolute low income with area of prevalence including north Liverpool, south Sefton and east Wirral, mirroring the general picture of deprivation across the city.

Figure 12: Children living in the City Region are more likely to be negatively impacted by income deprivation than nationally.



Wage rates in the City Region remain below national averages but are showing steady improvement. The median annual Real Time Pay in LCR is £26,500, which is 6% below the national average of £28,100.

One in five jobs in the area (compared to one in six nationally) are paid below the National Living Wage (set at £12.21 per hour for employees over the age of 21 from April 2025) highlighting the ongoing challenge of low pay and persistent pay gaps within and between districts and demographic groups

LCR has relatively low business density

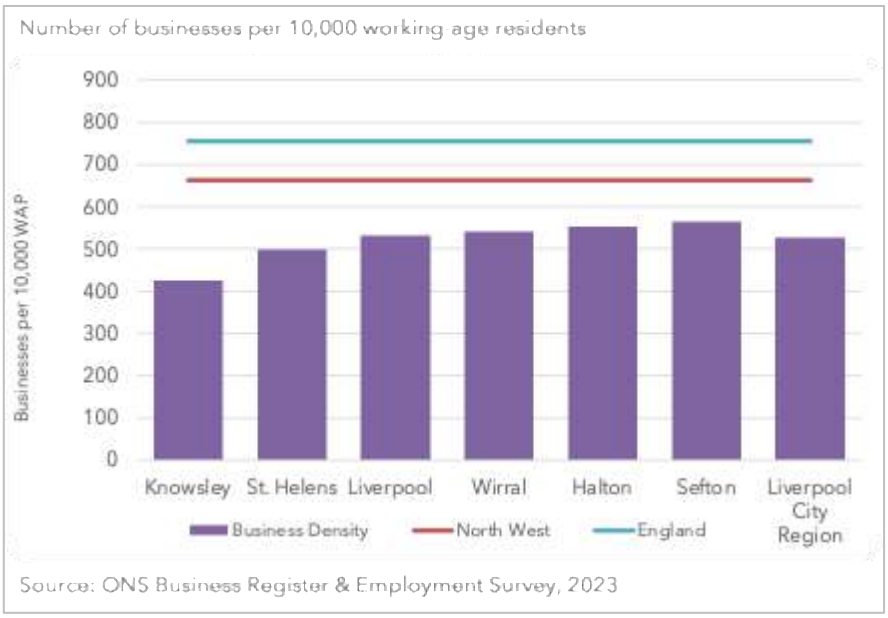
The LCR has a positive record of creating new businesses, since 2017 the business birth rate has consistently exceeded both regional and national rates. In 2023, LCR had the third highest business birth rate of all England MCA areas, above Greater Manchester, South Yorkshire and East Midlands.

However, in the City Region we see much worse business survival rates than in many other regions. 91% of businesses in the city region survive their first year, which is marginally below the national average (92%) indicating that newly established

businesses in the region are competing relatively effectively. However, when the three-year survival rate is considered, the LCR has the lowest business survival rate of all MCA areas at 47% compared to the national average of 53%. Similarly, the five-year survival rate at 35% is below the national rate of 39%.

LCR has much lower than average rates of self-employment at 6.95% compared to the regional (7.74%) and national (9.52%). The LCR has the fourth lowest proportion of self-employment of all MCAs below comparators such as Greater Manchester, West Yorkshire and West Midlands.

Figure 13: Relatively low business density.



The City Region experiences relatively low business density, at 526 per 10,000 working age residents the business density of the area ranks the fourth lowest of the MCA areas, and significantly lower than the England average of 755 per 10,000. Business density directly influences productivity and inhibits the benefits such as knowledge sharing and scale benefits arising from firms operating in more concentrated markets.

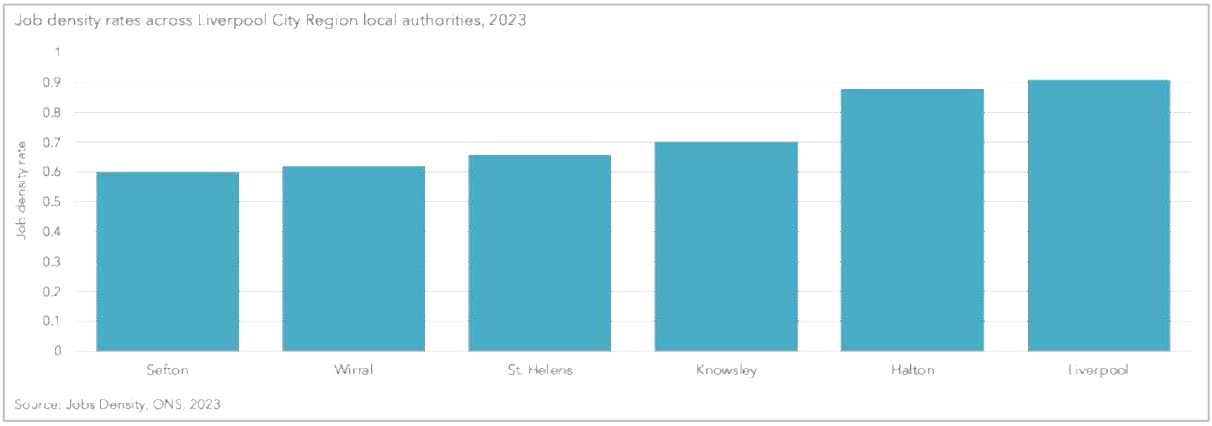
Micro and small enterprises (fewer than 50 employees) make up 97.7% of the LCR business base, medium businesses with 50-249 employees making up 1.7% and large businesses (250+ employees) at 0.4%.

The predominance of SMEs makes the City Region economy more sensitive to local and national challenges, such as low wages, skills gaps, reduced access to training and barriers to scaling and growth. Small businesses require clearer signposting to support, more tailored interventions and proactive outreach from support agencies.

LCR has lower than average job density

Job density is a measure of the number jobs per resident aged 16-64, providing an indicator of labour market demand in the City Region. The overall job density for LCR is 0.75 which is significantly below the UK average of 0.87.

Figure 14: LCR has below average job density.



District variation is notable, Liverpool has a job density of 0.91, whilst Sefton (0.60), Wirral (0.62) and St Helens (0.66) have significantly lower than average densities. This pattern highlights the spatial challenge across LCR, with jobs most readily available in Liverpool, whilst other districts face lower resident to job levels. The City Region overall lags the majority of MCA's, most notably the West of England, Cambridgeshire and Peterborough and Greater Manchester.

This gap has significant implications for the local labour market, alongside economic development and local prosperity. Lower than average job density means fewer employment opportunities relative to the working age population. This can lead to:

- Increased competition for available roles, contributing to higher unemployment, greater economic inactivity and underemployment, particularly for those lacking higher level skills or experience.
- Reduced career progression and wage growth due to a limited number of job openings and constriction at entry and intermediate levels, forcing more residents into insecure or lower paid work.
- Stagnant local growth, slower economic expansion, reduced productivity and less innovation.
- Out commuting pressure, whereby residents may be forced to travel further or relocate for suitable work, weakening local communities and potentially draining skills from the area.
- Reduced living standards, as a deficit of local jobs exacerbates inequalities with disadvantaged cohorts at heightened risk of long-term unemployment or labour market exclusion.

To move towards the 80% employment aspiration, it is critical to address the City Region's low job density to:

- Drive investment: Proactive efforts to attract and retain employers, alongside infrastructure and skills investment, helping to generate higher quality roles and economic activity locally.
- Targeted job creation, and business support programmes to boost vacancies in the area.
- Foster inclusive growth, ensuring activity benefits all segments of the population, particularly communities that have missed previous waves of economic expansion.

Chapter 4: Drivers and causes of labour market issues.

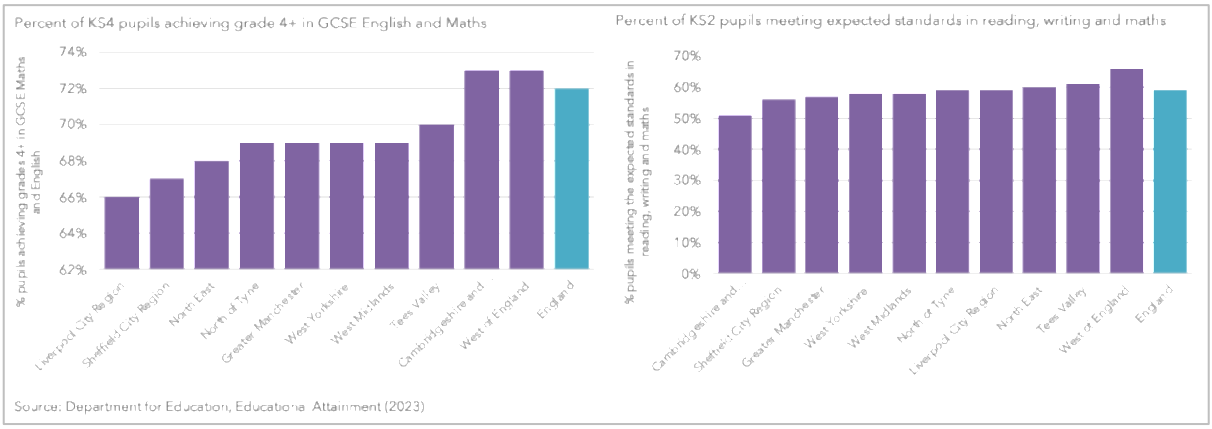
Supply side drivers

Education and skills

Skill levels are improving in the City Region. Over the past 20 years there has been a sustained increase, and the skills gap is beginning to close. The city region has however relatively low levels of educational attainment beginning whilst at school.

- At Key Stage 2 (KS2) educational attainment is in line with national levels, with 59% of pupils classified as meeting the expected standards in reading, writing and mathematics. This rate is slightly above other MCA areas such as West Midlands, Greater Manchester and Sheffield City Region.
- However, by Key Stage 4, achievement (66%) is significantly lower than the England average of 72% and is lowest of all 10 MCAs. This impacts upon young people's opportunities and ability to access further education or employment. Many young people spend time "catching up" rather than developing technical skills valued by employers, impeding workforce readiness.
- 21.1% of LCR residents (16+) have no qualifications, of which 69.7% are economically inactive, compared to 22.9% economic inactivity for those whose highest qualification is Level 4.

Figure 15: Educational achievement in KS2 pupils in the City Region is in line with national trends, however this decreases below national levels for KS4 pupils.



Across the City Region 6.1% of 16- and 17-year-olds are not participating in education, employment or training (NEET) which is above regional (5.6%) and national (5.8%) rates, with only Sefton and Wirral with rates below the national level.

- Being NEET has a significant adverse impact upon an individual's life chances. Evidence shows that both short and especially long-term periods as NEET are strongly linked to poorer outcomes across multiples domains of life.
- NEET experiences have long lasting consequences, with former NEETs much more likely to remain disadvantaged, unemployed or in precarious work.

The most recent UK Employers Skills Survey data shows that LCR has a slightly higher proportion of businesses with at least one skill gap in their workforce, but the City Region is in line with both regional and national averages for hard to fill and skills shortage vacancy levels.

- Analysis of specific skills shortages points to LCR employers having specific challenges securing basic computer literacy and IT skills. With projections expecting to see the workforce moving towards a growth in digital, creativity and AI.

Graduate retention in the city region sees higher level skills and qualifications move away from the area. LCR retains 41% of its graduates, ranking ninth out of all English NUTS 2 regions for graduate retention, behind areas such as Greater Manchester, West Yorkshire and West Midlands.

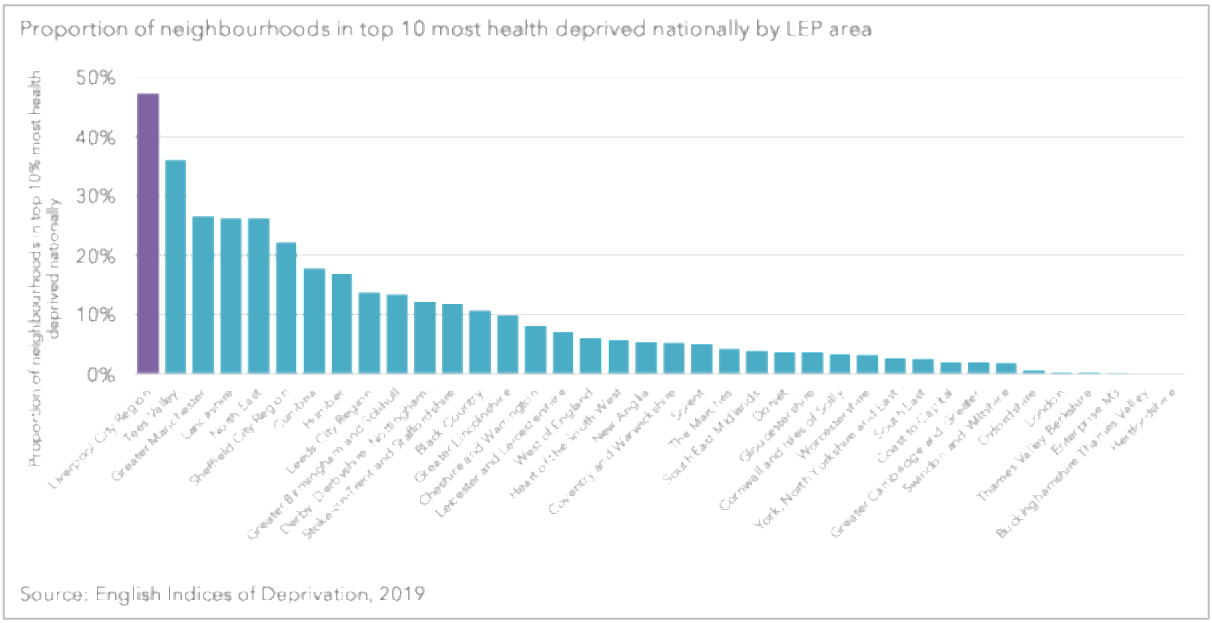
- 71% of graduates leaving LCR entered high-skilled occupations, whilst less than half of graduates remaining in the LCR entered high skilled occupations.
- Evidence shows that many students are staying in the city – and settling for non-graduate level jobs with the number working in non-graduate roles almost doubling between 2021 and 2022.
- Projections prepared for the City Region suggest that there is likely to be a shift towards an increase in roles demanding tertiary and higher-level qualifications (Level 4+). These projections place further emphasis on the

importance for LCR to support the progression of its population through tertiary and higher-level education, but they also point to a broader focus on the development of skills and qualifications across the economy.

Health inequalities

The City Region has the worst health deprivation of any English LEP area with the highest proportion of neighbourhoods (47%) in the top 10% nationally. These high concentrations of health deprivation, coupled with poor health outcomes and high levels of work limiting illness and disabilities adversely impact economic activity in many communities.

Figure 16: High levels of long-term poor health and wellbeing contributes to labour market challenges in LCR.



LCR residents are more likely to fall into poor health and spend a greater share of their life in poor health. The City Region's healthy life expectancy (HLE) is on average 3.5 years for females and 4.4 years lower for males than the national average, rising to six years in Liverpool. There are significant variations between and indeed within districts. Wirral has the single biggest variation in HLE of any local authority area in the country, with its healthiest area having an average female HLE 25 years above that of the lowest.

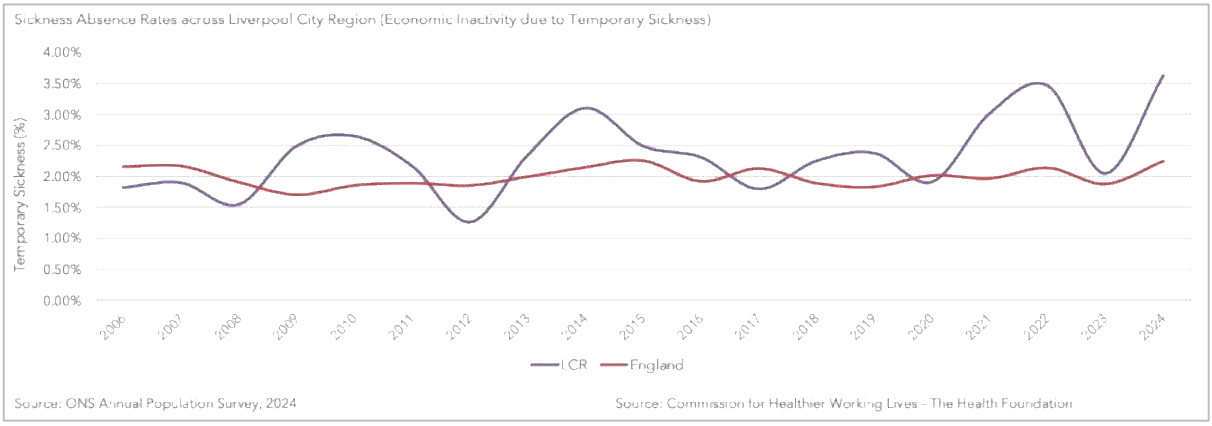
Life expectancy is reducing with the COVID-19 pandemic exacerbating existing health inequalities, whilst this backwards trend mirrors challenges in other UK deprived urban areas, the City Region remains amongst the geographies most affected.

The City Region has high levels of economic inactivity due to ill health, with 74,000 residents reporting that a long-term health condition prevents their ability to work. LCR's disabled residents experience very high levels of economic inactivity, with 75% of disabled residents aged over 16 economically inactive.

There is a prevalence of long-term mental health problems (16+) at 13% compared to the national average of 9.9%.

Sickness absence rates are higher than average, and currently at their highest ever level. In December 2024, over 9,000 residents were absent from work due to temporary sickness which has doubled since 2008. Mental and behaviour disorders make up 20% and musculoskeletal conditions account for 8% nearly of all recorded fit notes.

Figure 14: Short-term sickness rates in the City Region are above national rates, but this could be an area for targeted intervention to avoid economic inactivity due to long-term sickness.



Additionally, the area suffers from lower-than-average rates of physically active adults 63.5% to national average of 67.4%, and those with a healthy diet make up only 25.4% of our population compared to 31.3% nationally.

Figure 15: Liverpool City Region is also behind the national averages on a wide range of health-related indicators.

Health Related Indicators - Liverpool City Region and National rates

Indicator	LCR	England	LCR Rating
Under 75 mortality from all causes (per 100k residents)	435.0	336.5	**Worse than national average**
Under 75 mortality from preventable causes (per 100k resident)	195.2	104.5	**Worse than national average**
% of physically active adults	24.5%	22.0%	**Worse than national average**
% of adults classed as overweight or obese	67.6%	64.5%	**Worse than national average**
Smoking prevalence in adults (aged 18+)	11.6%	11.6%	**Same as national average**
Hospital admissions for alcohol related conditions (per 100k residents)	566 per 100,000	504 per 100,000	**Worse than national average**
Infant mortality rate (per 1,000 live births)	4.2	3.9	**Worse than national average**
% of Year 6 pupils classed as overweight or obese	38.7%	35.8%	**Worse than national average**
Prevalence of long-term mental health problems (aged 16+)	13.0%	9.9%	**Worse than national average**

Health inequalities are stark, persistent and set to worsen without joined up action. Addressing wider determinants including poverty, unemployment, housing and early childhood disadvantage alongside investment in prevention and health equity is central to improving outcomes for all communities.

Good work is good for health, providing a sense of purpose, financial security and social connection. Yet poor health is increasingly a major barrier to people finding work. The government's 10 Year Health Plan for England recognises that employment is one of the most important determinants of physical and mental health.

Poor health outcomes and low productivity are strongly correlated. Addressing health inequalities through innovation in public services will be critical to our wider growth ambitions, with a long-term approach ensuring that more people are active within the labour market and more talent being enabled.

Demographics and population change

The Liverpool City Region has a total population of around 1.6 million, with a working age population of nearly 1 million. The city region has seen modest population growth

over recent years, but forecasts indicate that growth is expected to slow, with possible contraction post 2033 with an aging population leading to a rising dependency ratio and shrinking working age population placing constraints on labour supply.

Workforce Challenges: Declining working-age numbers could limit economic growth unless offset by improved participation and inclusion from underrepresented groups (older workers, disabled people, ethnic minorities, young people not in education, employment, or training).

Ethnic Breakdown: 84% of residents identify as white, 5.7% as Asian / Asian British, 3.5% as Black/Black British, and 3.5% as Mixed or multiple ethnic groups. The area is becoming more diverse, though still less ethnically mixed than the national average.

Recent Migration: Shifts in migration patterns have contributed to local population growth and greater diversity, with new communities settling in the Liverpool City Region.

Language Barriers: Demand for language support has surged in LCR, reflecting increased linguistic diversity. The number of residents whose main language is not English doubled from 2011 to 2021, when nearly 17,600 LCR reported limited or no English proficiency. Language barriers can inhibit job applications, workplace integration and career progression.

Disparities: Economic outcomes - including employment and economic inactivity - vary by ethnicity, with ethnic minority communities facing persistent barriers and higher rates of inactivity.

Disability: Almost 29% of residents are disabled, over 10% higher than the national average – impacting upon labour market participation and driving specific workforce support needs.

Caring responsibilities

Caring responsibilities are a major factor driving economic inactivity in LCR with thousands of residents providing unpaid care for children, relatives and other dependents. The complex interplay between carers' availability for work, health challenges and the sufficiency and affordability of support services means caring is both a personal and economic concern for the city region.

Census and local survey data consistently evidence that caring responsibilities disproportionately affect women, older residents and those from disadvantaged communities.

The lack of reliable, affordable child and eldercare services means carers are often not available to the labour market or are under employed due to a lack of flexible working arrangements.

Digital exclusion

Is a persistent barrier for many. Lack of access to devices, affordable broadband and digital literacy skills mean many residents particularly in low-income households or deprived neighbourhoods are unable to benefit from online job searches, remote work opportunities, digital services or upskilling programmes.

Demand side drivers

The demand side of the labour market in LCR is driven by the needs, behaviour and investment decisions of employers. Understanding these factors is essential for tailoring policies that support job creation, workforce inclusion and “good” economic growth.

Sectoral and economic growth patterns

The LCR Growth Plan 2025-2035 focuses upon growing the most productive areas of the economy fastest, whilst ensuring this supports growth and stimulates demand elsewhere. Priority growth sectors include.

- Health and life sciences.
- Advanced manufacturing.
- Creative Industries.
- Digital and technologies.

Other key supporting and emerging sectors.

- Clean energy industries.
- Maritime.
- Visitor economy.

The foundational economy – encompassing a range of essential sectors such as construction, logistics, retail and social care play a critical role in the LCR social and economic fabric, directly employing a large proportion of residents and underpinning the resilience of individuals and communities. Its stability and growth are central to the inclusive ambitions of this GLCRWP, which seeks to tackle economic inactivity and promote good work through strengthening everyday services. By encouraging investment and improvement in the foundational economy, the region is better able to advance its wider goals of equitable growth, labour market participation and community well-being.

The pace of business growth and market confidence directly affects employers’ willingness to recruit, train and retain staff.

Sectoral challenges are described in documents such as Cluster Action Plans, alongside the development of Sector Skills Plans – which will set a template for collaboration between employers, HEI / FE and the public sector for making good growth happen.

Job quality and employment practices

Job quality and employment practices are central to raising living standards and creating sustainable, inclusive growth in Liverpool City Region (LCR). Workers in the city region face challenges around pay, job security, contract types and access to progression opportunities.

The average weekly wage for LCR workers is £571, which is £59 or 9% less than the English average, nearly one in five workers (18.8%) are in severely insecure work. Insecure work and low pay are more concentrated in sectors such as retail, hospitality, care and parts of the service industry.

Low wages, second jobs, temporary contracts and zero hours are more common than in other combined authority areas, particularly among women, disabled, younger, and ethnic minority workers.

Employers' recruitment and retention strategies are shaped by the quality of jobs offered, locally we see persistent job vacancies in care, hospitality and key technical roles reflecting concerns over pay, shift patterns and job security.

Technological change and innovation

Growing demand for digital skills and new technologies, such as artificial intelligence and automation is creating new roles while transforming or eliminating others.

The transition to a net zero economy is driving demand for green skills, particularly in construction, energy and transport.

Spatial distribution and transport

The spatial distribution of residents, employers and infrastructure across the city region shapes economic opportunity and labour market participation. Transport connectivity is a key determinant of access to jobs, education and essential services, influencing the inclusivity and productivity of the region's workforce.

Major employment hubs, such as the Port of Liverpool, health and science campuses, retail centres and logistics corridors, attract workers from across LCR and beyond. However, travel to work times can be long or complex for people living in outlying area, especially where transport links are limited or poorly integrated.

Barriers persist including high travel costs, inadequate bus frequencies in some districts, congested routes and gaps in services for shift workers and those with disabilities.

Deprived neighbourhoods in North Liverpool, East Wirral and South Sefton experience spatial "lock out" from high-quality jobs and major growth sites, even where physical distance is not that great. Poor connectivity compounds other disadvantages (skills, childcare, health) limiting social mobility.

Skills gaps and employer expectations

Skills gaps remain a persistent challenge, with many employers reporting difficulties filling roles requiring higher level technical or digital capabilities, alongside reporting gaps in basic skills and work readiness.

Businesses often seek candidates with both qualifications and relevant experience, but pathways for in-work progression or training are sometimes lacking or limited.

Risk aversion in recruitment and slow adoption of inclusive employment practices can prevent employers from tapping into the full range of local talent, including those returning from economic inactivity.

The independent Keep Britain Working review, led by Sir Charlie Mayfield, is due to report in Autumn 2025, aimed at reducing economic inactivity by strengthening the role of employers and the public sector in supporting people with ill health and disabilities to access and sustain employment.

The review is expected to identify the key barriers and practical employer led interventions including improvements in workplace health, recruitment practices and retention strategies with particular emphasis on those furthest from the labour market.

The findings and recommendations of this review will be of importance moving forward in shaping further local actions to drive inclusive employment by ensuring employers are equipped, supported and incentivised to unlock opportunities for disadvantaged groups, while linking public health and employment support for lasting inclusion and helping to maximise social value.

Chapter 5: Current system and offer.

The City Region has a comprehensive, multi-agency employment support offer aimed at helping residents overcome barriers, build skills, and secure or sustain employment. The system is collaborative, involving longstanding locally focused local authority programmes, national partners, community and voluntary sector support, specialist organisations, and employer engagement initiatives.

Support is delivered through a mixture of devolved Adult Skills Funds, UK Shared Prosperity Fund, Department for Work & Pensions (DWP), and local / community sources.

LCR Combined Authority

The LCRCA is made up of the six constituent authorities, who together use the devolved powers and funding we receive to create an environment that allows the local economy to thrive for the good of everyone who lives and works in the Liverpool City Region. The Strategic Authority works with partners to advance economic growth through convening and connecting stakeholders, enabling partners to deliver and thrive, investing to help business growth and job creation and advocating for the City Region. We also directly deliver and commission projects and programmes.

The Strategic Authority has devolved responsibility for the **Adult Skills Fund** and **Skills Boot Camp** funding, procuring provision from a wide range of partners including further education colleges, local authorities, independent training providers and voluntary sector organisations supporting over 30,000 adult learners per year, with a particular focus on those form disadvantaged backgrounds.

Households into Work (HiW) aims to tackle long-term and entrenched worklessness by supporting entire households in which more than one adult is unemployed and receiving benefits rather than focussing on individuals. Focussed on households with complex, multiple barriers to employment such as mental health, debt, addiction, domestic abuse, housing issues and low self-confidence. Each eligible household is assigned a dedicated Employment Advocate for up to 12 months, providing one-one tailored support including specialist referrals.

Youth Guarantee / Mayoral Young Person's Guarantee aims to support young people into jobs and training opportunities through an enhanced service offer that will be delivered by partners across the City Region. Youth Guarantee funding has been passed from Government to LCRCA for the 2025/26 and 2026/27 financial years, utilising the programmes to test and learn to develop and inform national policy.

Be More is the City Region's comprehensive skills and careers electronic portal, bringing information on jobs, apprenticeships, training opportunities and careers support for all residents and businesses across the six local authority areas. Be More is continuously updated to reflect new funding streams, sectoral needs and labour market trends and is a unique asset.

The LCRCA's **Employer Skills Brokerage Service** is a free and impartial service that connects local businesses with training providers and funding opportunities to upskill employees and recruit apprenticeships. The service aims to match employer needs to talent, including support for diversity and inclusion, recognising the disconnect between the skills that employers require from their employees and the skills that jobseekers possess.

Fair Employment Charter: Promotes and celebrates, fair, just, inclusive, and healthy employment practices across all sectors. It is core funded by the CA as part of its economic development and social value agenda and is a key Mayoral manifesto commitment to ensure

- It aims to drive up employment standards by recognising organisations that provide fair pay (including the Real Living Wage), safe working conditions, employee engagement and opportunities for development.
- The Charter is a key tool for the vision of an equitable regional labour market, helping to stamp out poverty pay, exploitative contracts and poor workplace practices. It has four key themes.
    - Fair pay and secure work.
    - Inclusive and just.
    - Healthy workplaces.
    - Social value.

- Over 140+ employers have achieved Aspiring status covering over 100,000+ employees.

LCR Careers Hub: supports secondary schools, special schools and colleges to ensure every young person receives outstanding, relevant careers education aligned to the world of work.

- It facilitates collaboration between schools, colleges, with a focus on fulfilling the eight Gatsby Benchmarks for good careers guidance and enabling real-world exposure through enterprise adviser networks and employer engagement.
- Connecting schools and students with a diverse network of employers and enterprise advisers for meaningful work experience, curriculum-linked learning and careers inspiration.
- Funding comes from the Careers and Enterprise Company (CEC), with additional funding and resourcing through the Growth Platform (the LCR growth company) which provides strategic alignment with skills and economic growth priorities.

LCR Local Authorities

Local Authorities in the LCR play a strategic, multi-faceted role in driving economic development, regeneration, employment and employer support, with particular focus upon supporting disadvantaged cohorts leveraging powers over business growth, inward investment and infrastructure planning.

Through a wide range of activities and initiatives local authorities support residents in gaining skills, qualifications and sustainable employment especially for those facing barriers to accessing work, including NEET young people and those leaving care. They partner closely with local employers, skills and education providers and stakeholders to better align workforce supply and demand to boost local economic participation.

Local authorities leverage their strong working relationships with both local employers and contractors, utilising opportunities to maximise social value, encourage good employment and leverage opportunities for LCR residents including employment, supported internships and apprenticeships.

Local Authorities deliver the **Ways to Work** programme. Currently funded through UKSPF and supplemented in some areas (such as Knowsley) though additional local authority funding. The programme is longstanding and well established, having been previously funded through the European Social Fund (ESF).

The programme is a flagship employment and skills initiative aimed at supporting residents, particularly those facing barriers to employment into work, training or further education. The programme is a core element of the City Regions approach to reducing worklessness, supporting personal development and individuals in accessing new job and skills opportunities. Notable features include:

- **Integrated Services:** The programme takes a holistic approach, offering practical employment support alongside services addressing personal and social challenges that affect job readiness.
- **Partnerships:** Collaboration between local authorities, Jobcentre Plus, third sector partners and employers to match jobseekers with vacancies and appropriate training.
- **Employer Engagement:** The programme supports local businesses with recruitment services by matching and screening candidates, providing a bridge between employers and local job candidates.

Whilst maintaining a defined core model, the programme is delivered flexibly, with variations between local authorities to meet resident and employer needs.

The discontinuation of UKSPF funding from end of March 2026 creates uncertainty around the future of the employment support landscape. Alternative programmes such as the nationally designed Connect to Work will commence and be delivered locally by Local Authorities. The traditional short-term funding of such programmes has created instability and affected longer term planning for commissioners and delivery partners. A commission to look at the future of employment support in the City Region will provide potential long-term solutions to this issue.

DWP / Jobcentre Plus

Jobcentre Plus (JCP) delivers a wide range of employment support programmes across LCR with a strong regional presence through 15 permanent offices and youth hubs, providing standard and enhanced employment support to help jobseekers and economically inactive residents move into work, training or education.

JCP services include personalised job search support from Work Coaches, access to training, pre-employment and sector-based training, job matching and coordination with local employers.

A range of DWP funded programmes support LCR residents:

- **Flexible Support Fund**: Funds locally procured provision and pays for upfront childcare.
- **Work and Health Programme, Restart, Youth Hubs:** Nationally commissioned specialist support for people with health conditions, long term unemployment and young job seekers. Delivered locally through JCP and partners, with job coaching and wraparound support integrated into LCR's wider skills system.
- **Connect to Work**: A major new programme supporting people in hidden unemployment, especially the long-term sick, disabled or disadvantaged into work introduced as part of the national Get Britain Working plan.
- **JCP employer engagement:** – Employment Advisors support employers and residents to find and retain work.

- **SWAPs:** Sector Work Academy Programme. Skills / employment support / guaranteed interviews.
- Specialist roles.
    - Disability Employment Advisors.
    - Prison based Work Coaches.
    - Family based Work Coaches.
    - Youth Hub offer.
    - Schools Advisors.

Additionally, the City Region has two proofs of concept "**Jobs Plus**" pilots. These are postcode based (focussed upon Toxteth and Bidston Rise) and led by local Housing Associations alongside a range of partners. The pilot model offers:

- Onsite employment services and community led employment support, including community champions and neighbour to neighbour support.
- Financial incentives, including In Work Credit, Back to Work Bonus and credit against rent arrears.

Voluntary and community sector

The social economy is vital to addressing inequity by supporting vulnerable communities, encouraging innovation, and promoting inclusive growth. LCR's social economy is diverse and serves those communities that need it most. By supporting the social economy and engaging underrepresented groups, LCR can unlock untapped potential, improve labour market outcomes, and drive inclusive productivity growth.

The VCFSE sector is a vibrant and essential partner in delivering a wide range of services, including employment support, targeting those most at risk of social and labour market exclusion. The sector partners with both CA and LAs on programmes funded through UKSPF and other place-based initiatives acting as both a deliver and bridge to reaching and supporting often vulnerable groups.

The Progress Partnership is a UKSPF programme which started in March 2024 and is now in its second and final year, delivered by the voluntary and community sector and managed by the Voluntary Organisations Learning Alliance Consortium (VOLA) providing intensive employment support to those who are economically inactive.

- **VOLA Consortium** has a membership of 68 local VCFSE organisations, 14 of which formed The Progress Partnership, with several delivery partners selected for their specialisms.
- Engages participants through a grass roots, community development approach and to sustain engagement through a welcoming programme of Key Worker support facilitating onward progression.
- Proactive referral to other activities and services to support personal and social development.

- The programme is delivered at a hyper local level with community-based delivery through its 14 participating organisations distributed throughout the city region.

Additionally, there are a number of other employment support programme delivered by the sector including:

- **LCR Talent Match**, delivered by the Merseyside Youth Association (MYA) providing intensive mentoring and transition workshops for young people who have been out of work, training or education for an extended period.
- **Employment Plus,** specialist employment support for adults facing multiple barriers to work, including training, job search assistance and personal guidance led by The Salvation Army.
- **The Women's Organisation**, leads a programme of employment support for women, focusing on confidence building, skills development and tailored support for women to enter work or further training.

Health Related Provision

The ICB operates across the footprint of Cheshire and Merseyside (including LCRCA constituent Local Authorities), working closely with local stakeholders to integrate health and employment support and encourage stable, and sustainable outcomes.

Each of the nine places within the ICB footprint is required to have a Health and Wellbeing Board. The job of each board is to improve the health and wellbeing of the local population, as a partnership committee, producing a joint assessment of health needs and a joint health and wellbeing strategy. An ICB review of each of the nine Places' Health and Wellbeing strategies indicates alignment in prioritising employment as a key social determinant of health and wellbeing across the region

Programmes across the Liverpool City Region include:

- **Employment Advisors in NHS Talking Therapies** working alongside therapists to address the emotional challenges related to work through integrated psychological treatment and employment support.
- **Child and Adolescent Mental Health provision,** delivered through the NHS supporting young people that are NEET to ensure opportunities into education and training and or paid employment.
- **Individual Placement Support in drug and alcohol services** supporting people who want to move into paid employment. The program provides advice about health and wellbeing, regular sessions with a personal keyworker, support groups, and guidance on next steps, including education, training and employment support.
- **Supporting young people with their mental health needs** through two ICB funded pilots ensuring that they can maintain their engagement with education and training.

Additionally, the ICB has worked with Local Authorities on development of its Work and Health Strategy, aligning primary care, housing, and employment support to address long-term sickness and the main drivers of inactivity including musculoskeletal conditions and mental health conditions.

Neighbourhood Health Implementation

From September 2025, the government is rolling out the Neighbourhood Health Service in 43 places across England, targeting communities with the lowest life expectancy and highest deprivation. Within the Liverpool City Region, St Helens and Sefton have been selected as two of the pioneering places where people will benefit from improved end-to-end care and tailored support closer to home, looking beyond conditions to the wider causes of health issues.

There is opportunity to test this in St Helens and Sefton, as they pioneer this joined-up neighbourhood approach, ahead of scaling out more widely across the Liverpool City Region.

Chapter 6: Systemic issues and challenges.

Feedback – from stakeholders.

As part of the production of this plan, semi structured interviews were undertaken with a wide range of stakeholders, and despite concerted effort and good practice, a number of issues and challenges were articulated including:

- Agreement that the employment support landscape is complex, with multiple sometimes competing programmes.
- Frustrations exist over short term funding mechanisms from multiple sources, (employment support has tended to be delivered through “initiative funding” such as ESF or UKSPF). This creates a fragmented service landscape with gaps caused by rigid eligibility criteria. A push for more integrated, flexible funding that enables a universal service model and a “no wrong door” approach.
- Short term funding mechanisms can lead to exclusion, and lack of integration with the VCFSE whose support is crucial in this agenda.
- The key barriers to entering the workplace are complex, individual and often spatial. They cut across a range of public services and broader social issues and often challenges need to be addressed / minimised before individuals are ready to even work.
- Social barriers make the move into work challenging for employment support organisations, and present risks to the individual and potential employers, highlighting a need to consider incentives (for employers to engage with cohorts who require additional support) alongside encouraging and supporting employers to add social value.
- There are gaps in tailored support for people with experience of the criminal justice system and care leavers, who face unique challenges.

- Educational transitions are increasingly interrupted, made more challenging due to reductions in school attendance, increasing school refusal and increasing levels of elective home schooling this is impacting upon NEET volumes and longer term will potentially impact upon worklessness and increased support needs.
- There is a lack of accessible post 16 technical provision, and benefits traps impact upon individual and parental choices.
- Opportunities exist to better integrate employment support services, with health services ensuring follow up mechanisms between services to ensure individuals do not fall out of the system.
- There is a lack of strategic cohesion between employment and skills programmes overlapping and, in some cases, excluding cohorts through strict eligibility criteria.

Chapter 7: Our collective ambition.

This plan provides partners within LCR with an opportunity to work collectively to address systemic challenges holding back the potential of LCR residents. The following actions will support our collective ambition.

1. **Ensuring employer and community engagement.** Employers are integral to this partnership / whole system approach as are the views of those with lived experience and from disadvantaged groups. The VCFSE sector is a key enabler utilising its unique ability to engage with underserved communities.
2. **Enhanced data sharing.** Subject to legal and Data Sharing Agreements we will utilise the LCR Office for Public Service Innovation (OPSI) to develop enhanced data sharing protocols and analysis mechanisms bringing information together from partners including DWP, NHS and local authorities to target interventions to address spatial and cohort inequalities alongside providing intelligence for future iterations of this plan.
3. **Increased oversight of 16-19 skills provision.** This plan will act as a catalyst for the development of stronger partnerships with DfE with the aim of developing routes to greater local influence over post-16 education and skills provision. We will utilise the Right to Request process to pursue greater oversight of 16-19 skills provision (initially technical education) with a view to additional skills funding devolution opportunities over time whilst ensuring that opportunities such as Foundation Apprenticeships are maximised in the City Region.
4. **Utilise our distinctive health and life sciences assets.** Leverage our local leading health and life sciences capabilities to support better health and wellbeing outcomes for our residents. Utilising our strengths in personalised therapeutics, infection control and highly distinctive data science capabilities.

Considering the policy context, evidence base and stakeholder feedback there are four key emerging strands identified as areas for focus.

Chapter 8: Priority Actions.

We will continue to improve the integration of skills, health and employment through an enhanced “whole system” approach to enable talent and ensure a co-ordinated approach that better addresses the city regions critical challenges.

Figure 15: GLCRWP Four Key Strands

System change

1. **Collaboration Agreement.** We will develop a Collaboration Agreement between LCRCA including our constituent authorities, DWP, the NHS to work collectively together to address the multi-dimensional issues leading to worklessness and economic inactivity through leadership, data sharing and systems change.
2. **Review of employment Support.** We will commission a comprehensive review of the current employment support eco-system informing the design and implementation of a transformational blueprint for the long-term approach to employment support throughout LCR post March 2027.
3. **Geographic alignment.** In line with Mayoral Manifesto ambitions, LCRCA will develop a proposal to Government to explore greater geographic alignment across public services and explore ‘total place funding’, to pool local public budgets to ensure better service delivery around the needs of communities.
4. **Careers and employment support functions.** We are committed to working closely and in partnership with DWP nationally to inform the shape, design and function of the anticipated Jobs and Careers Service in the short term, with a view to exploring the future devolution of careers and employment support functions within the integrated settlement.
5. **Test multi-disciplinary support hub models.** Through the OPSI framework we will adopt a test, learn and grow approach to test a range of community focussed multi-disciplinary hubs building upon and amplifying existing good practice / models targeted at supporting residents at a local level improving

access to a range of services to address the multi-dimensional challenges of worklessness and economic inactivity.

Work

1. **Workplace health and wellbeing.** We will improve awareness of the importance of employer policy and practice upon employee health and wellbeing and explore early interventions to prevent people falling out of work due to ill health.
2. **Use employer facing assets to drive outcomes and social value.** To provide a seamless service to support employers, we will utilise the range of local employer focussed assets such as employment charters and other resources e.g. DWP employment advisors in FE/HE and health settings to provide a seamless service to support employers and emphasise good and inclusive employment practices.
3. **Provide the right information.** We will utilise local careers and guidance assets including Be More to emphasise the benefits of learning, work experience and job opportunities.
4. **Specialist support specific barriers to work.** We will engage with government to secure resource to test flexible employment support targeting groups that face significant structural barriers to employment.
5. **Employer incentives.** We will explore the use of incentives to encourage employers to hire, train and retain individuals facing barriers to employment, learning from both previous initiatives and the new Youth Guarantee to de-risk inclusive recruitment increasing opportunities for local people.
6. **Economic growth.** We will continue to create the right economic conditions to increase job density across the LCR by aligning employment and skills initiatives with sector priorities and the foundational economy as outlined in the Local Growth Plan.

Skills

1. **LSIP 2.0.** We will refresh LSIP to strengthen and improve skills alignment, addressing skills shortages and making the skills system more responsive to employer demand and meeting the needs of local residents.
2. **Deepen talent pool.** As stated in the local growth plan, we will mainstream the LCR Access to Opportunities Framework as a systemic way to deepen the talent pool in key sectors.
3. **Targeted flexible local skills programme.** We will utilise local skills funding to develop tailored and flexible support programmes targeted at those with significant barriers to work. We will take learning from the Youth Guarantee Trailblazer to inform this provision.
4. **The LCR pathway.** In the longer term, we are ambitious about having the highest quality technical education that meets demand. A bespoke 'LCR Pathway' programme will focus on providing this for 16-19-year-olds, matched to the skills needs of employers and businesses and ensuring young people, no matter their circumstances, can realise their potential.

5. **Targeted levy funding.** We will continue to influence Government thinking relating to the new Growth and Skills Levy, to provide employers with great flexibility to invest in workforce development exploring opportunities to target priority cohorts, alongside support for priority sectors.

Health

1. **Working together.** We will deepen collaboration with ICB, DWP, Local Authorities and health system partners to develop a fully integrated health, employment and skills system and address the complex and intersecting challenges that stop people from finding and staying in work.
2. **Health in all policies.** We will improve population health and tackle health inequalities by formalising LCRCA's role through the adoption of the statutory health duty and advancing and embedding Health in All Policies to scale up action across the wider determinants of health.
3. **Health and growth accelerators.** We will work with central government to explore the rollout of Health and Growth Accelerators, following evaluation of this novel trailblazer approach where local NHS systems are supported to increase the impact they have on people's work status.
4. **Prevention demonstrators.** We will explore options to expand 'prevention demonstrators', as outlined in the NHS 10 Year Health Plan for England, to test innovative approaches.
5. **Mental health.** We will work with health system partners to support the development of new and innovative treatments to improve mental health and wellbeing.

The high-level priority actions – across the pillars of system change, skills, work and health – reflect the core areas where coordinated effort will unlock sustainable employment opportunities for LCR residents. We will continue to support and refine actions throughout the implementation of this plan, maintaining an iterative approach and ensure that emerging needs and stakeholder feedback shape all stages of our work.

Throughout implementation, we will place particular emphasis on cohorts facing complex and multifaceted barriers - such as care leavers, people with disabilities, ex-offenders, people with long-term health conditions, residents with caring responsibilities, and long-term unemployed residents. Working as part of a whole-system approach across the Liverpool City Region, our aim is to ensure everyone who wants to work can access clear progression pathways backed by bespoke solutions that respond directly to individual barriers. In doing so, we are committed to an inclusive labour market where no one is left behind.

Chapter 9: Governance, local engagement, and future iterations.

This plan has been developed through a Partnership Board which it is proposed continues meeting regularly to collaboratively drive delivery of the plan and further develop "whole system" partnership working. In taking forward high-level priorities and

longer-term ambitions, LCR Equality Panels – comprising residents with lived experience across disability, gender, race, sexuality and their intersections – will be engaged to ensure interventions are both informed by their experience and grounded in the principles of diversity and inclusion, supporting our ambition of a fairer City Region where no one is left behind.

Political oversight of the plan will be undertaken through the existing Education, Employment and Skills Cabinet Board. In addition, LCRCA will draw on existing governance and assurance processes including the Overview and Scrutiny Committee.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 September 2025

Proposed draft Board Assurance Framework Strategic Risks for the 2025-2028 period

Agenda Item No: ICB/09/25/19

Responsible Director: Clare Watson
Assistant Chief Executive

Proposed draft Board Assurance Framework Strategic Risks for the 2025-2028 period

1. Purpose of the Report

1.1 The purpose of the report is to present the proposed draft 2025-28 Board Assurance Framework (BAF) and strategic risks within for Board approval.

2. Executive Summary

2.1 As a publicly accountable organisation, the ICB is required to evidence that its decision-making structure is aligned with a robust system of internal control and based on principles of good governance. This is underpinned by an effective risk management system which is designed to ensure the proactive identification, assessment and mitigation of risks against the ICB's strategic objectives, priorities and core purposes.

2.2 This process is central to providing the Board with assurances that all required activities are focussed on the continued delivery of strategies and plans whilst maintaining compliance with legislation and regulatory requirements.

2.3 At the May 2025 Board meeting, it was agreed that the principal risks included in the 2024/25 Board Assurance Framework should be reviewed in light of new strategic challenges and, more specifically against a landscape of considerable change in terms of the future 'model ICB blueprint' and the publication of the government's 'Ten Year Health Plan for England'.

2.4 Work commenced in July 2025 to re-assess the 2024/25 principal risks against the newly published Ten Year Health Plan for England, the proposed transition of ICBs to 'strategic commissioners' and the shift from hospital-based care to community and the establishment of a neighbourhood health service.

2.5 Following individual review meetings with risk leads / Executive Officers throughout August 2025 and discussion at the Executive Committee meeting on 18 August 2025, it was agreed that a new set of strategic risks should be drawn up, taking into consideration the revised priorities within the Ten Year Health Plan for England, the Cheshire and Merseyside Health Care Partnership Plan 'All Together Fairer' and the four core purposes of ICBs.

2.6 The proposed strategic risks within the Board Assurance Framework in Appendix One therefore reflects these discussions and encompasses the strategic priorities contained within Ten Year Health Plan and the C&M Health and Care Partnership Plan 'All Together Fairer' whilst maintaining focus on wider NHS reform and the transition of ICBs to 'strategic commissioners' by 2027. The proposed principal risks within the 'new' BAF are aligned against each of the four core purposes of an ICB, specifically:

- Improve outcomes in population health
- Tackle health inequalities in outcomes, experiences and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development.

2.7 Additionally, due to the changes to the ICB as a result of the requirements of the Model ICB blueprint and due to the future changes to the ICBs key decision making committees and senior leadership team, work still needs to continue to work up further the strategic risks so that the Board receives proposed risk scores (current/target) as well as the plans behind to mitigate, and confirmation of lead Executive and ICB Committee owner. Furthermore, there is a planned workshop with Board members to be undertaken regarding risk appetite, the output of which will influence the final BAF. This is planned to be completed before the November 2025 Board.

2.8 It is also being proposed that the refreshed Board Assurance Framework runs for a three-year period (as opposed to the 12-month time frame usually adopted by NHS organisations). The rationale for this key change is to ensure a degree of consistency and 'future proofing' by aligning principal strategic risks against the four ICB 'core purposes; particularly given the scale of impending NHS reforms and the financial and economic challenges the ICB faces in the short to medium term.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- **APPROVE** the proposed draft strategic risks within the draft Board Assurance Framework
- **APPROVE** the proposal for the Board Assurance Framework and strategic risks within to run for a three-year period
- **NOTE** the next steps which are critical to submitting a fully worked up Board Assurance Framework for consideration and approval at the November 2025 Board meeting.

4. Reasons for Recommendations

4.1 The Board has a duty to assure itself that the organisation has properly identified the risks it faces and that it has processes in place to mitigate those risks and the impact they have on the organisation and its stakeholders. The Board discharges this duty as follows:

- identifying risks which may prevent the achievement of its strategic objectives
- determining the organisation's level of risk appetite in relation to the strategic objectives
- proactive monitoring of identified risks via the BAF and Corporate Risk Register

- ensuring that there is a structure in place for the effective management of risk throughout the organisation, and its committees (including at place)
- receiving regular updates and reports from its committees identifying significant risks, and providing assurance on controls and progress on mitigating actions
- demonstrating effective leadership, active involvement and support for risk management.

5. Background

5.1 As part of the annual planning process the Board undertakes a robust assessment of the organisation's emerging and principal risks. This aims to identify the significant external and internal threats to the achievement of the ICB's strategic goals and continued functioning. Risk owners and the Executive Committee have reviewed and refreshed the BAF for 2025-28 in light of revised priorities and plans.

5.2 The ICB must take risks to achieve its aims and deliver beneficial outcomes to patients, the public and other stakeholders. Risks will be taken in a considered and controlled manner, and the Board has determined the level of exposure to risks which is acceptable in general, and this is set out in the ICBs core risk appetite statement.

5.3 The Risk Management Strategy incorporates the board assurance arrangements and sets out how the effective management of risk will be evidenced and scrutinised to provide assurance to the Board. The Board Assurance Framework (BAF) is a key component of this. The Board is supported through the work of the ICB Committees in reviewing risks, including these BAF risks, and providing assurance on key controls. The outcome of their review is reported through the reports of the committee chairs and minutes elsewhere on the agenda.

5.4 In addition to the revised / new strategic risk descriptions, further work is required to develop a 'risk appetite statement' for Cheshire & Merseyside ICB. The eventual agreement of a risk appetite statement will be vital for the Board and its committees / decision-making groups to use when considering and making decisions and recommendations (particularly those in response to dramatically changing circumstances and an uncertain landscape). It is expected that this work will be concluded by the November 2025 Board meeting when both the Board Assurance Framework and risk appetite statement can be formally approved.

6. Next Steps

6.1 The establishment of effective risk management systems is vital to the successful management of the ICB and local NHS system and is recognised as being fundamental in ensuring good governance. As such, the BAF underpins all themes, but contributes particularly to leadership, good governance, effective

management and financial sustainability. Should the Board approve the refreshed draft principal strategic risks, the following will form the next steps:

- agreement of a risk appetite statement to be included in all Board, committee and routine risk reporting to ensure the connection between risks and decision-making is clear and consistently applied.
- agree scoring for all principal risks in line with the ICB's Risk Management Strategy / consequence matrix.
- drafting of full summary documents for each strategic risk which describe the controls, assurances and further actions required to mitigate the risk.
- agree the frequency of reporting to the Board and with it an update schedule for risk leads / lead officers to refresh risk summaries (with support from officers from the Corporate Governance Team).

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

1. **Tackling Health Inequalities in access, outcomes and experience**
2. **Improving Population Health and Healthcare**
3. **Enhancing Productivity and Value for Money**
4. **Help the NHS support broader social and economic development**

7.1 The proposed BAF supports the objectives and priorities of the ICB through the identification and effective mitigation of those principal risks which, if realised, will have the most significant impact on delivery.

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

8.1 The Annual Delivery Plan sets out linkages between each of the plan's focus areas and one or more of the BAF principal risks. Successful delivery of the relevant actions will support mitigation of these risks.

9. Link to meeting CQC ICS Themes and Quality Statements

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

9.1 The establishment of effective risk management systems is vital to the successful management of the ICB and local NHS system and is recognised as being fundamental in ensuring good governance. As such the BAF underpins all themes, but contributes particularly to leadership, good governance, effective management and financial sustainability.

10. Finance

10.1 There are no financial implications arising directly from the recommendations of the report. However, the proposed BAF does cover a number of financial risks as detailed in Appendix 1.

11. Communication and Engagement

11.1 No patient and public engagement has been undertaken.

12. Equality, Diversity and Inclusion

12.1 Principal risks which have the potential to adversely impact on equality, diversity and inclusion in service delivery, outcomes or employment are detailed in Appendix One

13. Climate Change / Sustainability

13.1 There are no identified impacts in the BAF on the delivery of the Green Plan / Net Zero obligations.

14. Officer contact details for more information

Stephen Hendry
Head of Business Support
NHS Cheshire and Merseyside ICB

15. Appendices

Appendix One: Board Assurance Framework Summary 2025-2028 (Draft)

Draft Cheshire and Merseyside Integrated Care Board - Board Assurance Framework 2025-2028– Summary (v1.3. Sept 2025)

ICB Core Purpose	BAF ID	Strategic risk	Risk appetite	Current score	Target Score	Lead director(s) / board lead	Lead committee / board
Improve outcomes in population health	**P4**	**Quality & Safety failures in commissioned services:** There is a risk that commissioned services will not consistently deliver high-quality, safe, and equitable care, undermining our statutory duty to improve population health and reduce inequalities. This risk is heightened as we shift resources from hospital to community and redesign care pathways to deliver the 10-Year Plan's ambitions for neighbourhood health, digital enablement, and prevention.				Exec Director of Nursing / Medical Director	Quality & Performance Committee
	P11	**Digital and Cyber Resilience Gaps:** Failure to ensure robust digital infrastructure, data sharing, and cyber security across the system could disrupt care, undermine public trust, and impede delivery of the "analogue to digital" shift. This would threaten our ability to deliver on the 10-Year Plan's requirements for a digitally enabled, data-driven, and patient-empowered NHS.				Medical Director	Executive Committee
Tackle inequalities in outcomes, experience and access	**P12**	**Failure to reduce health inequalities and improve population health:** Risk that ICB will not deliver measurable reductions in health inequalities or improvements in population health outcomes, particularly for the most deprived and vulnerable groups, if resources, commissioning, and partnership actions are not sufficiently targeted and aligned with All Together Fairer, Core20PLUS5, and the prevention and equity ambitions of the 10-Year Plan.				Assistant Chief Executive	Executive Committee
Enhance productivity and value for money	**P13**	**Inability to achieve financial sustainability and productivity:** risk that the ICB and system partners will not achieve required financial savings, productivity gains, and operational cost reductions, as mandated by the Model ICB Blueprint and the 10-Year Plan. This could limit our ability to invest in prevention, neighbourhood health, and digital transformation, and may result in failure to meet statutory financial duties.				Executive Director of Finance & Contracts	Finance, Investment and Resources Committee
	P14	**Failure to Recover Access and Performance Standards:** If we do not commission innovative, community-based, and digital solutions to elective care backlogs, urgent and emergency care pressures, and access to primary/mental health/dental care, there is a risk we will not meet national recovery targets. This would undermine public confidence, exacerbate inequalities, and fail to deliver the 10-Year Plan's commitment to timely, accessible care closer to home.				Director of Performance & Planning	Quality & Performance Committee
	P15	**System Fragmentation and Provider Sustainability:** If we do not proactively shape and support a sustainable provider landscape, especially as we commission at-scale, integrated neighbourhood and digital-first services there is a risk of service loss, fragmentation, or failure. This would compromise our ability to deliver the Model ICB Blueprint's vision for joined-up, efficient, and resilient care.				Medical Director	Executive Committee
Help the NHS support broader social and economic development	**P16**	**Failure to Deliver the Shift to Neighbourhood and Community-Based Care:** There is a risk that the ICB will not achieve the required shift from hospital-centric to neighbourhood and community-based models of care, as set out in the 10-Year Plan and Model ICB Blueprint, due to insufficient investment, workforce capability, or provider collaboration. This would undermine prevention, integration, and local access ambitions.				Assistant Chief Executive	Executive Committee
	P17	**Workforce Capacity, Capability, and Morale:** The scale and pace of organisational redesign, including significant headcount reductions and new ways of working, may disrupt strategic commissioning functions, destabilise workforce morale, and impede delivery of transformation priorities. This threatens our ability to build the skills and capabilities needed for the Model ICB and to deliver the 10-Year Plan's workforce and leadership ambitions.				Chief People Officer	Finance, Investment & Resources Committee
	P18	**Failure to Embed Prevention and Address Wider Determinants:** There is a risk that the ICB will not embed prevention and action on wider determinants (housing, employment, environment) into commissioning and system leadership, limiting our impact on long-term health outcomes and economic prosperity.				Assistant Chief Executive	Executive Committee

NHS
Cheshire and Merseyside

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

Held at 40/Twenty Lounge, The Halliwell Jones Stadium, Warrington Conference Centre, Warrington

Thursday 2025
9am-12.20pm

Unconfirmed Minutes

ATTENDANCE	
Name	**Role**
Members	
Raj Jain	Chair, Cheshire & Merseyside ICB (voting member)
Cathy Elliott	Chief Executive, Cheshire & Merseyside ICB (voting member)
Tony Foy	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Mark Bakewell	Executive Director of Finance (Interim), Cheshire & Merseyside ICB (voting member)
Dr Ruth Hussey, CB, OBE, DL	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Christine Douglas, MBE	Executive Director of Nursing and Care, Cheshire & Merseyside ICB (voting member)
Trish Bennett	Partner Member (NHS Trust), Cheshire & Merseyside ICB (voting member)
Prof. Rowan Pritchard-Jones	Medical Director, Cheshire & Merseyside ICB (voting member)
Adam Irvine	Partner Member (Primary Care), Cheshire & Merseyside ICB, (voting member)
Erica Morriss	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Mike Burrows	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Prof Hilary Garratt, CBE	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Ann Marr, OBE	Partner Member (NHS Trust) (voting member)
Delyth Curtis	Partner member (Local Authority) (voting member)
Dr Naomi Rankin	Partner Member (Primary Care) (voting member)
In Attendance	
Clare Watson	Assistant Chief Executive, Cheshire & Merseyside ICB (regular participant)
Anthony Middleton	Director of Performance and Planning, Cheshire & Merseyside ICB (regular participant)
Dr Fiona Lemmens	Deputy Medical Director, Cheshire & Merseyside ICB (regular participant)
John Llewellyn	Chief Digital Information Officer, Cheshire & Merseyside ICB (regular participant)
Prof. Paul Kingston	Chair of ICB Research and Innovation Committee, (regular participant)
Louise Barry	Chief Executive (Cheshire Healthwatch), C&M Healthwatch Representative
Louise Robson	Chair, Health Innovation North West Coast (regular participant)
Prof. Ian Ashworth	Director of Population Health, Cheshire & Merseyside ICB (regular participant)
Rev. Dr Ellen Loudon	Director of Social Justice & Canon Chancellor of Liverpool Cathedral, Vice Chair of C&M HCP, (regular participant)
Mike Gibney	Chief People Officer, Cheshire & Merseyside ICB (regular participant)

Mandy Nagra	Chief System Improvement and Delivery officer, Cheshire & Merseyside ICB (regular participant)
Carl Marsh	Warrington Place Director, Cheshire & Merseyside ICB
Alison Lee	Knowsley Place Director, Cheshire & Merseyside ICB
Simon Banks	Place Director (Wirral) and Strategic Lead for Mental Health, Learning Disabilities and Autism - *Presented item ICB/07/25/15*
Julie Kelly	Associate Director of Population Health NHS Cheshire and Merseyside - *Presented item ICB/07/25/18*
Chris Leese	Associate Director of Primary Care - *Presented item ICB/07/25/19*
Neil Evans	Associate Director of Strategy and Consultation - *Presented item ICB/07/25/20*
Cheryl Meaden	Executive Assistant, Cheshire & Merseyside ICB – Notetaker

Apologies	
Name	**Role**
Andrew Lewis	Partner Member, (Local Authority) (Voting Member)
Warren Escalade	Partner Member, (VCFSE) (Voting Member)

Agenda Item, Discussion, Outcomes and Action Points

Preliminary Business

ICB/03/2401 Welcome, Introductions and Apologies

All those present were welcomed to the meeting and advised that this was a meeting held in public. The meeting was declared quorate. Apologies for absence were noted as above.

ICB/03/25/02 Declarations of Interest

There were no declarations of interest in relation to the agenda.

ICB/03/25/03 Chairs announcements

Southport – one year on

On 29 July 2025, marking one year since the Southport incident, a three-minute silence will be held at 3pm to honour Elsie Dot Stancombe, Bebe King, Alice Dasilva Aguiar, and all those affected. In lieu of flowers, donations to local causes are encouraged. The ICB and NHS partners continue working with Sefton Council to provide psychological support, with a dedicated resource page available. The commitment to supporting impacted individuals and fostering resilience remains strong across Cheshire and Merseyside.

Partner Member Update

Delyth Curtis, Chief Executive of Cheshire West and Chester Council, has been appointed as the new Local Authority Partner Member on the NHS Cheshire and Merseyside Board, succeeding the retired Prof. Steven Broomhead.

Non-Executive Member Updates

Neil Large has resigned as a Non-Executive Member of the ICB following his formal appointment as Chair of the Countess of Chester NHS Foundation Trust. Gratitude and thanks were given for his support and experience and wished well in new role.

Mike Burrows has been appointed as an interim Non-Executive Member for six months, with his term extended to June 2026 to ensure leadership stability amid ongoing ICB redesign work and the release of the 10 Year Plan.

Tony Foy has agreed to serve a second term as a Non-Executive Member and will continue as Deputy Chair of the Board, with thanks expressed for his ongoing commitment and valuable contributions.

Raj Jain announced his intention to retire from role later this year, and a new Chair would be sought.

ICB/03/25/04 Experience and achievement Story

A short video was Shared regarding the Smoke Free Programme and the positive differences being made in Cheshire and Merseyside, focusing on support during maternity to give up smoking.
https://youtu.be/yLa24dvCaFs

Leadership Reports

ICB/03/25/05 Report of the ICB Chief Executive

Cathy Elliott introduced herself as the new ICB Chief Executiveat her first Board meeting, emphasising the leadership team's focus on addressing current needs while laying foundations for future community care. Cathy summarised key items within her report to Board, namely:

Measles
Rising measles cases in Cheshire and Merseyside have prompted a public health drive to boost MMR vaccination uptake. The region has the third highest case count in England. Targeted initiatives include community-focused pilots, extended GP out-of-hours clinics in outbreak areas, staff training, and data monitoring through a dashboard. Efforts are also underway to reach young adults and promote vaccination through schools, colleges, and universities.

Doctors Strike
A doctors' strike begins tomorrow, and the ICB has activated its emergency and resilience plans in coordination with provider services. While priority services are being maintained, some disruption and patient impact are expected. The ICB is working closely with NHSE, the BMA, and local services to monitor the situation around the clock. Efforts are being made to protect routine care, and the public is asked to show kindness and understanding to staff during this period.

Turnaround Work
PWC is supporting turnaround efforts to address financial challenges, ensuring spending delivers best value and quality care. With NHS reforms underway and formal ICB structures changing, plans are being developed to maintain strong collaboration across communities and providers. Emergency care performance remains a key priority.

Risk Summit
A Risk Summit on 21 July 2025 brought together leaders from ambulance, community, acute, and social care to collectively address system-wide risks. The event marked the beginning of ongoing collaboration, with workstreams to be developed and information shared with NHSE. Emphasis was placed on putting patients at the centre, integrating clinical and social care priorities, and fostering open, cross-sector dialogue.

10-year health plan
Ongoing work continues in line with the Government's July-announced 10-Year Health Plan, with updates to follow from the September meeting. The plan identifies the NHS at a critical turning point, focusing on three key areas: shifting care from hospital to community, accelerating digital transformation, and moving from sickness to prevention. It introduces a new care and operating model, including merging NHSE with DHSC, refocusing ICBs as strategic commissioners, enhancing transparency through league tables, and revitalising the National Quality Board. Additional priorities include workforce transformation, adoption of five key technologies (AI, data, genomics, robotics, wearables), and financial sustainability through value-based care and 2% productivity gains. Alignment with these national priorities will continue.

The Board acknowledged the update.

ICB/03/25/06 NHS Cheshire and Merseyside Finance Report Month 2

The ICB Director of Finance provided an update to Board.

The ICS has reported a year-to-date deficit of £67.1M, slightly better than the planned £67.3M, but concerningly 38% of the annual £178.3M deficit target has already been incurred in just two months. This reflects a heavily back-loaded recovery plan, requiring urgent acceleration of cost improvement programmes (CIPs) and system recovery efforts.

Support from PwC is ongoing, with focused work on financial recovery, governance, and performance management. Mental health spending is currently below plan, while ophthalmology is above. Cash flow remains a significant concern, with deficit support withheld and recovery measures being negotiated with NHSE for Q3.

The Board acknowledges the financial pressures and the need for discipline while maintaining safe, high-quality care. Assurance is being provided to organisations facing cash shortages, with a collective commitment to managing resources system-wide. Patient safety remains the top priority, with executive leadership united in making transparent, clinically informed decisions.

The Board noted the financial report and metrics for month 2 of 2025/26.

ICB/03/25/07 Highlight report of the Chair of Finance, Investment and Our Resources Committee

Noted the financial position for Months 1 and 2, highlighting the reported deficit and key risks. Cheshire and Merseyside (C&M) is currently an outlier and under turnaround, with PwC support until the end of August and Simon Worthington assisting with CIP schemes. Performance and finance indicators are closely monitored, with mitigations applied as needed, while keeping patients at the centre of all decisions.

Six key savings areas have been identified, risk-rated, and are being continuously tracked, with robust engagement across partners. While Continuing Healthcare is improving, prescribing remains a concern due to data delays, incentive issues, and external cost pressures. Educational webinars and contract reviews are planned to address prescribing challenges.

There are concerns about the private sector's influence, with a focus on ensuring quality referrals and care tracking. Market management, including the use of independent care providers and financial oversight, will be discussed further in private session. Approval has been granted to proceed with re-procurement of NEPTs, despite associated risks.

The Board noted the report.

ICB/03/25/08 NHS Cheshire and Merseyside Integrated Performance Report

The system continues working to deliver services efficiently amid rising demand across all areas. A&E performance remains marginal, with improved ambulance handovers and progress on discharge. Emergency and urgent care require further improvement, and elective and theatre productivity is being optimised. The Cancer Alliance expects to exceed the national 75% target, aiming for 80%.

Significant variation remains across organisations, with ongoing structural challenges. Provider oversight groups are supporting improvements, and East Cheshire has addressed a previously identified mortality outlier. CPD prevention is still a challenge, again have a programme of work. Preventive work on hypertension, smoking, and lipid management is progressing, though challenges remain due to staffing and capacity issues. HCAI is being tackled with toolkits and shared learning across organisations.

Focus continues on mental as well as physical health, recognising system-wide variation. Strong local initiatives are being identified for wider adoption, including increased GP appointments. Efforts are underway to reduce 65-week and child waiting times, with attention on improving transition pathways in children's services. Across the system, there is commitment to improvement despite financial and

operational pressures, with a strong emphasis on data-driven, neighbourhood-level impact and collaboration.

The Board noted the report.

ICB/03/25/09 Highlight of the report of the Chair of ICB Quality and Performance Committee

The Board discussed two key alerts highlighted in the report.

The alert regarding the vaccination programme was noted, with recognition of the thoughtful approach taken to understand why some healthcare workers are not coming forward for vaccination—an essential step in shaping an effective response.

Additionally, collaborative work has been undertaken with Halton and Warrington hospitals, alongside close engagement with patient safety experts. As a result, structured programmes are now in place to monitor and enhance quality and safety, including specific initiatives focused on sepsis.

The Board noted the report.

ICB/03/25/10 Highlight report of the Chair of ICB Audit Committee

The Committee received an update on the ICB's cyber security progress under the CAF and DSPT. Most audit criteria were met, with some additional IT evidence needed. An Improvement Plan will address expected gaps. Five minor data incidents occurred in Q4, and staff training is ongoing. The Committee approved the 2024/25 DSPT audit submission to NHS England and noted progress toward compliance with CAF-aligned standards.

The Committee endorsed the final draft of the ICB's 2024–25 Annual Report and Accounts at a meeting in June, following external audit and internal audit review, and supported the Committee Chair's recommendation for approval by the ICB Board.

The Committee reviewed the Risk Register, noting four high-rated risks, and approved the closure of risk G10 related to information governance re-procurement, now considered stable.

The Board noted the report.

ICB/03/25/11 Highlight report of the Chair of System Primary Care Committee

Aware of pressure on Prescribing budgets, multiple issues, need to understand challenges and have mitigations in place. Will be discussed at August SPCC.

The Access Improvement plan aims to reduce variation in primary care access through consistent contract oversight and commissioning to improve patient experience. After national review, it will return to the Committee. Ongoing steps include data-driven governance, with further Board updates expected, including patient feedback from a recent Healthwatch survey of over 7000 patients, showing progress but persistent GP access issues.

The Board noted the report.

ICB/03/25/12 Highlight report of the Chair of the Remuneration Committee

The Committee received an update on the new national Very Senior Manager (VSM) framework, approving its use for future appointments. Due to financial pressures and potential redundancies, it was agreed to defer this year's VSM pay award. The salary for the interim Director of Finance was approved in line with the new framework. The Committee also reviewed a proposed structure for the ICB Executive Team, with further work ongoing in line with VSM principles. Engagement with Government on related reports continues.

The Board noted the report.

ICB/03/25/13 Highlight report of the Chair of the Children's and Young People Committee

The Committee endorsed a proposal to co-fund an Engagement Worker to enhance youth voice across Cheshire and Merseyside. Hosted by Youth Focus Northwest with £20,000 match funding from the VCFSE sector, the role will support youth engagement, including input into CYP Committee meetings, a

youth-led conference, and embedding co-production. The funding request is now going through the formal governance for decision.

The Board noted the report.

ICB/03/25/14 Highlight report of the Chair of the Shaping Care Together Joint Committee

Programme focused on urgent and emergency care, partnership programme. Committee membership reflects this partnership.
The Shaping Care Together pre-consultation business case has been approved, and the formal consultation launched on 4 July. A comprehensive engagement plan is underway, involving a broad range of stakeholders. The outcomes of the consultation will be brought forward in due course.

The Board noted the report.

ICB/03/25/14a Highlight report of the Chair of the North West Specialised Services Joint Committee

The Committee noted collaboration across three ICBs. Issues with the Adult Critical Care Transport service provider are under review, with further discussion planned for September. NHSE has delayed the transfer of Specialised Commissioning staff pending a new framework. Concerns were raised about recruitment and financial pressures potentially slowing progress on key change programmes, posing a recognised risk.

The Board noted the report.

ICB/03/25/14b Highlight report of the Womens Hospital Services in Liverpool Committee Chair of the Committee

The minutes were noted as read. The Committee reviewed a comprehensive list of options for the Liverpool Foundation Trust programme, with encouraging progress on both medium- and long-term plans. A prevention and equity profile policy was also received and included in the papers—highlighted as a sobering read, showing that the majority of service users come from deprived backgrounds.

Good progress was reported on on-site safety, with associated risks reduced on the programme risk register. The importance of aligning this work with neighbourhood-level initiatives was emphasised, as it will inform future strategic planning.

The Board noted the report.

Short Break in Meeting for 15 Minutes

ICB Business Items

ICB/03/25/15 Intensive and Assertive Community Mental Health Care Update

The report provided updates on the action plan regarding Intensive and Assertive Community Mental Health and included additional action from the Mental Health Independent Investigation report published by NHSE.

The Committee reviewed ongoing efforts to improve care for individuals with psychosis, particularly those requiring additional support due to vulnerability. A proactive outreach model is being developed to enhance mental health (MH) care, including in emergency settings. A report completed last September outlined short- and long-term actions, with trusts implementing initial steps and NHSE issuing guidance.

The review focused on adult care but identified the need for greater assurance around children, young people, and disability services. Updates to the action plan were endorsed, including a request to complete a RAG-rated survey template. Emphasis was placed on embedding community-based crisis support and addressing long-term workforce and resource challenges.

The plan aims to embed community-based support for individuals in crisis or with escalating mental health needs. Workforce and resource challenges are acknowledged, particularly over the 10-year scale-up, with mitigations being developed. The importance of a robust DNA (Did Not Attend) policy and escalation process was highlighted, along with ensuring GPs are kept informed while patients are

under mental health team care. These actions will be taken back for further implementation and oversight.

Key areas include better communication between MH teams and GPs, developing a consistent health model across regions, incorporating family input into care design, and understanding community-to-crisis care pathways. Cultural and practice change, data on patient disengagement, and discharge funding were also discussed. Headline measure around MH care, and more detailed pathways, and what measures and areas we are focusing on. Need more data and clarity as commissioners. Concerns were raised about unmet "never event" policy requirements, with assurances that work is underway and updates will follow. Collaboration with education providers was confirmed.

The request was to move to quarterly updates, to continue to monitor progress. Point raised will be included in the next reiteration of the action plan.

The Board noted the updates and actions outlined in Appendix one, and agreed the frequency to be quarterly going forward.

ICB/03/25/16 Developing a framework for Neighbourhood Helth Services in Cheshire and Merseyside

This key initiative focuses on delivering coordinated, community-based care to ease service pressures, building on existing multiagency work and aligning with national priorities. Baseline data is being tracked, and most local areas plan to bid for a limited national management programme (42 places), with support provided regardless of outcome.

The work involves defining local boundaries, embracing digital tools, and fostering deeper community engagement. Success will require cultural change, organisational learning, and sharing best practices. A clear shift in budget planning is also needed, with greater focus on ringfencing and investing in out-of-hospital services.

There are 4 key items to the framework:

- National and regional policy context for Neighbourhood Health ambitions and expectations
- Information resulting from Neighbourhood Health Maturity Assessments completed by Place based teams in April 2025
- An outline of the Framework, vision and driver diagram for Neighbourhood Health in Appendix One to this paper
- Information about the National Neighbourhood Health Implementation Programme Cheshire and Merseyside Neighbourhood Health Principles and Next Steps

The vision outlines a consistent, clear framework focused on improving outcomes, starting with areas of lowest life expectancy—through neighbourhood health centres and expanded to community services. Hoping this work will provide a better winter. It aims to simplify access for communities and is based on the Liverpool model, integrating NHS, social care, and community-led support.

Key components include local leadership, provider roles tailored to each area, and alignment with NHS England's impact models. The approach is preventative, people-centred, and designed for long-term evolution as work proceeds, including integration with the 10-year plan.

The driver diagram outlines the scope, key influences, and service inclusion within the programme, emphasising local leadership, accountability, and the identification of lead, non-prescribing providers. Each area will determine the most appropriate way to assign provider roles. The model prioritises community-led approaches, recognising the value of grassroots engagement and collaboration. It is fundamentally preventative in nature, aligned with NHS England's impact models, and dependent on community sign-off to ensure relevance and shared ownership.

The Board acknowledged the significance of this long-term initiative and agreed that further in-depth discussion is essential to help shape its strategic direction and clarify expectations. It was recognised

that dedicated time will be needed to collectively explore and challenge what is required and what the Board hopes to achieve over the 10-year programme.

The Board reviewed and strongly welcomed a draft neighbourhood health framework developed with wide input, recognising it as a vital foundation for the first phase of work. Members endorsed the framework as a developing and evolving tool, noting its alignment with national priorities and its potential as a template for wider adoption. The initiative marks the beginning of a long-term transformation towards community-based, preventative care and requires sustained commitment, strategic planning, and financial modelling.

Key themes included the importance of local flexibility, asset mapping, and co-design with communities, particularly in defining "neighbourhoods." The need for robust data, sustainable funding models, workforce development, and inclusion of elected representatives and local authorities was emphasised. The framework also highlights the need to rethink performance metrics to reflect outcomes beyond traditional NHS measures, such as poverty and wellbeing.

There was strong support for progressing bids to demonstrate commitment and ensure place-based ownership, with agreement that the work will require national policy backing, new commissioning models, and cultural change across the system. The Board agreed this will be a standing agenda item, recognising its strategic importance and transformational potential.

ACTION: Updates on implementation of Neighbourhood Health framework will be a standing item for the foreseeable future for the Board, due to its strategic importance and transformational potential.

The Board noted the update around the work being undertaken and approved the Neighbourhood Health Framework and principles as described in the report, and agreed the next steps in the delivery of the plan.

ICB/03/25/17 Cheshire and Merseyside Winter Plan 2025/26

NHS Cheshire and Merseyside's 2025/26 winter plan sets out how urgent and emergency care priorities will be met, focusing on ambulance response times, A&E and mental health delays, and discharge improvements. Developed across five localities, the plan uses strong evidence and feeds into a system-wide submission by July 2025. While no extra revenue funding is available, national capital supports infrastructure. It aligns with urgent care objectives and will undergo NHS stress-testing later in the year.

The plan will return to the Board at the end of September for further discussion on next steps, including the importance of conducting our own internal stress test. The insights and data from this plan will also play a key role in shaping the neighbourhood strategy.

ACTION: Bring paper back to Board in September to discuss next steps, and to run our own stress test, as is integral as part of neighbourhood plan.

The Board noted the planning for Cheshire and Merseyside which include the national expectations.

ICB/03/25/18 Seasonal Vaccinations 2024/25 look back and plans for 2025/26 with a spotlight on improving vaccination uptake in Health Care Workers

Recent data shows a notable decline in seasonal vaccination uptake across all eligible groups in the UK compared to pre-pandemic levels. Improving uptake is essential to protect lives and maintain community health and productivity, requiring a coordinated system-wide approach.

NHS Cheshire and Merseyside is well positioned to lead this work, leveraging its role as both strategic commissioner and system convener to engage providers across primary and secondary care. Insight work commissioned by the ICB—based on interviews with 1,500 healthcare workers, including those in

primary care and domiciliary settings—will inform targeted actions to boost vaccination rates among both patients and staff.

Key findings -
Several hospitals have declared critical incidents due to staff shortages, some of which are linked to flu and other preventable illnesses. To address this, all trusts are required to commit to at least a 5% increase in vaccination uptake as part of the urgent and emergency care (UEC) plans, with expectations for stretch targets.

Engagement is ongoing with CEOs and Trust leaders to encourage greater involvement and drive improvements. Recognising that each service faces unique challenges to uptake, it's vital to foster open, compassionate dialogue about vaccination, while also considering workforce diversity, job roles, and the cultural sensitivities of local communities to better support increased vaccination rates.

Key recommendations -
To improve vaccination uptake, efforts will focus on increasing capability through clear and credible information, addressing COVID fatigue and misinformation, expanding access opportunities, boosting motivation, and rebuilding trust.

Ask of Board is to endorse the need for coordination, endorse NHSP developing staff vaccination plans, approve regular flu vaccination uptake reporting to ICB Board meetings.

The plan benefits from involving unions and HR as valuable resources, emphasizing a multipronged approach. With COVID vaccination no longer mandatory for healthcare staff, flu vaccine uptake will be closely observed. The presentation will be shared with the DAS network for support, alongside efforts in primary care and adult social care to promote vaccination. Local engagement, strong leadership, accessibility, and effective use of social media are crucial to matching the ambition of improving uptake.

ACTION: Send Vaccination Presentation to C&M Directors of Adult Social Services network and ask for their support with seasonal vaccination uptake amongst staff.

The Board:

- **endorsed** the need for a co-ordinated and systemwide response from the ICB, primary care, secondary care, specialist trusts and Local Authorities to improving seasonal vaccination uptake in all eligible groups, including health care workers and domiciliary staff
- **endorsed** that NHS Providers develop staff vaccination plans which act on the recommendations of the ICB commissioned Health Care Worker insight work
- **approved** the recommendation to receive regular flu vaccination uptake reporting to future ICB Board meetings

ICB/03/25/19 Update on Improving access to Primary Medical (General Practice) Services

The Board had approved a two-year Access Improvement Plan, emphasizing the importance of patient experience feedback to measure its impact. Under NHSE's operational guidance, general practice access improvement remains a key focus. Patient and GP feedback was gathered, and national plans submitted, awaiting feedback. Healthwatch conducted a broad survey of 7,000 people using mixed methods, revealing consistent themes despite varied response rates across nine local areas.

The survey highlighted varied methods of accessing GP services, with 66% using the phone and others using apps or visiting in person. However, 70% reported not accessing their GP due to difficulties booking an appointment. Receptionists often receive negative feedback, partly due to misunderstandings about their role and the broader practice team. Education about GP roles and service availability is key, as this varies by practice. Despite access issues, 85% felt their appointment was with the right person and 92% were satisfied with how it was delivered—challenging common misconceptions. Issues with dental service access also influenced the report findings.

The way forward will focus on keeping people well-informed through clear signposting and timely dissemination of up-to-date information. We will continue to monitor the impact of these communications, with ongoing data reporting and oversight through the Primary Care Committee.

The national GP Patient Survey enables comparison with previous years, national averages, and neighbouring ICBs, highlighting key themes such as high telephone access, the growing role of mobile technology, and concerns over convenience and face-to-face availability. Findings emphasise the need to address variations between practices, share best practice, improve public understanding of available services and roles, manage future demand, and better communicate the broad range of general practice services to patients.

There is a need to challenge misconceptions about appointment availability and promote awareness of alternative options such as prescribing nurses. Education around digital access is also key. Work is underway to tackle the 8am rush, with digital phone systems now providing valuable data that is helping to improve access. However, ensuring equity remains essential, particularly for those without digital access. Commissioners are using practice-level data to identify and support areas with low or no digital uptake.

We are committed to delivering exemplar standards of care, underpinned by clearly defined minimum expectations. A key priority is addressing variation across services and supporting practices to reach a consistent, high-quality level of provision. The June plan outlines the proportion of practices identified as requiring support, the nature of that support, and the confidence in its effectiveness—all informed by robust data and stakeholder feedback. This is an ongoing and dynamic piece of work, with initial Level 1 practices already identified. There is strong scrutiny around how we invest and drive improvement, and this plan enables us to spotlight variation across localities and use detailed data insights to target our efforts effectively.

The Board noted the update.

ICB/03/25/20 NHS Cheshire and Merseyside 2025/26 Annual Delivery Plan

In recent years, our annually refreshed Joint Forward Plan has set out our key priorities. At the Board meeting on 27th March, and in alignment with the national approach—particularly in light of the delayed publication of the NHS 10-Year Plan—it was agreed that re-publication of a full Joint Forward Plan would be deferred until this national direction becomes clearer.

The evolving role and functions of the ICB, shaped by the revised NHS operating model, will see a sharper focus on strategic commissioning, improving population health outcomes, and advancing neighbourhood health models. To fully realise this shift, further organisational development will be essential. The year 2025–26 will serve as a transitional period, during which the implementation of national plans and supporting frameworks will continue to take shape.

There is a clear commitment to return to the Board with further detail to provide assurance. In the meantime, locally developed interim place plans are in place, supported by a tracking framework aligned with current governance. This will be regularly refreshed and updated to reflect progress and changes. Assurance will be provided through detailed metrics and performance measures, and we will continue close collaboration with Programme Leads as plans evolve.

A more detailed discussion will be held with the NEDs and CEO to explore this further. It would be beneficial to involve programme leads to provide deeper insight and ensure the conversation is well-informed and constructive. As we continue to develop our strategies, this will help shape a clearer understanding of both what we want to achieve and what needs to be included.

ACTION: Arrange a dedicated meeting with NEDs and the CEO for a more detailed discussion. Invite relevant programme leads to provide deeper insight and support informed conversations. The session will help shape strategic development by identifying priorities and required elements for inclusion.

The Board noted the update.

Meeting Governance

ICB/03/25/21 Minutes of the Previous Meetings

Minutes of the previous meetings: -

- The minutes of the previous meeting held on 29 May 2025 were accepted and recorded as a true and accurate reflection of the meeting.
- The minute of the previous meeting held on 19 June 2025 were accepted and recorded as a true and accurate reflection of the meeting.

ICB/03/25/22 Board Action Log

The Action log was taken as read, but it was noted that it needed some further improvement and updating.

Reflection and Review

ICB/03/25/23 Closing Remarks and review of the meeting

Productive and enjoyable meeting, thanks given to all for active participation.
The Chair closed the meeting.

CLOSE OF MEETING

Date of Next Meeting:
Thursday 25 September 2025 – 09:00am
Authority Chamber, No 1 Mann Island, Liverpool, L3 1BP

CONSENT ITEMS

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

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

ICB Board Meeting Action Log

Updated: **19.09.25**

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status	Recommendation to Board
IBC-AC-22-69	25/01/2024	**NHS C&M Quality and Performance Report**	Board to receive information on secondary prevention measures in primary care (link to QOF)	**Clare Watson**	Mar-25	*Performance metrics are provided to System Primary Care Committee (SPCC) and Board informed via SPCC Chairs report and committee minutes*	COMPLETED	Board is recommended to close the action
ICB-AC-82	27/03/2025	**Integrated Performance Report**	Provide updates on the impact of the hydration in care homes project and explore opportunities to broaden it out across wider area	**Anthony Middleton**		*Update provided within the September Chief Executive Report*	COMPLETED	Board is recommended to close the action
ICB-AC-83	27/03/2025	**Director of Nursing Report**	Proposed System wide Safety Priorities to be brought for approval at the May Board.	**Chris Douglas & Rowan Pritchard Jones**	Sep-25	*Updates to be provided to Quality Committee with future reports to Board via the reports of the Quality Committee*	COMPLETED	Board is recommended to close the action
ICB-AC-84	27/03/2025	**Director of Nursing Report**	An update to come to the Board regarding the outcomes of the NHS England's paediatric audiology programme review and the subsequent improvement plans	**Chris Douglas**	Sep-25	*Updates to be provided to Quality Committee with future reports to Board via the reports of the Quality Committee*	COMPLETED	Board is recommended to close the action
ICB-AC-87	27/03/2025	**Place Director Report**	Future report to come back to help Board understand the progress and impact of primary care network activities, ensuring alignment with broader neighborhood health models	**Clare Watson & Alison Lee**	Sep-25	*Action to be merged with Action: AC-100.*	COMPLETED	Board is recommended to close the action
ICB-AC-91	27/03/2025	**Supporting Care Leavers into Employment**	Chief People Officer to develop a delivery plan and budget for the care leavers recruitment initiative and provide a report back to Board.	**Mike Gibney**	Nov-25	*Added to Forward Plan for November Board. Close action following November Board*	ONGOING	
ICB-AC-94	28/05/2025	**Report of the Chair of Specialised Commissioning Joint Committee**	Clare to follow up with the Spec Comm leadership team to identify actions to reduce overconsumption of resources of SpecComm, with a report back to Board in three to six months.	**Clare Watson**	Nov-25	*Added to Forward Plan for November Board. Close action following November Board*	ONGOING	
ICB-AC-97	28/05/2025	**Integrated Research & Innovation System**	A further report to come back to the Board in 9 months time updating the Board on the impact and realisation of investment and to include patient experience and outcomes.	**Rowan Pritchard-Jones**	Mar-26	*Added to Forward Plan for 9 months time*	COMPLETED	Board is recommended to close the action
ICB-AC-100	24/07/2025	**Neighbourhood Health framework**	Updates on implementation of Neighbourhood Health framework will be a standing item for the foreseeable future for the Board, due to its strategic importance and transformational potential.	**Clare Watson & Alison Lee**	Nov-25	*Added to Board Forward Plan with updates to be either via Chief Executive Report or standalone reports. Neighbourhood Health updates being provided to Board at Board development sessions in September and October. Formal Board paper providing update to come to November Board meeting*	COMPLETED	Board is recommended to close the action
ICB-AC-101	24/07/2025	**Cheshire and Merseyside Winter Plan 2025/26**	Bring paper back to Board in September to discuss next steps, and to run our own stress test, as is integral as part of neighbourhood plan.	**Anthony Middleton**	Sep-25	*On the September Agenda*	COMPLETED	Board is recommended to close the action
ICB-AC-102	24/07/2025	**Seasonal Vaccinations 2024/25 look back and plans for 2025/26 with a spotlight on improving vaccination uptake in Health Care Workers**	Send Vaccination Presentation to C&M Directors of Adult Social Services network and ask for their support with seasonal vaccination uptake amongst staff.	**Ian Ashworth / Julie Kelly**	Sep-25	*Presentation was supplied to DAS network*	COMPLETED	Board is recommended to close the action
ICB-AC-103	24/07/2025	**NHS Cheshire and Merseyside 2025/26 Annual Delivery Plan**	Arrange a dedicated meeting with NEDs and the CEO for a more detailed discussion. Invite relevant programme leads to provide deeper insight and support informed conversations. The session will help shape strategic development by identifying priorities and required elements for inclusion.	**Clare Watson & Cathy Elliott**	Sep-25	*Added to Board Forward Plan with updates to be either via Chief Executive Report or standalone reports. Updates being provided to Board at Board development sessions in September and October. Formal Board paper providing update to come to November Board meeting*	COMPLETED	Board is recommended to close the action

Meeting of the Board of NHS Cheshire and Merseyside

25 September 2025

CONSENT ITEMS

All these items have been read by Board members and the minutes of the September 2025 Board meeting will reflect any recommendations and decisions within, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.			
AGENDA NO	**ITEM**	**Reason for presenting**	**Page No**
ICB/09/25/23	Board Decision Log **(CLICK HERE)**	For information	-
ICB/09/25/24	**Confirmed Minutes of ICB Committees** **Click on the links below to access the minutes:** • Audit Committee – June 2025 **(CLICK HERE)** • Finance, Investment and Our Resources Committee – June 2025 **(CLICK HERE)** • Finance, Investment and Our Resources Committee – July 2025 **(CLICK HERE)** • Quality and Performance Committee – July 2025 **(CLICK HERE)** • System Primary Care Committee – June 2025 **(CLICK HERE)** • North West Joint Specialised Commissioning Committee – June 2025 **(CLICK HERE)**	For assurance	Page 316