NHS
Cheshire and Merseyside

Annual Report and Accounts 2025-26

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1. Performance Report

1.1 Performance Overview

The purpose of this performance overview is to provide a summary of NHS Cheshire and Merseyside Integrated Care Board's (ICB) activities during 2025-26, including the organisation's purpose, aims, performance and achievements throughout the year - as well as key issues and risks. In the interest of both brevity and accessibility, and in line with our corporate house style, the organisation will be referred to simply as NHS Cheshire and Merseyside.

1.1.1 Statement from the Accountable Officer

Welcome to the Annual Report and Accounts of NHS Cheshire and Merseyside, covering the period 1st April 2025 to 31st March 2026.

2025-26 was a year of significant change for everyone who works in the NHS – and particularly those in NHS commissioning. National reforms guided by the Model ICB Blueprint led to an extended period of uncertainty for NHS Cheshire and Merseyside staff. More broadly, a re-focussed NHS ambition and policy objectives were set by the national 10-Year Health Plan, published in July 2025, which changed expectations for how we plan and operate and who we work with.

Significant contextual and environmental changes include the planned abolition of NHS England and transfer of many of its functions to the Department of Health and Social Care and corresponding changes to NHS regional teams. This has accelerated plans to transfer out functions that we have previously been responsible for and make preparations to receive new functions too.

Throughout these changes we continued to work closely with our NHS partners and collaborated with wider partners, but it is also important to acknowledge that these conditions have resulted in challenges for our staff, our capacity and - as a result - our delivery.

In November 2025 NHS Cheshire and Merseyside formally accepted enforcement undertakings from NHS England. This means that the Integrated Care Board (ICB) has committed to delivering rapid improvement work and providing additional assurance in a number of key areas, including:

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

Our acceptance of these undertakings culminated in a number of leadership changes, resulting in Sir David Henshaw and I being brought in as Interim Chair and Chief Executive, respectively, in October and November 2025 - and the confirmation of a new-look Executive team in early 2026. These changes were accelerated by a deteriorating mid-year financial picture but provided us with a fresh opportunity to

actively consider our role, our optimal operating model and set out the structures we believe we need to be successful going forward.

Our response to our undertakings is set out within our Single Improvement Plan. An update on our approach – which is being developed with oversight from NHS England – was received by NHS Cheshire and Merseyside's Board on 26 March 2026 and will be enacted during 2026-27.

Alongside this we have been responding to the national target for ICBs to reduce their running costs, including via a nationally supported voluntary redundancy scheme which supported the exit of 151 colleagues by the end of March 2026. I want to place on record my thanks to those colleagues who have now left the NHS and those who remain.

Our wider system remained challenged throughout 2025-26 with both NHS Cheshire and Merseyside and a number of provider Trusts welcoming external support and additional scrutiny to support performance turnaround and enhanced financial stewardship.

A number of our services also experienced significant demand. Winter remains too challenging for many of our emergency departments, with too many patients experiencing sub-optimal care or treatment delays. Industrial action also impacted on our providers' ability to treat as many patients as we would want in a timely way. We have also seen demand for a range of services including neurodiversity support grow - often exceeding capacity. Responding to these challenges will be key in 2026-27.

Over the last year we have seen progress made through a number of significant strategic system changes initiated by NHS Cheshire and Merseyside in previous years. In Liverpool we have seen the establishment of the University Hospitals of Liverpool Group, with similar partnerships and joint working in place in Wirral and Warrington as providers of hospital services work more closely together to integrate with community services. Critically, we have also enacted decision making which will support safer services and better care for women in Liverpool.

Encouragingly we have also seen more patients access primary care across all disciplines and – while recognising there remains more to do – access to NHS Dentistry has improved. As a sign of the level of excellence in primary care, teams and staff from Cheshire and Merseyside won three categories and were highly commended in another at the national General Practice Awards, while Women's Health Hubs are helping to transform access to contraception and wider reproductive health support.

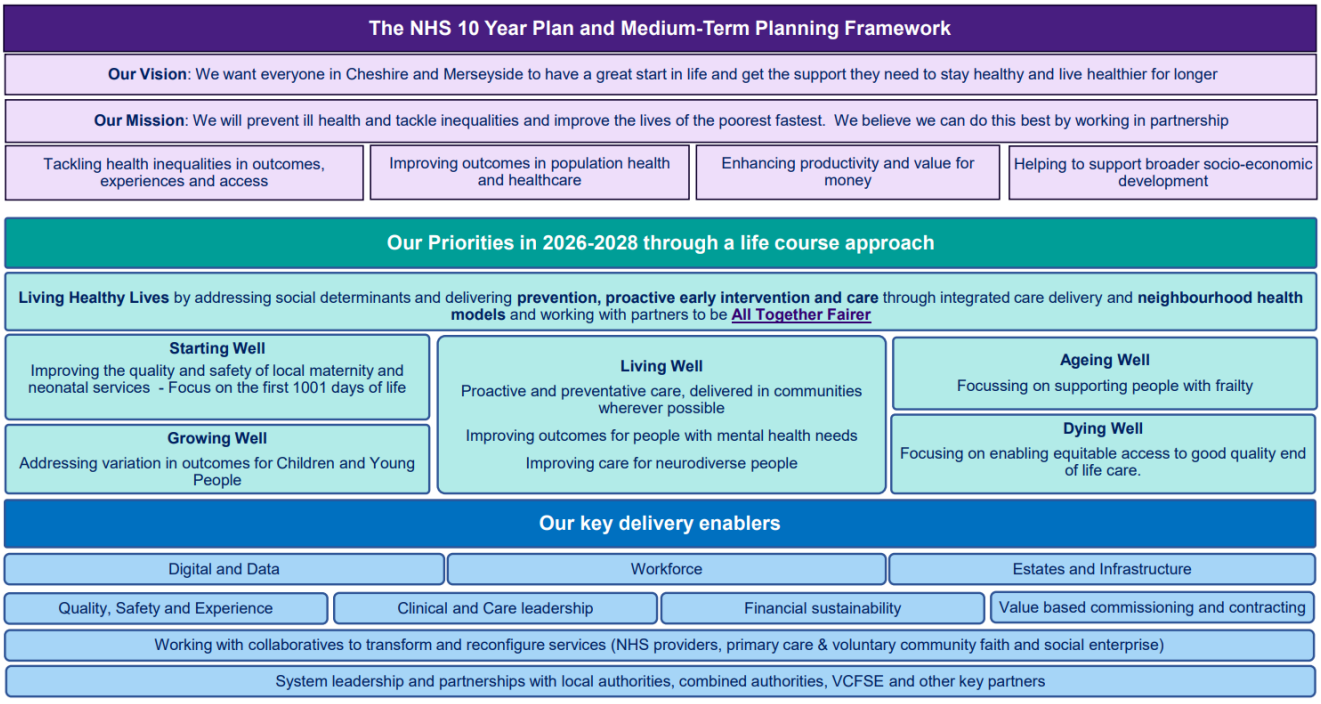
We have also championed alternative ways of accessing health advice, support and services in the community - for example via pharmacies - and continue to work closely with partners in progressing our many interdependent statutory functions across SEND.

There is much to be both proud and optimistic about. Our Chair, Sir David Henshaw and I have been prioritising work to improve relationships across the system and have been impressed by the work that is happening across the system to improve care and the experience of care for people across Cheshire and Merseyside.

In addition to innovative use of AI and technology to help improve patient care and outcomes, the NHS in Cheshire and Merseyside has led the way nationally as the first health system to develop an urgent cancer care strategy and transformation programme spanning 111, primary and community care, acute hospitals and specialist cancer services. Advances in cancer detection and care mean survival rates among Cheshire and Merseyside residents are now as high as they have ever been.

We are also excited about opportunities to further embed models of neighbourhood health locally and were delighted that both Sefton and St Helens were confirmed as national neighbourhood health 'pioneers'. NHS Cheshire and Merseyside continues to drive a shared vision of delivering better care, closer to where people live, through Integrated Neighbourhood teams (INTs) and collaborative working and, in January 2025, our pioneer sites welcomed the national lead, Dr Minal Bakhai, to showcase the progress to date and discuss challenges and opportunities.

Looking ahead, in 2026-27 we will continue to embed our new Operating Model – responding to feedback from NHS Cheshire and Merseyside staff and partners – and commence delivery of our five-year Clinical and Strategic Commissioning and Population Health Improvement Plans, which were refreshed in March 2026 to align with the NHS 10-Year Plan, national planning priorities and Cheshire and Merseyside Integrated Needs Assessment. This work, our vision and our plan will guide our focus over the next 12 months.



Liz Bishop

Liz Bishop
Chief Executive
18th June 2026

1.1.2 Purpose and activities of the organisation

NHS Cheshire and Merseyside was formally established on 1st July 2022 and is the statutory NHS organisation responsible for planning, funding and overseeing NHS services for our population of 2.7 million people - across a footprint spanning large towns and cities, and more rural areas.

Cheshire and Merseyside is a large and complex Integrated Care System (ICS). NHS Cheshire and Merseyside forms part of this system alongside:

- **Cheshire and Merseyside Health and Care Partnership**: a statutory joint committee between NHS Cheshire and Merseyside and the nine local authorities, with membership and attendance from a range of partners.
- **Nine Place-Based Partnerships**: partners working together on local authority footprints to support the integration of health and care services and delivery of joint Health and Wellbeing Strategies.
- **One Provider Collaborative**: the Cheshire and Merseyside Provider Collaborative (CMPC), has brought together the two collaboratives previously known as the Cheshire and Merseyside Acute and Specialist Trust Alliance (CMAST) and the Mental Health, Learning Disability and Community Provider Collaborative (MHLDC), with the aim of creating a shared opportunity for provider engagement, improvement and transformation across the health and care system. Its focus is on aligning in-hospital and out-of-hospital services to improve care and ensure services are more streamlined and efficient.
- **55 Primary Care Networks**: groups of GP Practices working together.
- **58 Neighbourhoods**: planning footprints of 30-50,000 people which are recognised as key building blocks of neighbourhood care in the 10-Year Health Plan.
- **c19,500 Voluntary, Community, Faith and Social Enterprise sector (VCFSE):** organisations which contribute to the sector by being a key strategic partner for public sector organisations - providing research, consultation and commissioning services on top of frontline service delivery, helping to respond to community need and address inequalities.

NHS Cheshire and Merseyside also works closely with neighbouring Integrated Care Boards - NHS Greater Manchester and NHS Lancashire and South Cumbria - and NHS England to commission a number of specialised services across the North West.

The four core purposes of all Integrated Care Boards are to:

- **Tackle health inequalities in outcomes, experiences and access** - *We will identify where inequalities exist and focus on proactively addressing these inequalities in everything we do.*
- **Improve outcomes in population health and health care** - *We will take an evidence and intelligence-based approach to turn data into action in addressing where we need to improve outcomes the most with a focus on moving from treatment of ill-health to prevention.*
- **Enhance productivity and value for money** - *We will maximise the value of every pound we spend to ensure that we are best meeting the needs of our*

patients and communities; investing our resources where evidence shows we can have the greatest impact on outcomes.

- **Help to support broader social and economic development** - *We will work to support our communities by growing our role as Anchor organisations investing in our communities economically and environmentally.*

The shared vision, mission and purpose across Cheshire and Merseyside is articulated in **All Together Fairer: Our Health and Care Partnership Plan** (referred to going forward as 'our HCP Plan'):

Vision

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

Mission

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

As part of this work, NHS Cheshire and Merseyside has committed to making a positive impact on the wider determinants of health - the social, economic and environmental conditions in which people are born, grow, live, work and age to:

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

Figure 1: All Together Fairer Health and Care Partnership Headline Ambitions

In line with these six headline ambitions, NHS Cheshire and Merseyside focuses on:

- The development and delivery of a work and health strategy. We are also a partner in the development of the Get Britain Working Plans in both Liverpool City Region and Cheshire and Warrington.
- Continuing to expand our commitment to social value and support the development of the Anchor framework and institutions and prevention pledges.
- Targeted work on housing and health and benefits optimisation.
- Sustainability and delivery of the Green plan – net zero target by 2040, with an ambition to reach an 80% reduction (from 1990 levels) by 2032.

All nine Cheshire and Merseyside Health and Wellbeing Boards have committed to our shared All Together Fairer ambitions. Collectively, through the All Together Fairer programme funded by NHS Cheshire and Merseyside, we have successfully implemented a range of programmes designed to reduce health inequalities, with progress regularly provided through the Chief Executive's assurance reports to the Board.

Case Study – All Together Fairer: Programmes aimed at reducing health inequalities

Maximising household income - in collaboration with the Department of Work and Pensions (DWP) we have created a resource which showcases all of the income support offered by the DWP alongside QR codes that take people directly to the support available.

Free school meal auto-enrolment - Six out of the nine local authorities in Cheshire and Merseyside now have auto-enrolment in place. Establishing this process in three additional Local Authorities over the past 12 months has led to 1,320 additional school-aged children being awarded free school meals and £1.8m being generated in pupil premium for schools alongside increased access to school holiday meal provisions through the Holidays Activity and Food fund.

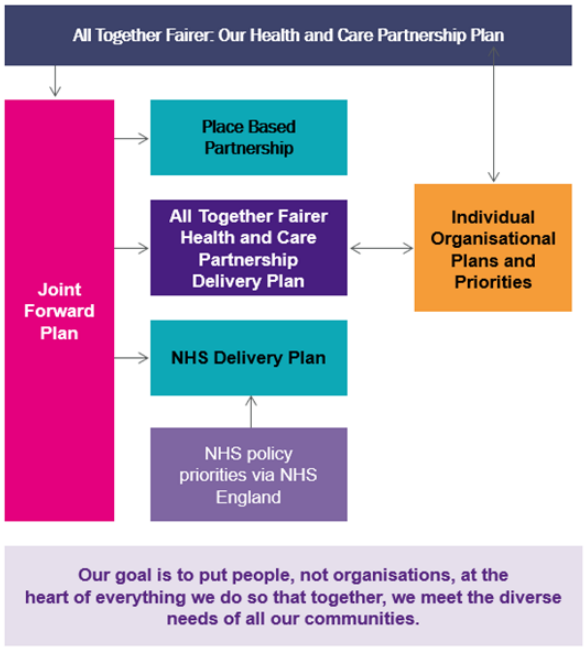
Increasing uptake of the NHS Healthy Start Scheme - Self-assessment checklists have been developed for use across health and social care to increase take-up of the healthy start scheme by eligible pregnant mothers and their families. By supporting eligible families to access this scheme we can improve the health and wellbeing of low-income families through improved nutrition and development and reduced food security stress.

To support the delivery of our HCP Plan, NHS Cheshire and Merseyside published the Cheshire and Merseyside Joint Forward Plan, which articulates how we will work as a system to deliver on our statutory duties under Section 14Z52 of the Health and Care Act and contains three core elements:

- **All Together Fairer: Our Health and Care Partnership Delivery Plan** - actions we are taking as a partnership to positively impact social determinants of health.
- **Place Partnership Delivery Plans** – developed locally in each of our nine local authority areas.

- **NHS Delivery Plan (Cheshire and Mersey-wide)** – builds on local plans and Cheshire and Merseyside priorities and describes how NHS Cheshire and Merseyside, partner NHS trusts and wider system partners work together to meet the needs of our population.

Figure 2 Overview of Plans



Supported by the following strategic and enabling programmes, we have developed a detailed Annual Delivery Plan Tracker to define reporting routes, outcomes and metrics – with Board oversight via an integrated performance report:

- Mental Health Learning Disability and Neurodiversity
- Children and Young People (Beyond Programme)
- Women's Health and Maternity (WHaM)
- Quality safety and experience
- Digital and Data
- Workforce

Statutory Duties

During the 2025-26 reporting period, NHS Cheshire and Merseyside has discharged its statutory duties to improve the quality of services, reduce health inequalities and secure continuous improvement through a clear, Board-led assurance framework.

The Board has demonstrated the key characteristics expected of an effective Integrated Care Board, that being to act as a system leader, strategic commissioner and steward of population health, and by maintaining oversight through an integrated approach combining performance data, risk management and system intelligence.

This included routine receipt and scrutiny of an Integrated Performance Report to its Board and Quality and Performance Committee meetings, which brought together

quality, safety, patient experience, inequalities and operational performance metrics across all commissioned services. These were considered alongside other intelligence to provide assurance that services were safe, effective and responsive to need, in line with NHS Cheshire and Merseyside's statutory duty to continuously improve quality and promote patient involvement.

The Board met its duties through active challenge and structured escalation, supported by the Quality and Performance Committee and the Board Assurance Framework (BAF). Principal risks relating to quality, safety failures, inequalities in outcomes and access and delivery of constitutional standards were clearly articulated, monitored and subject to regular deep-dive review. This enabled the Board to demonstrate robust stewardship of risk and clear line of sight from operational performance to strategic oversight.

In line with its statutory duty to reduce inequalities, the Board has embedded a population health management approach, using data and insight to identify variation and prioritise action for communities experiencing the poorest outcomes. The routine consideration of Core20PLUS5 metrics, geographical variation and wider determinants of health, through programmes such as All Together Fairer, demonstrates how NHS Cheshire and Merseyside has met its duty to have regard to inequalities in access, experience and outcomes. Importantly, this intelligence informed commissioning decisions, service redesign and targeted interventions, evidencing NHS Cheshire and Merseyside's maturity in moving from reporting to action.

The Board also fulfilled its duty to promote continuous improvement and innovation by ensuring that learning from incidents, complaints, safeguarding reviews and service feedback was systematically captured and translated into improvement activity. This is reflected in targeted quality improvement programmes across infection prevention and control, urgent and emergency care, maternity services and community provision, alongside a strong focus on patient experience and involvement in decision-making. Through this approach, NHS Cheshire and Merseyside has demonstrated the core qualities of a well-led organisation: openness to challenge, effective governance, clear accountability and a culture of learning and improvement.

Taken together, these arrangements provide assurance that NHS Cheshire and Merseyside has met its statutory responsibilities during the year, not only by monitoring quality, safety, experience and inequalities, but by taking proportionate and evidence-based action as a strategic commissioner and system leader to improve outcomes for its population.

The Health and Care Act 2022 conferred a number of statutory duties onto Integrated Care Boards, which NHS Cheshire and Merseyside is committed to fulfilling. The Annual Report demonstrates how NHS Cheshire and Merseyside has discharged its general duties per sections 14Z34 to 14Z45 and 14Z49 of the National Health Service Act 2006 (as amended) (Table 1).

Table 1

Section	Duty	Annual Report Reference	Rationale
14Z34	Improvement in quality of services	Sections 1.2.2, 1.2.3, 1.2.3.11; 1.1.4	Systematic oversight via Integrated Performance Report and QPC; targeted quality improvement actions demonstrate active duty discharge.
14Z35	Reducing inequalities	Section 1.2.3.8; 1.1.2; 1.2.1–1.2.3	Population health approach, Core20PLUS5 monitoring and targeted interventions via All Together Fairer programme.
14Z36	Promote involvement of each patient	Section 1.2.3.14; complaints and experience sections	Structured engagement, consultations and systematic use of feedback to inform commissioning decisions.
14Z37	Patient choice	Sections 1.2.1, 1.2.2; Primary Care and planned care sections	Enhanced access pathways, mutual aid and digital routes enable improved patient choice.
14Z38	Obtain appropriate advice	Sections 1.2.1, 1.2.2; Primary Care and planned care sections	Enhanced access pathways, mutual aid and digital routes enable improved patient choice.
14Z39	Promote innovation	Sections on AI, virtual wards, diagnostics	Adoption of digital, AI and new care models to improve outcomes and efficiency.
14Z40	In respect of research	Population Health and programme sections	Use of evidence, pilots and evaluation demonstrates research-informed decision-making.
14Z41	Promote education and training	Workforce and programme training sections	Delivery of system-wide training and development strengthens workforce capability.
14Z42	Promote integration	Section 1.1.2; partnerships and collaboratives	Clear evidence of integration through place partnerships and provider collaboratives.
14Z43	Have regard to wider effect of decisions	All Together Fairer; anchor work	Consideration of social, economic and environmental impacts in decision-making.
14Z44	Climate change	Section 1.2.3.15; Green Plan	Implementation of Green Plan and sustainability actions to address climate impacts.
14Z45	Public involvement and consultation by	Section 1.2.3.14	Formal consultation exercises and public engagement embedded in decisions.

Section	Duty	Annual Report Reference	Rationale
	Integrated Care Boards		
14Z49	Keep experience of members under review	Complaints, surveys, Healthwatch sections	Ongoing review of patient experience using multiple feedback sources.
14Z58 2(d) & 3	Health and Wellbeing Strategy	Section 1.1.2; Joint Forward Plan	Alignment with HWB strategies and place-based planning frameworks.

1.1.3 Performance Summary

Despite a challenging context in 2025-26, there were a number of notable achievements across the Cheshire and Merseyside region which are outlined further throughout this report.

Performance across urgent and emergency care showed only limited improvement, with modest gains in four-hour and ambulance response times, while 12-hour waits and patient flow remained significant challenges. In contrast, elective care saw clear and sustained progress, with robust performance on diagnostics, delivery against the 18-week referral-to-treatment trajectory and reductions in both overall waiting lists and long waits. Most providers met planned targets and long waits of 52 weeks reduced materially.

Cancer services remained the strongest area, with recovery delivered and provisional March data indicating that key standards, including the 62-day target, were achieved, alongside consistent outperformance relative to the national position.

Overall, the system delivered significant progress in elective recovery and maintained strong cancer performance, but only partially improved system flow and did not meet urgent and emergency care access standards.

Looking beyond core acute performance standards, 2025-26 saw strong progress in community transformation, prevention and primary care access, set against a background of continued challenges in capacity, workforce and growing demand. Significant achievements included the expansion of neighbourhood health models and community-based care, with national recognition for ‘pioneer’ sites and a marked increase in virtual ward activity and urgent community response services.

There were also notable improvements in primary care delivery, including record levels of GP appointments, expanded multi-disciplinary workforce and targeted initiatives in dentistry and women’s health that improved access - particularly for underserved groups.

The system strengthened its focus on population health and tackling inequalities, embedding ‘Marmot principles’ and used data-driven approaches to target high-risk populations, alongside impactful prevention programmes such as cardiovascular disease and smoking reduction initiatives. Innovation and digital transformation

continued to support delivery, with advances in AI, diagnostics and digitally-enabled pathways improving efficiency and patient experience.

However, there remain ongoing challenges, including rising demand for mental health and neurodevelopmental services, with significant waiting list pressures, particularly for autism and ADHD pathways. Workforce pressures, organisational change and financial constraints also impacted delivery, alongside variability in performance across providers and services. Community service demand continues to grow faster than capacity.

Overall, the system has made meaningful progress in shifting towards a more preventative, community-focused model of care, but further work is required to match capacity to demand and deliver consistent outcomes across all services.

Financial Performance: NHS Cheshire and Merseyside delivered a surplus of £30,000 for the year to 31 March 2026 against its spending allocation.

NHS Cheshire and Merseyside has a number of financial duties under the NHS Act 2006 (as amended). For the year to 31 March 2026, NHS Cheshire and Merseyside achieved its financial duties as outlined in Table 2.

Table 2

Duty	Achieved
Expenditure not to exceed income	Yes
Revenue resource use does not exceed the amount specified in Directions	Yes
Revenue administration resource use does not exceed the amount specified in Directions	Yes

NHS Cheshire and Merseyside met its statutory duties but did not meet the financial targets set out in its plan - which anticipated a higher surplus. In response to the organisation's NHS England enforcement undertakings, a system-wide recovery programme is underway, including a revised 2026-27 Financial Plan, strengthened financial governance and controls, enhanced oversight and external support to support financial recovery and sustainable improvement.

1.1.4 Key issues and risks

The key issues, both locally and nationally, which impacted on NHS Cheshire and Merseyside in 2025-26, are summarised below - along with actions being taken to mitigate the impact on future delivery and performance:

- During 2025-26, NHS Cheshire and Merseyside operated within a period of significant national transition, including implementation of the NHS 10-Year Plan, the Model ICB Blueprint and evolving NHS England structures. These changes affected commissioning capacity, workforce stability and the pace of transformation required across the system.
- Locally, NHS Cheshire and Merseyside faced sustained pressures relating to quality and safety in commissioned services, recovery of statutory access and

performance standards, system financial constraints, health inequalities and increasing cyber-security threats.
- A number of high-scoring operational risks further affected delivery, including delays in neurodevelopmental assessments, risks associated with women's hospital services in Liverpool, safeguarding capacity, CHC compliance and financial pressures across primary care and community pharmacy.
- NHS Cheshire and Merseyside took forward a series of mitigating actions, including: establishing a refreshed three-year Board Assurance Framework (BAF), strengthening committee oversight and risk escalation, implementing a cyber-resilience programme supported by new NHS England funding, undertaking a systemwide review of risk controls, progressing neighbourhood-based care transformation and aligning actions with 2026-27 planning priorities.

Our Board Assurance Framework holds the principal risks identified by the Board of NHS Cheshire and Merseyside as posing the most significant external and internal threats to the achievement of NHS Cheshire and Merseyside's strategic goals and continued functioning.

Progress was made in mitigating these risks during 2025-26, but continued action will be required over a number of years to reduce some of these risks to an acceptable level.

The BAF identifies eight principal risks aligned to the statutory purposes of an Integrated Care Board. The most significant risks in 2025-26 were:

- **Quality and Safety Failures in Commissioned Services (P4)** – reflecting pressures in service quality and the shift to community-based models. Mitigations include strengthened quality oversight, enhanced assurance processes and targeted improvement actions.
- **Financial Sustainability and Productivity (P13)** – driven by national efficiency requirements and system cost pressures. Mitigations include strengthened financial oversight, productivity programmes and prioritised investment in prevention and digital transformation.
- **Recovery of Access and Performance Standards (P14)** – with continuing risks across elective, urgent and cancer pathways. Mitigations include performance recovery plans, provider collaboration and enhanced committee scrutiny.
- **Digital and Cyber Resilience Gaps (P11)** – reflecting heightened cyber threats. Mitigations include a systemwide cyber strategy, new revenue funding, and development of a shared cyber team.
- **Health Inequalities and Population Health (P12)** – with risks around delivering measurable improvement for deprived communities. Mitigations include alignment with All Together Fairer, prevention priorities and targeted commissioning.
- **Shift to Neighbourhood and Community-Based Care (P16)** – mitigated through transformation programmes, integrated planning and development of neighbourhood models.
- **Workforce Capacity, Capability and Morale (P17)** – linked to organisational change and capability requirements. Mitigations include leadership development, workforce planning and change support.

- **System Fragmentation and Provider Sustainability (P15)** – mitigated through provider collaboration, revised commissioning models and work on future risk-sharing approaches.

NHS Cheshire and Merseyside continues to monitor these risks through quarterly BAF reporting, committee assurance processes and structured deep-dives, ensuring effective oversight and alignment with strategic and operational plans.

1.2 Performance analysis

There are a number of indicators that we monitor throughout the year to assess the performance of services and quality of patient outcomes in Cheshire and Merseyside. This work is guided by:

- the NHS Constitution - This sets out what patients have a right to expect from their local health and care services, but also what their responsibilities are to look after themselves.
- the NHS Oversight Framework 2025-26 - This sets out a single, transparent approach for assessing both integrated care boards (ICBs) and NHS providers, but it applies to them in different ways. For ICBs, the framework focuses on their role as strategic commissioners and on supporting a year of transition, meaning they will not receive a formal segment rating in 2025-26 due to ongoing restructuring and implementation of the Model ICB Blueprint. Oversight for ICBs instead concentrates on ensuring safe delivery of their transformation plans and meeting national priorities, without applying the segmentation methodology used for providers. In contrast, providers (NHS trusts and foundation trusts) are fully assessed and segmented using a defined set of operational metrics, with segmentation results expected annually. Providers are placed into segments based on performance—now across up to five segments—and are subject to a financial override that prevents organisations in deficit from achieving higher than segment 3. This segmentation determines the level of support, scrutiny, and potential regulatory intervention they receive from NHS England.
- delivering against the Cheshire and Merseyside Joint Forward Plan
- the NHS Operational Plan - This sets out the main areas Integrated Care Boards must plan for over the coming year. This includes specifying targets against which measurement will take place.
- quality standards and ensuring continuous improvement in the quality of services.

This performance analysis focuses on NHS Cheshire and Merseyside's performance against key constitutional standards and operational planning metrics over the year, covering how we measure progress, implement our Annual Business Plan, fulfil statutory duties and manage finances.

Wider examples of good practice and key delivery achievements are highlighted within case studies throughout the report.

1.2.1 How performance is measured

Integrated Care Boards are responsible for arranging health services and overseeing NHS services within their areas. The NHS Oversight Framework 2025-26 helps Integrated Care Boards and NHS England work together on oversight, considering

local needs and priorities - setting out a standardised scoring, ranking, and segmentation method for NHS providers. The purpose is to create a comparative league table for each type of provider (acute, mental health, community, ambulance) and assign each organisation to a segment (1–5) based on relative performance.

NHS Trusts are categorised segments according to their support needs as follows (based on Q2 segmentation):

- Segment 1 – High performing: Providers operating well with strong delivery against priorities and minimal need for support. 5 of 16 providers in Cheshire and Merseyside are in this segment.
- Segment 2 – Performing with some concerns: Generally stable performance but with some areas requiring targeted support to stay on track. This applies to one provider.
- Segment 3 – Significant concerns: Providers facing notable operational or financial challenges; those in deficit cannot be rated above this segment. This applies to 3 providers.
- Segment 4 – Major concerns / intensive support: Providers experiencing substantial issues needing intensive scrutiny and intervention from NHS England. This applies to 7 providers.
- Segment 5 – Most in need of support: The highest level of concern, identifying organisations requiring the most intensive improvement support. No Cheshire and Merseyside providers are in this segment.

Providers in segments one and two are overseen via regular contract, quality and performance arrangements, while segment three and four NHS Trusts are supported through more detailed oversight of key performance areas, with a focus on improvement plans and tailored support.

Table 3 sets out the current segmentation and ranking for Cheshire and Merseyside Trusts:

Table 3 – Acute and Specialist Trusts

Trust	Published Ratings			Published Rankings		
	Q1	Q2	Q3	Q1	Q2	Q3
Liverpool Heart & Chest NHSFT	1	1	1	4/134	3/134	**5/134**
The Clatterbridge Cancer Centre NHSFT	1	1	1	8/134	9/134	**7/134**
The Walton Centre NHSFT	1	1	1	7/134	5/134	**13/134**
Alder Hey Children's Hospital NHSFT	1	1	1	16/134	10/134	**14/134**
Mersey and West Lancashire Teaching Hospitals NHSFT	3	3	3	56/134	51/134	**83/134**
Liverpool Women's NHSFT	3	4	**3**	68/134	109/134	**93/134**
Warrington and Halton Teaching Hospitals NHSFT	4	4	4	118/134	125/134	**106/134**
Liverpool University Hospitals NHSFT	4	4	4	116/134	111/134	**113/134**
Mid Cheshire Hospitals NHSFT	3	4	4	96/134	115/134	**118/134**
East Cheshire NHS Trust	3	4	4	99/134	119/134	**122/134**
Countess of Chester NHSFT	4	4	4	133/134	132/134	**122/134**
Wirral University Teaching Hospital NHSFT	4	4	4	107/134	110/134	**124/134**

Table 4 – Non-Acute Trusts

Trust	Published Ratings			Published Rankings		
	Q1	Q2	Q3	Q1	Q2	Q3
Wirral Community Health and Care NHSFT	1	1	1	12/61	9/61	**9/61**
Mersey Care NHSFT	2	2	2	25/61	22/61	**24/61**
Bridgewater Community Healthcare NHSFT	3	3	3	39/61	30/61	**36/61**
Cheshire and Wirral Partnership NHSFT	4	3	3	49/61	44/61	**48/61**

Note: Green text indicates an improvement in rating/ranking between Q2 & Q3, Red text indicates a deterioration.

1.2.2 Performance monitoring systems and processes

NHS Cheshire and Merseyside has a Quality and Performance Committee to:

- review integrated performance reports - focusing on quality, safety, patient experience and outcomes.
- monitor contract quality performance monthly.
- identify and review significant Key Performance Indicator (KPI) variations and management actions.

- quantify contract over/under-performance in financial and activity terms.
- benchmark recovery plans and report underperformance.
- oversee procurements and major service changes, ensuring quality, safety, and compliance with legal requirements.

The Board of NHS Cheshire and Merseyside also receives an Integrated Performance Report at each of its meetings on key metrics from the 2025-26 operational plans, including urgent care, planned care, diagnostics, cancer care, mental health, learning disabilities, continuing healthcare, health inequalities, quality, workforce and finance. These reports summarise issues, impacts and mitigations.

Programmes in the Annual Business Plan focus on key outcomes, using a robust management approach aligned with the Board Assurance Framework for progress reporting.

Over the past year, NHS Cheshire and Merseyside has worked closely with the Cheshire and Merseyside Health and Care Partnership, alongside local authorities, NHS providers, primary care, and the voluntary, community, faith and social enterprise (VCFSE) sector, to take forward the ambitions of *All Together Fairer: Our Health and Care Partnership Plan*, the NHS Joint Forward Plan and the NHS Delivery Plan.

This collaborative approach has ensured shared progress on addressing the wider determinants of health, tackling inequalities and shifting the system's focus towards prevention and early intervention. Partnership efforts have increasingly centred on neighbourhood-level integration, co-design with communities and aligning system resources to where they deliver the greatest benefit - particularly for groups who experience the poorest health access, experience and outcomes.

Through joint programmes on work and health, anchor institution commitments around housing and health, and sustainability, NHS Cheshire and Merseyside has contributed to a co-ordinated, system-level response to improving population wellbeing and narrowing inequalities.

During the year, NHS Cheshire and Merseyside has also made significant progress in developing and strengthening its strategic commissioning role. Guided by the NHS Operating Model, the Model ICB Blueprint and the NHS Strategic Commissioning Framework, the organisation has begun transitioning towards a more mature strategic commissioner, acting as system convenor, architect and steward. This has involved developing a new operating model, clarifying roles and responsibilities, strengthening governance and building analytical, commissioning and contracting capability.

NHS Cheshire and Merseyside has increasingly applied population-health insights, integrated needs assessment and data-driven prioritisation to inform long-term planning, pathway redesign and resource allocation. This has supported the development of a five-year Clinical and Strategic Commissioning Plan focused on the "three shifts": hospital to community, sickness to prevention, and analogue to digital.

Key developments have included the growth of provider collaboratives, early work on integrated health organisation models, new outcomes-based commissioning

approaches and investment in neighbourhood health as the foundation for future care models.

1.2.3 Performance Metrics 2025-26

The key performance metrics for NHS Cheshire and Merseyside, together with targets and regional and national comparators are set out in Table 5. The following sections provide further explanation of our performance and achievements, the extent to which we achieved our objectives in 2025-2026 and the further action we will take.

Table 5 Performance Metrics 2025-2026

(updated on 02.06.26 to reflect end of year positions)

Category	Metric	Latest period	Latest Performance	Local Trajectory	National Target	Region value	National value	Latest Rank
Urgent care	4-hour A&E waiting time (% waiting less than 4 hours)	Mar-26	73.8%	78.2%	**78%** by Year end	75.0%	77.1%	29/42
	Ambulance category 2 mean response time	Mar-26	00:30:05	-	**00:30:00**	00:24:36	00:26:27	30/42
	Mean Ambulance Handover time (ED and Non ED)	Mar-26	00:32:41	00:28:20	**00:15:00**	00:26:06	00:25:48	29/42
	A&E 12 hour waits from arrival (Type 1 & 2)	Mar-26	16.3%	15.6%	-	12.3%	9.0%	41/42
	Adult G&A bed occupancy (all acutes)	Mar-26	95.7%	94.9%*	**92.0%**	95.1%	94.8%	25/42
	Percentage of beds occupied by patients no longer meeting the criteria to reside (Rolling 7-day average last week of month)	Mar-26	20.2%	17.2%	-	n/a	n/a	-
	Discharges - Average delay (exclude zero delay)	Mar-26	8.9	9.0		7.4	6.2	39/42
	Percentage of patients discharged on discharge ready date	Mar-26	86.0%	86.7%		86.1%	85.3%	20/42
Planned care	Total incomplete Referral to Treatment (RTT) pathways	Mar-26	328547	334,989	-	963,778	7,014,879	-
	The % of people waiting less than 18 weeks on the waiting list (RTT)	Mar-26	64.5%	62.9%	**92.0%**	64.6%	65.3%	25/42
	The % of people waiting more than 52 weeks on the waiting list (RTT)	Mar-26	1.1%	1.0%		1.3%	1.3%	25/42
	Number of 52+ week RTT waits, of which children under 18 years.	Mar-26	501	560	-	n/a	n/a	-
	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Mar-26	36	-	**0 by Sept 2024**	107	4,302	
	Patients waiting more than 6 weeks for a diagnostic test	Mar-26	9.8%	5.0%	**5.0%**	12.7%	21.2%	3/42
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Mar-26	79.9%	75.0%	**85.0%**	77.4%	72.7%	4/42
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Mar-26	95.7%	96.0%	**96.0%**	95.8%	92.8%	12/42
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Mar-26	81.2%	80.0%	**77%** by Year end	80.7%	79.4%	18/42
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028. (Rolling 12 months)	Jan-26	59.1%	70.0%	**75% by 2028**	58.8%	59.2%	24/42

Category	Metric	Latest period	Latest Performance	Local Trajectory	National Target	Region value	National value	Latest Rank
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Mar-26	86%	**70.0%**	**70.0%**	88.0%	85.0%	**26/42**
	Virtual Wards Utilisation	Mar-26	82.4%	**80.0%**	**80.0%**	69.9%	83.5%	**18/42**
	Community Services Waiting List (Adults)	Mar-26	63,365			118,703	892,435	-
	Community services Waiting List (CYP)	Mar-26	25,464			47,287	321,817	-
	Community Services – Adults waiting over 52 weeks	Mar-26	100	**0**		460	7,502	-
Mental Health	Referrals on the Early Intervention in Psychosis (EIP) pathway seen in 2 weeks	Mar-26	78.0%	**60.0%**	**60.0%**	59.0%	72.3%	**24/42**
	People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months	to Mar-26	59.0%	-	**60.0%**	63.0%	65.0%	**32/42**
	Dementia Diagnosis Rate	Mar-26	68.3%	**66.7%**	**66.7%**	70.3%	66.3%	**16/42**
	CYP Eating Disorders Routine	Mar-26	80.0%	**95.0%**	**95.0%**	75.0%	80.4%	**3/42**
	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact	Mar-26	38,260	**37246**	-	129060	879955	-
	Number of people accessing specialist Community PMH and MMHS services	Mar-26	3,810	**3420**	-	8825	67146	-
	Talking Therapies 1st to 2nd Treatment >90 days	Mar-26	18.00%	-	**10%**	30%	23.6%	**6/42**
	Talking Therapies completing a course of treatment - % of plan achieved	Mar-26	102.0%	**100.0%**	**100.0%**	99.0%	96.0%	**18/42**
	Talking Therapies Reliable Recovery	Mar-26	47.0%	**48.0%**	**48.0%**	45.0%	48.4%	**25/42**
	Talking Therapies Reliable Improvement	Mar-26	68.0%	**67.0%**	**67.0%**	67.0%	68.7%	**26/42**
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Mar-26	75	**46**	-	240	1,900	**13/42**
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Mar 26 YTD	80.5%	**60.0%**	**75%** by Year end	82.0%	79.8%	**20/42**

Category	Metric	Latest period	Latest Performance	Local Trajectory	National Target	Region value	National value	Latest Rank
Primary Care	Units of dental activity delivered as a proportion of all units of dental activity contracted	Mar-26	90.0%	80.0%	100.0%	91.0%	89.0%	18/44
	Number of unique patients seen by an NHS Dentist – Adults (24 month)	Mar-26	954,250	950,302		2,688,288	18,368,383	-
	Number of unique patients seen by an NHS Dentist – Children (12 month)	Mar-26	342,405	346,638		1,054,133	7,373,012	-
	Appointments in General Practice & Primary Care networks	Mar 26 YTD	1,450,671	1,404,738		-	-	-
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care. (rolling 12 months)	Feb-26	7.43%	10.0%	10.0%	-	7.62% (Dec 24)	-
	Total volume of antibiotic prescribing in primary care	Feb-26	0.90	0.871	0.871	-	1.00	-
Integrated care - BCF metrics	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (average of place rates)	Dec-25	188	-	-	-	198.8	-
	Percentage of people who are discharged from acute hospital to their usual place of residence	Dec-25	80.9%	-	-	-	80.2%	-
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 (average of place rates)	Oct-25	145	-	-	-	133.8	-
Specialised Commissioning	Cardiac Treatment waiting list (LH&CH)	Mar-26	369	376				-
	Neurosurgery waiting list (TWC)	Mar-26	915	967				-
	Specialised Paediatrics waiting list (AHCH)	Mar-26	225	248				-
	Vascular waiting list (LUFT)	Mar-26	198	180				-
Health Inequalities & Improvement	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q3 25/26	67.8%	77.0%	80.0%	69.14%	69.5%	35/42
	CVD treated to cholesterol threshold LDL-cholesterol less than or equal to 2.0 mmol/l or non-HDL cholesterol less than or equal to 2.6 mmol/l)	Q3 25/26	48.2%		50.0%	49.9%	50.63%	32/42
	Smoking at Time of Delivery V2	Q3 25/26	5.4%	-	6.0%	5.4%	4.70%	31/42
	Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems. (Aged 15+)	Mar-26	16.1%	12.0%	12.0%	-	12.7%^	-

Category	Metric	Latest period	Latest Performance	Local Trajectory	National Target	Region value	National value	Latest Rank
Continuing Healthcare	Standard Referrals completed within 28 days	Q4 25/26	57.9%	80.0%	>80%	74.5%	74.2%	35/42
	Number eligible for Fast Track CHC per 50,000 population (snapshot at end of quarter)	Q4 25/26	31.29	18.00		23.69	17.20	42/42
	Number eligible for standard CHC per 50,000 population (snapshot at end of quarter)	Q4 25/26	50.77	34.00		43.40	32.49	40/42
Maternity	HIE (Hypoxic ischemic encephalopathy) grade 2 or 3 per 1,000 live births (>=37 weeks)	Q4 25/26	0.3	2.5	2.5	0.8		
	Still birth per 1,000 (rolling 12 months) (GP Reg MSDS)	Feb-26	2.39	-	2.6*	-	3.7	-
Quality & Safety	Healthcare Acquired Infections: Clostridium Difficile - Place aggregation (All cases)	12 months to Mar 26	1074	843		2906	17111	
	Healthcare Acquired Infections: E.Coli Place aggregation (All cases)	12 months to Mar 26	2433	2001		6008	44854	
	Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation	12 months to Dec 25	1.007	0.887 to 1.127 *	-	1.000	-	
	Never Events	Mar-26	29	0	0	-	-	-
Workforce / HR (ICS total)	Staff in post	Mar-26	74,326	72,773	-			
	Bank	Mar-26	5,159	4,015	-			
	Agency	Mar-26	460	598.0	-			
	Turnover	Feb-26	9.5%	11.2%	-			
	Sickness	Jan-26	6.2%	5.8%	-			

1.2.3.1 Urgent and emergency care

Urgent and Emergency Care (UEC) services across Cheshire and Merseyside operated under sustained pressure throughout 2025-26, driven by high demand, workforce challenges and pressures in hospital flow. Demand increased further over winter, in line with national trends, due to respiratory illness, flu and a seasonal increase in the number of people needing urgent care.

Despite these challenges, the system demonstrated improved resilience and co-ordination. There were measurable improvements in ambulance performance, alongside more stable services. Importantly, this year marked a shift from a reactive approach to demand management towards a more strategic focus on reducing and redirecting demand - in line with the 10-Year Health Plan and local UEC strategy.

Ambulance performance improved compared to the previous year, with Category 2 response times showing fewer extreme peaks and greater overall stability. While performance remained above the national standard, ambulance handover delays reduced, with fewer patients waiting more than 45 minutes. Average handover times also improved, evidencing better system co-ordination.

The four-hour A&E waiting times saw a modest improvement, particularly towards year end, but continued to vary across providers. Encouragingly, paediatric performance showed a shorter seasonal dip and quicker recovery. However, 12-hour waits increased slightly, particularly in January 2026, reflecting a sustained period of pressure across the system.

Corridor care reduced in severity but remains an area of concern. The ICB maintains a clear system-wide position that corridor care is not acceptable as routine practice and should only ever be used as a last resort during periods of exceptional operational pressure. During 2025-26, the system strengthened escalation processes through the NHS Cheshire and Merseyside's System Co-ordination Centre (SCC); embedding real-time oversight of Emergency Department pressures, ambulance handover delays, bed occupancy and long waits to support earlier intervention and mutual aid across providers.

Acute providers implemented a range of flow and safety measures to reduce the risk and duration of corridor care, including enhanced site escalation, executive oversight, frequent operational huddles, improved discharge coordination, use of Fit2Sit principles, and strengthened ambulance handover processes aligned to the HO45 programme. Monitoring of corridor care was incorporated into daily operational assurance arrangements, alongside review of 12-hour waits, ambulance handovers and OPEL escalation status, enabling targeted support to organisations experiencing sustained pressure.

While periods of significant operational challenge remained, particularly during winter surge periods, the severity and visibility of corridor care reduced in a number of organisations compared to previous years, supported by stronger system coordination and a continued focus on patient safety and flow.

Patients' journey through our hospitals continues to be the primary challenge, with bed occupancy consistently above the 92% target and a high proportion of patients remaining in hospital despite being medically fit for discharge. These factors

contribute to emergency department crowding, ambulance delays and impact on patient experience.

A comprehensive demand management programme has been developed to support the shift towards increasingly proactive demand management. This included the introduction of digital streaming tools in emergency departments, enabling patients with less urgent needs to be redirected to more appropriate services.

The system has also established Single Points of Access (SPOA), working alongside Urgent Community Response (UCR) services. This enables patients with less serious health conditions to be safely supported in the community, reducing the need for ambulance conveyance and hospital attendance.

There continued to be a strong focus on improving care for people living with frailty. This included the development of step-up pathways into community beds to support earlier intervention, help prevent deterioration and reduce the number of avoidable hospital admissions.

In addition, access to mental health crisis care is being strengthened via alternatives to emergency departments. This is improving access to the right support and reducing delays for people experiencing mental health crises.
Together, these initiatives represent a step-change in how the system manages demand, with a greater focus on prevention, community-based care and sustainability.

Despite the seasonal challenges, there were fewer sudden spikes in pressure than we would usually expect over winter. Early evidence from frailty and community-based models showed positive impact, including reduced hospital admissions and improved patient outcomes, which provides a strong foundation for continued transformation.

Looking ahead, Cheshire and Merseyside will build on this progress by focusing on a number of key priorities for 2026-27.

These include continuing to shift care closer to home through demand management and community-based services, establishing neighbourhoods as the front door for urgent care and improving flow through hospitals by reducing long waits and embedding discharge as a routine, seven-day process.

There will be a continued focus on providing consistent, joined-up care for people living with frailty, alongside strengthening urgent care services for people with mental health needs and for children and young people.

These priorities align with both national policy and our local system strategy and will support more sustainable improvement across urgent and emergency care.

Case Study – Clinical Assessment Service (CAS)

The Clinical Assessment Service (CAS) provides enhanced clinical triage for Category 3 and 4 patients following a 111 or 999 call. By using the expertise within Urgent Community Response (UCR) teams, patients are directed to the most appropriate care setting - helping to reduce unnecessary ambulance conveyances to emergency departments.

Referrals are sent electronically for review by experienced community nurse clinicians. Patients may receive a UCR visit, be referred to community services, directed to an urgent treatment centre, or supported with alternative transport. Where acute assessment or diagnostics are needed, cases are returned to ambulance services.

Launched in phases between October and December 2025, the service has shown significant early impact. By January 2026, 26.02% of referrals were managed through 'hear and treat', avoiding emergency department attendance, compared to a year-to-date figure of 16.2%. The programme is now moving into its next phase, focusing on strengthening triage, staffing, referral pathways and governance.

Case Study – Urgent and Emergency Care and Ageing Well in Cheshire West

Cheshire West's five Community Response Hubs became fully operational in 2025-26, bringing together health, social care and voluntary sector partners to support early discharge, rehabilitation and avoid hospital admissions. Dementia services were strengthened through a newly commissioned Dementia Nurse, improving hospital support, piloting delirium recovery beds and expanding community support for newly-diagnosed patients.

The Single Point of Access has been highly effective in managing Category 3 and 4 calls, reducing pressure on emergency services. Frailty scoring has been introduced across all GP practices, enabling earlier identification of at-risk patients and supporting co-ordinated care planning through multidisciplinary teams, while a new Cheshire West Frailty Group is driving a shared approach to reducing risks, preventing admissions and helping older people maintain independence and enjoy healthier ageing.

1.2.3.2 Planned care

In 2025-26 there has been significant collaboration to improve experiences and outcomes for those receiving planned care - led by Cheshire and Merseyside Provider Collaborative (CMPC), which consists of all 15 NHS provider Trusts in Cheshire and Merseyside.

This has resulted in substantial performance improvements and measurable benefits across both the planned care agenda and the system as a whole.

Elective performance

Pathway interventions and a considerable reduction in waiting times have improved patient experience, with the number of patients waiting 65 weeks or more decreasing from 990 in April 2025 to just 36 in March 2026. Those waiting 52 weeks or more also reduced significantly from 3.5% of the total waiting list in April 2025 to 1.1% in March 2026, narrowly missing the national ambition of 1.0%.

In addition, system performance against the 18-week Referral to Treatment (RTT) standard increased from 58.0% in April 2025 to 64.5% in March 2026, exceeding our target for 2025-26.

In dermatology, major clinical and financial benefits have been realised through the rollout of Derm AI technology, supported by £1m of national funding. Six Trusts are now live, five of which are operating autonomously.

In 2025, 29% of Urgent Suspected Skin Cancer referrals were safely discharged via the AI pathway, avoiding 4,640 face-to-face appointments. A pilot also generated significant efficiencies from reduced outpatient and biopsy activity. This success has led to a three-year contract extension, embedding AI-led dermatology as a core component of future service delivery.

In ophthalmology, a Single Point of Access model piloted across five local authority footprints contributed to the avoidance of approximately 1,600 outpatient appointments, supporting more efficient use of secondary care capacity. Clinical triage identified that 4.7% of referrals did not require onward referral, with a further 4.4% appropriately redirected into existing primary care services. Following this success, in November 2025 this pilot expanded to cover the full Cheshire and Merseyside footprint, with a procurement process underway for the longer term.

Diagnostics

95% of all patient pathways require a diagnostic test, so it is absolutely imperative that we work to diagnose people quickly so they can start on the correct treatment as soon as possible.

Cheshire and Merseyside Provider Collaborative's Diagnostics Programme is a critical enabler for regional and Trust-level performance - helping patients to wait less time for their diagnostic tests.

At year end, 90.2% of patients received a diagnostic test within in six weeks, ranking the third best performing system in England. NHS Cheshire and Merseyside were consistently in the top five performing systems throughout 2025-26.

Notable achievements include:

- NHS Cheshire and Merseyside secured the capital funding to build and open an Endoscopy Hub. The Halton Endoscopy Hub has been built and staffed to provide additional system capacity to those who require a colonoscopy, a flexible sigmoidoscopy or a gastroscopy. The Endoscopy Hub is being used to see

patients who require regular checks to prevent cancer and to ensure that waiting times across the system remain as low and equitable as possible.

- Performance for sleep study tests has seen the percentage of patient seen within six weeks increase from 76% in December 2024 to 96% December 2025, with NHS Cheshire and Merseyside now ranking as the best performing system in England. This has been made possible by introducing a standard approach, including home sleep study kits, which allow patients to be monitored at home instead of staying in hospital for tests.
- Advanced Acceleration Technology has been installed on 11 MRI scanners resulting in each scan taking less time. This technology has allowed an additional 5830 scans to be completed each year with no additional kit or staff.
- All NHS Trusts in Cheshire and Merseyside are working together through a mutual aid approach. If another hospital or diagnostic centre has a shorter waiting time, patients are offered the option to be seen sooner at a different location. So far, over 1,500 patients have benefited from earlier access to tests.
- Due to the use of advanced data sources, we can now see the proportion of patients with and without an appointment date. This enables appointment dates to be brought forward where possible and helps identify pressures and opportunities across sites where organisations operate multiple locations.

Waiting times for paediatric audiology remain a challenge, with patients in some trusts facing long waits. To help improve this, funding has been secured to install further audiology test facilities in a number of community settings across Cheshire and Merseyside and plans are in place to reduce the number of appointments that are lost when a patient does not attend.

Waiting times for echocardiography continue to be a challenge due to staffing shortages and high referral rates. To address this, work is underway with Trusts to increase productivity. The use of AI is also being piloted at Mersey and West Lancashire Teaching Hospitals NHS Trust, which is expected to reduce the time required for each test and allow more patients to be seen within existing clinics.

Case Study – CDCs reach one million milestone

The Cheshire and Merseyside Diagnostic Programme, part of the Cheshire and Merseyside Provider Collaborative (CMPC), has hit a major milestone in their Community Diagnostic Centre (CDC) programme by welcoming the millionth patient to receive a test in one of the 10 CDCs in Cheshire and Merseyside.

David Titchfield, from Lymm, was the millionth patient to be treated at a CDC in Cheshire and Merseyside after he attended the Warrington and Halton Diagnostics Centre on Monday 16 June.

David visited the centre for an MRI scan after going to his GP with prostate concerns. The new facility meant he was seen within 10 days of the referral, helping to provide him with an earlier diagnosis and treatment, if needed.
When asked about his experience, he said: *“I can’t thank the NHS enough. It was my first time at the new facility, and it immediately strikes you as very modern, well-equipped, and with very good staff. Everybody that I’ve dealt with has been very caring, considerate and extremely efficient.”*

Case study – Regional Sleep Service

The Aintree Regional Sleep Service expanded its offer by partnering with new community diagnostic centres, increasing access to sleep services across Cheshire and Merseyside. This responded to rising demand, with referrals for sleep studies increasing by 47% in one year.

New community-based diagnostic locations, including Paddington Community Diagnostic Centre and Liverpool Women's Hospital Community Diagnostic Centre, enabled more patients to access testing closer to home. The introduction of home-based sleep studies and improved digital systems helped ensure patients were directed to the most convenient location, improving both access and patient experience.

As a result, around half of all sleep diagnostics are now delivered in community settings, helping to reduce waiting times and support earlier diagnosis. The service has contributed to some of the shortest waiting times for sleep studies nationally, demonstrating the impact of shifting care closer to home and increasing diagnostic capacity.

1.2.3.3 Cancer

NHS Cheshire and Merseyside worked with the Cheshire and Merseyside Cancer Alliance throughout 2025-26 to support providers to deliver for our population against the ambitions of the 10-Year Health plan for England published in June 2025, and the National Cancer Plan for England, published in February 2026.

The Cheshire and Merseyside Cancer Alliance has focussed on performance improvement through 2025-26, in particular working to achieve the Faster Diagnosis Standard of 80% of patients diagnosed or ruled out for cancer in 28 days by the end of March 2026.

The Cancer Alliance supported providers to improve cancer standards through monthly Performance Forums focused on constructive dialogue and continuous improvement, alongside targeted funding to support pathway transformation.

The alliance has continued to lead the rollout of the Lung Cancer Screening Programme which makes a significant contribution to earlier diagnosis. The alliance has also continued to work to support NHS England's Supportive and Assistive ACCEND programme.

Programmes of work undertaken in 2025-26 include:

- Genomics
- Health inequalities and patient experience
- Innovation
- Living with and beyond cancer including Personalised care
- Lung Cancer Screening
- Pathway improvement

- Primary care
- Screening
- Timely presentation including campaigns and community engagement
- Treatment variation
- Urgent cancer care
- Workforce and education.

In addition, the alliance continues to work alongside the Cheshire and Merseyside Diagnostic Network, in recognition of the strong links between diagnostics and cancer pathways.

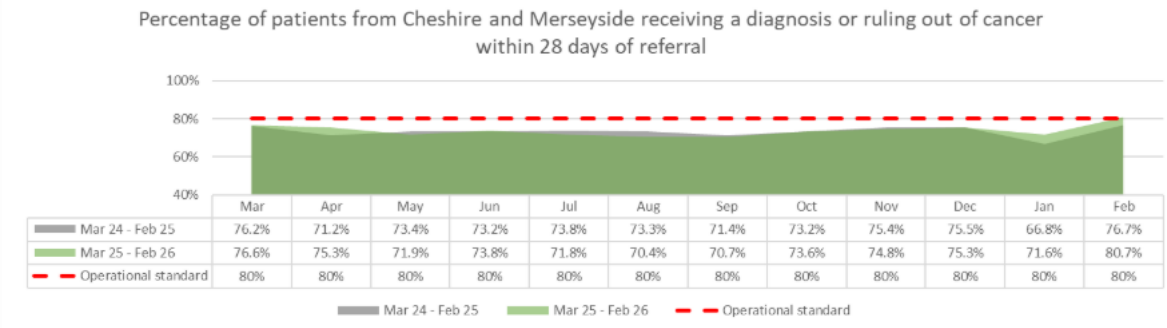
The focal delivery objectives for performance in year have been the headline constitutional standards:

Maximum 28 days from: Receipt of urgent referral for suspected cancer, receipt of urgent referral from a cancer screening programme (breast, bowel, cervical), and receipt of urgent referral of any patient with breast symptoms (where cancer not suspected), to the date the patient is informed of a diagnosis or ruling out of cancer	77% (rising to 80% by the end of 25/26)
Maximum two months (62 days) from: From receipt of an urgent GP (or other referrer) referral for urgent suspected cancer or breast symptomatic referral, or urgent screening referral or consultant upgrade to First Definitive Treatment of cancer 85%	85%
Maximum one month (31 days) from: From 'Decision to Treat'/Earliest Clinically Appropriate Date to Treatment of cancer	96%

Throughout the year, Cheshire and Merseyside has performed well against constitutional standards. In March 2026 28-day Faster Diagnosis Standard of 77% was exceeded, ending on 81.2%. On the 62-day standard, progress was made towards the 85% NHS Constitution standard, with the ICB exceeding its nationally set target of 75% with 79.9% in March 2026. On the 31-day standard the national target of 96% was narrowly missed at 95.7%.

A comparison of treatment activity in the 12 months to December 2025 showed a slight reduction compared to the previous 12-month period, however growth of 4% was seen against Systemic Anti-Cancer Therapies - including chemotherapy.

The trend in performance for Faster Diagnosis Standard is shown below:



Survival rates are higher in most cancer types when cancer is found at an early stage. Diagnosing cancer earlier is central to improving outcomes and delivering the National Cancer Plan's ambition to improve survival, with an aim to increase the proportion of cancers diagnosed at stage 1 and 2 by at least 20 percentage points above the 2019 level by 2035.

Cancer Research UK highlight that people from more deprived areas are more likely to be diagnosed with cancer via emergency presentation, compared to people from less deprived areas. People diagnosed with cancer via emergency presentation are more likely to be diagnosed at a late stage and have poorer outcomes. More than a third of Cheshire and Merseyside's population live in the top 20% most deprived areas in England and are therefore more likely to de diagnosed with cancer at a late stage.

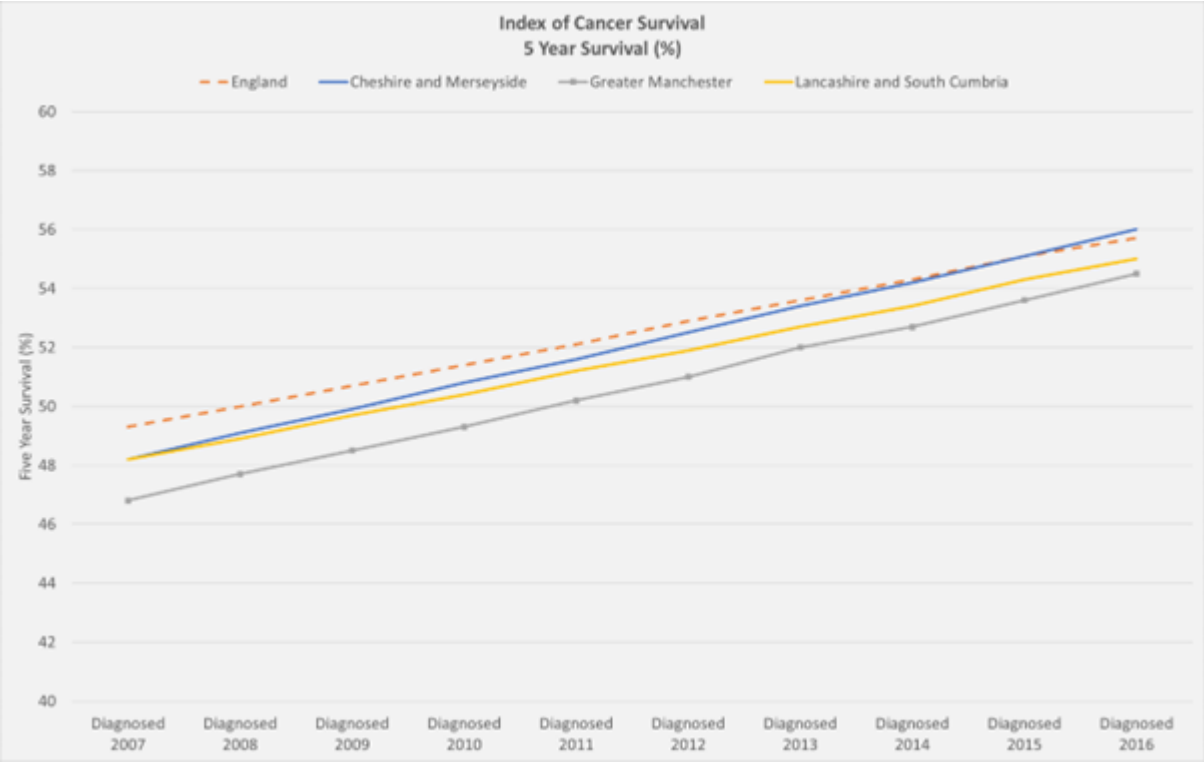
It is also recognised that cancer incidence is higher in more deprived areas. In real terms, this means that for the 890,000 people living in 20% most deprived areas of Cheshire and Merseyside, they are both more likely to develop cancer in their lifetime and more likely to be diagnosed at a later stage. By improving rates of early diagnosis in these areas, Cheshire and Merseyside Cancer Alliance can directly improve outcomes for people diagnosed with cancer.

NHS England's CORE20PLUS5 approach is aimed at reducing health inequalities experienced by those populations, with specific reference to the early diagnosis of cancer. Reducing health inequalities is integral to Cheshire and Merseyside Cancer Alliance's strategy - including using an intelligence-led approach to target early diagnosis and timely presentation work in areas of greatest need.

117,000 people in Cheshire and Merseyside are living with or beyond a diagnosis of cancer. This means that, for every 1,000 people living in Cheshire and Merseyside, 46 will have experienced a diagnosis of cancer. Around 17,000 new cancer diagnoses are recorded each year for Cheshire and Merseyside patients.

Between 2019 and 2024, the proportion of early diagnoses in Cheshire and Merseyside increased from 54.2% to 59.3%, meaning early diagnosis rates in Cheshire and Merseyside have improved from significantly below the England average in 2019, to slightly higher than the England average in 2024.

People in Cheshire and Merseyside are also living longer after a cancer diagnosis than ever before and surviving longer than the England average for the first time. Statistics show that patients in Cheshire and Merseyside are now surviving cancer for more than five years at a higher rate than the England average, despite proportionally more people in Cheshire and Merseyside being diagnosed with cancer than most areas of the country.



Data published in 2025 also showed that one-year survival in Cheshire and Merseyside was above the England average too.

Case Study – New service brings chemo to child patients in Cheshire and Merseyside

A new children's cancer service was launched across Cheshire and Merseyside, delivering chemotherapy and supportive care closer to home. Led by Alder Hey Children's NHS Foundation Trust and partners, the model enables specially trained nurses to provide treatment in patients' homes, reducing the need for hospital visits.

The service was developed in response to the significant travel burden faced by families, with children often travelling long distances to access specialist care. By bringing treatment into the community, the programme reduces disruption to family life, education and work, while maintaining high standards of clinical care.

As part of a wider 'Care Closer to Home' approach, the service improves access, supports better patient experience and helps address inequalities in access to specialist cancer care. Plans for a mobile treatment unit will further expand the model, enabling more children and young people to receive care in convenient community locations.

1.2.3.4 Community Services

In line with national guidance detailed within the 10-Year Health Plan to shift from hospital to community and treatment to prevention, there was significant work to enhance Cheshire and Merseyside's community services offer in 2025-26.

Nine NHS community health providers have worked in partnership through the Cheshire and Merseyside Provider Collaborative to identify and share best practice. There has been strong progress in developing urgent care services outside of hospital, helping more people get the care they need at home and reducing pressure on hospitals.

There has also been great progress in work to standardise the community services offer across Cheshire and Merseyside in line with the national guidance as part of the development of Neighbourhood Health. This has helped to ensure that residents have equal access to care and treatment options, irrespective of where they live.

Case Study: Two Cheshire and Merseyside areas become neighbourhood health 'pioneers'

Sefton and St Helens were selected as national 'neighbourhood health pioneers', recognising strong partnership working across local health and care organisations.

As part of a national programme backed by £10 million in funding, the sites are leading the development of new models of care focused on prevention and delivering services closer to home.

The programme aims to improve outcomes for people with multiple long-term conditions by providing more coordinated, community-based support, with a particular focus on reducing health inequalities in more deprived areas. Learning from Sefton and St Helens will be shared across Cheshire and Merseyside to support wider system transformation and development of neighbourhood health services.

Showcasing partnership working

Dr Minal Bakhai MBE, National Neighbourhood Health Implementation Programme Lead, visited Cheshire and Merseyside's pioneers on 15th January 2026.

During her time in St Helens, Dr Bakhai visited the St Helens South Community Hub. Opened by the council last year, the hub brings a wide range of one-to-one services together under one roof, including adult social care, housing support, affordable warmth services, NHS provision and Merseyside Police.

In Sefton, she visited the May Logan Centre, where she received an update on local priorities, progress and future ambitions. Dr Bakhai received updates on work relating to frailty, children and young people, individuals with complex lives and targeted support for people living with dementia in Netherton, as well as the shared vision for the future of neighbourhood health in Sefton.

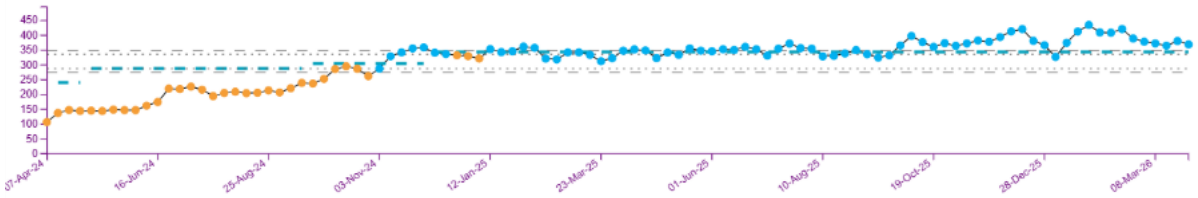
Virtual Wards

Use of virtual wards across Cheshire and Merseyside increased significantly during 2025-26, with 51% more patients receiving care at home under hospital supervision - meaning more than 5,000 more people were treated outside hospital throughout the year.

Following the transfer of leadership to the Provider Collaborative in 2024, work with local providers expanded clinical pathways, clarified roles and responsibilities and introduced improved reporting and performance monitoring. This led to stronger clinical and operational engagement, alongside the development of a health economics model which showed an average saving of £635 per patient.

Cheshire and Merseyside became the best performing system in the North West for virtual ward utilisation, with occupancy regularly exceeding 90% of capacity.

Figure 3 **Average Weekly Virtual Ward Bed Occupancy against 80% Target at All Providers**



For patients, virtual wards provide an alternative to hospital admission that maintains the same clinical oversight while avoiding many of the difficulties associated with hospital stays. Care is delivered in people's own homes, supported by daily clinical review, remote monitoring technology, escalation protocols and rapid access back into hospital if required. This enables patients to receive timely treatment without waiting for a physical bed to become available, reducing prolonged stays in emergency departments or delays on assessment units.

Patients consistently report benefits from remaining at home, including greater comfort, reduced disruption to family life, better sleep, and lower risk of hospital-acquired infections or deconditioning. This model is particularly beneficial for older people and those with long-term conditions, where avoiding unnecessary admission can support faster recovery and help maintain independence.

By maximising virtual ward capacity, the system has been able to protect inpatient beds for patients with the most acute needs, reduce avoidable admissions, and improve patient flow across urgent and emergency care pathways.

Overall, virtual wards have helped to address patient concerns about access to care in a context of constrained hospital bed capacity, providing timely, safe treatment without the need for admission, and offering a positive, more personalised experience of care.

Case study – Mrs H

"I was getting Mum up out of bed and the next minute she said, 'I don't feel right,' and fell on the floor. We phoned 999 and they sent an ambulance out.

"The ambulance team arrived and they were lovely. They said, 'We'll get the hospital at home frailty team in touch with you,' who called about an hour later and asked whether they could come out. They helped us put Mum in bed, diagnosed her with pneumonia and gave her IV antibiotics at home.

"We found it much better to keep her at home. We didn't have to get taxis back and forth to the hospital, and I think she got on a lot better at home. We had a direct number to ring in case she got worse, so we felt reassured.

"The team looked after her really well. We couldn't fault them at all. Everything they did was spot on."

Urgent Community Response

People in Cheshire and Merseyside also benefitted from ongoing improvements to the Urgent Community Response (UCR) services during 2025-26. The Urgent Community Response service is a community-provided model of care that offers an alternative to attendance at A&E. Instead, a clinician from within the community attends a patient's normal place of residence within two hours to assess and treat appropriate conditions.

The number of accepted referrals into Urgent Community Response services has increased by 26% compared to 2024-25 contributing to a reduction in ambulance conveyances.

Working with North West Ambulance Service, community teams can now receive direct referrals for people who call 999 but can be safely cared for at home. This has reduced the number of ambulance journeys to hospital by up to 67 each day. Originally established in December 2025, this Clinical Assessment Service is set to expand further in 2026-27.

The chart below (Figure 4) shows the steady increase in accepted referrals into the Urgent Community response service across all provider organisations.

Figure 4 Two-hour standard Urgent Community Response Referrals (standardised per 100K population)

Despite these improvements, there is an opportunity to expand services like Urgent Community Response and virtual wards further in 2026–27. Plans are also being considered to invest in the Clinical Assessment Service, which would help more people be cared for outside hospital and reduce pressure on beds.

Single point of access

A new single phone number for ambulance crews across Cheshire and Merseyside now helps them quickly connect with community services. This means patients can be directed to the right care - such as home treatment teams, virtual wards or urgent community response - without needing to go to hospital.

Community waiting times

During 2025–26, more people have been waiting for community services as we continue to develop and expand care closer to home. While overall numbers have increased, the number of adult patients waiting more than 52 weeks has reduced significantly due to a review of waiting lists, improvements to data quality and sharing of best practice across provider organisations.

The number of adult patients recorded as waiting more than 52 weeks for community services reduced from a peak of 613 in August 2025 to just 100 in March 2026. Waiting times of more than two weeks for some children and young people have not improved at the same pace, with more referrals being received - particularly for services affected by the COVID-19 pandemic, including autism and ADHD assessments.

Case Study – Liverpool Community Respiratory Team (CRT) Fuel poverty programme

Using an Enhanced Case Finding Tool for proactive review, the Liverpool Community Respiratory Team's fuel poverty programme worked with a wide range of stakeholders including Citizen's Advice on prescription, Healthy Homes and fuel charities to develop an effective intervention targeted at pensioners who are current or ex-smokers, live in highest quintile of deprivation, have COPD and live alone.

The pilot resulted in 74 patients with COPD having their care optimised as well as advice and direct referral as appropriate for wider support including smoking cessation, talking therapies, healthy homes and benefits / welfare advice.

1.2.3.5 Mental Health

In 2025-26, NHS Cheshire and Merseyside made progress in improving urgent and emergency care, reducing delays and improving access to services for children, young people and adults.

Our work brings together service improvements, investment in buildings and facilities and closer working between organisations to improve outcomes and experience for local people. Specifically, in 2025-26:

- **Mental Health Crisis Assessment Centres** were piloted by Cheshire and Wirral Partnership NHS Foundation Trust and Mersey Care NHS Foundation Trust providing support and treatment for more than 500 people in mental health crisis. Capital funding was approved to develop permanent Crisis Assessment Centres in Liverpool and Wirral and to refurbish Health Based Places of Safety in Knowsley and Warrington. This estate programme is on track to conclude in 2026-27.
- **Early intervention in psychosis** services consistently exceeded the national standard for timely access, ensuring people began treatment within two weeks. Early identification and treatment continued to support recovery, reduce relapse risk and improve long-term outcomes.
- The number o**f people with severe mental illness receiving a full annual physical health check** narrowly missed the national target of 60% at 59%.
- The dementia diagnosis rate exceeded the national ambition throughout 2025-26, reaching 68.3% in March 2026. A new Dementia Strategy now sets shared principles supporting prevention, earlier diagnosis and personalised care.
- Local data showed a drop in performance in Q4 due to increased demand and staff vacancies impacting on capacity for **children and young people's eating disorder services**. A new Best Practice Model for Community Eating Disorder Services was co-produced in 2025 to strengthen consistency and quality.
- Access to **children and young people's mental health services** improved, with the ICB exceeding the target. A strategic review of Mental Health Support Teams (MHSTs) in schools and colleges across Cheshire and Merseyside has been completed, assessing current coverage, activity, outcomes, and productivity. The review provides clear, data driven recommendations to guide the next phase of

expansion, ensuring growth remains evidence-led, strategically targeted and aligned with local need.

- **Talking therapy services** performed well, exceeding nationally set targets for the numbers of patients competing a course of treatment, and for reliable improvement, and only narrowly missing the target for reliable recovery. A six-week Readiness for Therapy campaign supported better engagement and outcomes.
- More people received **specialist perinatal mental health support** in 2025–26 than expected, with 3,810 women and birthing people accessing care from before pregnancy through to two years after birth, including a wider range of proven therapies.

Mental health and environmental factors

There is increasing recognition of the link between environmental factors and mental health. During 2025-26, system-wide sustainability work highlighted the impact of poor air quality, extreme weather and environmental pressures on wellbeing, particularly for more vulnerable people.

This approach is helping to shape more resilient services and communities and supports the ongoing integration of environmental factors into mental health planning and delivery.

Case Study – Perinatal Mental Health Team wins award for supporting families across Cheshire and Merseyside

The Cheshire and Merseyside Specialist Perinatal Service was named Psychiatric Team of the Year at the Royal College of Psychiatrists (RCPsych) North West Awards 2025.

The award recognised the outstanding work of the specialist service, delivered in partnership by Cheshire and Wirral Partnership NHS Foundation Trust and Mersey Care NHS Foundation Trust, to support parents, babies and families through pregnancy and the postnatal period.

The team provides compassionate, evidence-based mental health care to families, ensuring the right support is available at the right time during what can be one of life's most important – and sometimes most challenging – stages.

The award recognition coincided with the opening of Seren Lodge, a £7.5m, single-storey, eight-bed specialist Mother and Baby Unit in Chester. The unit provides compassionate inpatient care closer to home for pregnant and postnatal women experiencing severe mental ill-health across Cheshire, Merseyside and North Wales.

1.2.3.6 Learning disability and autism

Working with NHS England, NHS Cheshire and Merseyside has been working to reduce the number of people with a learning disability or autism staying in hospital

where this is not necessary. The aim was to reduce the number of inpatients to no more than 60, while ensuring that at least 75% of people with a learning disability receive an annual health check.

To support this, all areas across Cheshire and Merseyside now have a Learning Disability Intensive Support Function (ISF) - a specialist service that supports people in the community when they are in crisis.

An Autism Intensive Support Function (ISF) service for adults has also been piloted and is now in place, with plans to expand it across all areas. These services help identify people who need urgent support earlier and reduce the number of people needing to be admitted to hospital.

Meanwhile, funding has been invested across NHS Cheshire and Merseyside to address the number of adults and children waiting for an autism assessment, while regular multi-agency discharge events (MADE) also help monitor hospital admissions and support safe and timely discharges.

Table 6 summarises the position in March 2026 and the number of adult inpatients to achieve 10% and 20% reductions. This represented a significant improvement in our inpatient numbers, but the number of people diagnosed with autism is consistently increasing.

Table 6

Learning Disability and Learning Disability and Autism Adults					
	As at March 2024 (excluding S17)	**10% Reduction**	**20% Reduction**		**March 2026 (excluding S17)**
Learning Disability – Adults	57	51	46		33
Autistic Adults	35	32	28		40

In addition to the MADE meetings, the Transforming Care Programme has supported regular system calls. These are designed to ensure that all partners focus on moving people who are clinically ready for discharge to more appropriate care in the community.

A dedicated Housing Lead, supported by two housing specialists, continues to help people who are ready to leave hospital find suitable accommodation. They also track where housing is a barrier to discharge so the right support can be put in place. A Cheshire and Merseyside Housing Strategy has been developed in partnership with Housing Associations' Charitable Trust.

Funding has also been secured to build or improve specialist homes, helping ensure safe and appropriate accommodation for people with more complex learning disability and autism needs.

One of the biggest continuing issues facing Cheshire and Merseyside relates to an increase in the number of people with either suspected autism or a diagnosis of autism after being admitted to mental health beds. Many of these people have not been previously known to services so it is often difficult to find an alternative to admission.

During 2025-26, people with suspected or diagnosed autism who were admitted to adult mental health wards were identified earlier. Those needing additional support were regularly reviewed by teams across the system.

Children and Young People

A Cheshire and Merseyside Transition Policy has been developed in collaboration with Social Care that will support a better standard of transition from children's services to adult services.

Annual Health Checks

The year end position shows that Cheshire and Merseyside delivered 80.5% exceeding the target of 75% for 2025-26.

Case Study – Specialist Sensory Integration Assessment

A 15-year-old with severe learning disability and autism faced significant challenges affecting daily life at home, school and in the community. He experienced extremely high activity levels, sensory-seeking behaviours, difficulties tolerating clothing, disrupted sleep and limited ability to engage in learning or play. His needs required 2:1 support at home, placing considerable strain on his family, who reported carer burnout and concerns about safety.

A specialist sensory integration assessment provided a clearer understanding of his needs. Behaviours previously seen as "challenging" were reframed as sensory-driven, linked to differences in how he processes and responds to sensory information.

This new insight informed a more targeted, needs-led approach to care. It supported multi-agency planning, guided therapeutic interventions and provided evidence to inform decisions about appropriate support and placement. As a result, high-risk behaviours reduced, the young person is now thriving in a more suitable environment and his family feel better supported and understood.

Case Study – Tailored support package

A man in his 40s with a learning disability had spent more than 30-years in hospital, leading to significant institutionalisation.

Discharge was delayed by several factors, including frequent changes in professionals, out-of-area placements limiting local oversight and periods of limited NHS involvement. Legal restrictions, fluctuating capacity and the individual's uncertainty about leaving hospital also impacted progress, while changes to treatment during discharge planning caused setbacks and risks linked to previous offences required careful management.

Through sustained multi-agency working and a person-centred, 'least restrictive' approach, these barriers were addressed over time. He is now living successfully in the community with a tailored support package in place.

Cheshire and Merseyside neurodevelopmental pathways (ADHD and autism)

Children and Young People

The Cheshire and Merseyside Neurodevelopment Recovery Programme includes the development and implementation of a needs-led pathway for children and young people with neurodevelopmental needs and is a joint initiative across health, care and education. The overarching aim is for all neurodivergent children, young people and their families to have swift and easy access to effective, early and ongoing support that meets their needs.

The programme reports into the Beyond Programme Board, Children and Young People's Emotional Health Programme Group and nine Local Authorities - primarily via SEND Partnerships.

Demand for neurodevelopmental assessments remains high and continues to exceed current capacity, resulting in long and increasing waiting times. As of October 2025, 30,415 people were on waiting lists for neurodevelopmental pathways, with 9,834 waiting more than 52 weeks.

Our aim is to improve the identification and access to early and ongoing support for neurodivergent children and young people across Cheshire and Merseyside. This includes introducing the "Knowing Me" tool to help identify needs earlier, bring teams together to review referrals, make the process more consistent, streamline assessments and provide better ongoing support.

Extensive engagement in 2024 highlighted that children and families wanted:

- Improved access to early support
- To learn from early adopters of the profiling tool
- Incorporate learning from national PINS projects
- A standardised Cheshire and Merseyside approach to stratifying and prioritising the waiting list

- Improved communication with families on how to get help while they wait
- More consistent use of neuroaffirmative language
- Reduced waiting times for those with complex needs
- Concerns regarding medication issue addressed.

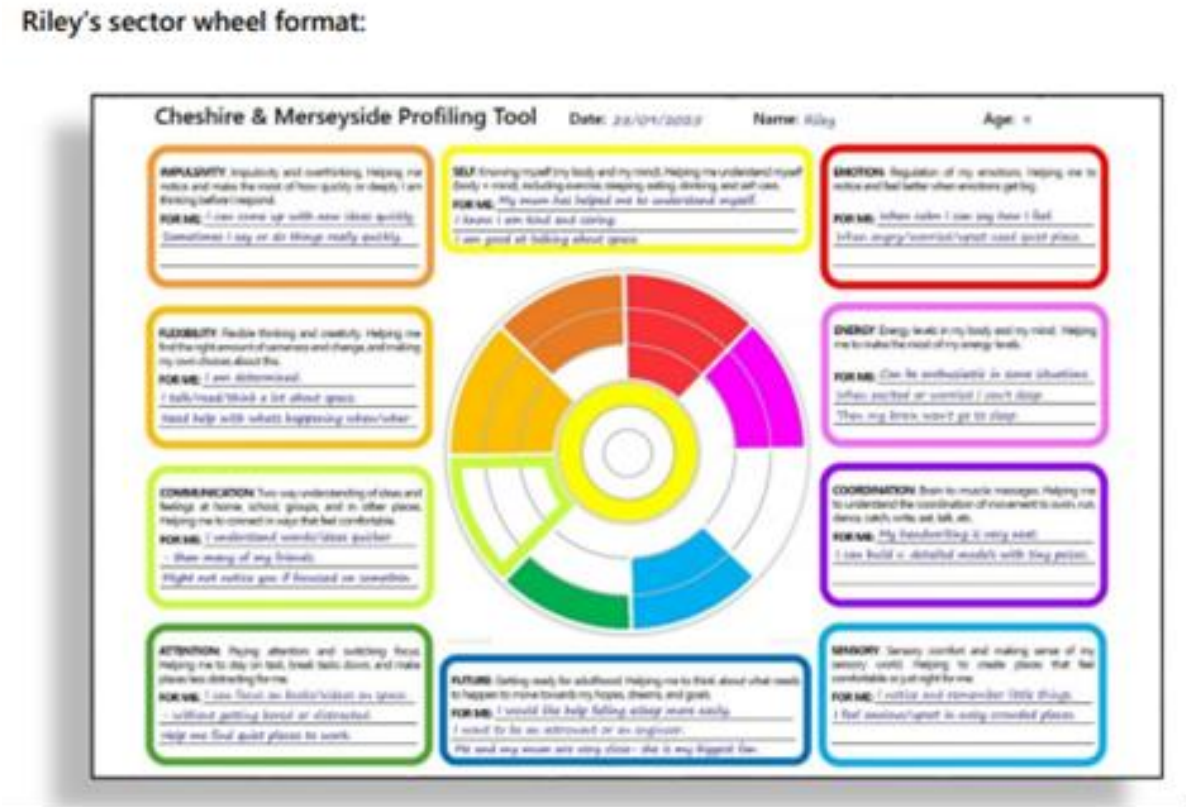
The Neurodevelopment Recovery Programme subsequently established a Children and Young People's work programme to oversee the development of a needs-led pathway. The programme has identified key changes to deliver a needs-led pathway across three key areas.

Empowerment and early support

Following collaboration with colleagues in Portsmouth and Cornwall, NHS Cheshire and Merseyside and local authorities commissioned CANDIDD - an independent evaluation organisation specialising in neurodevelopmental conditions - to work with experts by experience and wider stakeholders to develop a Cheshire and Merseyside needs mapping tool: the *Knowing Me* profiling tool.

Koala North West was commissioned to deliver training to professionals in education settings and early help teams across Cheshire and Merseyside to support the rollout and effective use of the profiling tool. Training resources have also been developed for parents and carers.

Diagram: Cheshire and Merseyside Knowing Me profiling tool



In addition to developing the profiling tool, CANDIDD have been commissioned to evaluate its impact on both professional and family experience, as well as its effect on demand for assessment.

Case Study: The Wirral Neurodiversity Hub

The Wirral Neurodiversity Hub is a free online resource providing information, tools and community support for neurodivergent children and young people and their parents and carers. The hub promotes a needs-led approach, enabling families to access support without requiring a formal diagnosis.

At the heart of the hub is the “Knowing Me” profiling tool, which helps build a personalised picture of a child’s strengths and needs across nine areas, supporting early identification and tailored support strategies. Alongside this, the hub offers practical guidance on topics such as sleep, anxiety and signposts families to local services, support groups and the ADDvanced Solutions learning programme.

Early findings have shown that c30% of children who complete the profiling tool do not go on to require assessment or diagnosis as their needs are already being met.

Assessment and diagnosis

A risk stratification and prioritisation tool has been developed for use across all Cheshire and Merseyside NHS providers. In addition, a new neurodevelopmental assessment model has been created and shared, setting out a more streamlined approach to combined autism and ADHD assessments.

Further discussions are underway to explore how to reduce the longest waits and better support individuals while they are waiting. This includes increasing assessment capacity, broadening the skill mix and making greater use of technology - including AI. There is also a focus on strengthening support from the voluntary sector to help families manage needs while waiting.

Adult ADHD

ADHD is suspected to affect 3-4% of adults in the UK. For Cheshire and Merseyside, this means there are approximately 81,000 adults with ADHD.

Currently, 40,825 people have a diagnosis of ADHD in Cheshire and Merseyside and a further 7,267 have a diagnosis of both ADHD and Autism.

NHS Cheshire and Merseyside commissions a range of local providers to deliver adult ADHD assessment, diagnosis and treatment services. In addition, independent sector providers deliver services through “Right to Choose.”

There is significant variation in referral and acceptance criteria between providers. For locally commissioned NHS services, this reflects legacy commissioning arrangements inherited from predecessor organisations, as well as differences in the detail and specification of existing contracts.

The significant growth in adult ADHD referrals has resulted in increased waiting times in NHS providers. These long waits have resulted in an increasing number of Independent Sector providers securing contracts nationally to deliver this service and a significant growth in Right to Choose non-contracted activity.

In November and December 2025, NHS Cheshire and Merseyside's Executive Committee approved the implementation of a standardised service specification and commissioning policy. This will ensure a consistent threshold and level of service across both NHS and independent sector providers, supporting a more integrated care pathway and reducing variation in patient experience. Full application of the new threshold is expected to reduce activity levels by c30%.

During 2025-26, the Adult ADHD Programme Board oversaw the development and progression of a new model of care for Adult ADHD, working with clinical leads, commissioners, Health Innovation North West Coast and those with lived experience.

The needs-led model includes:

- Commissioning an Adult ADHD Local Enhanced Service (LES) at Primary Care Network level to build capability and capacity in primary care to support adults with ADHD.
- Commissioning appropriate community-led support to compliment the LES and provide individuals with and without a diagnosis with peer support and structured help and resources.
- Management of secondary care activity whilst the LES is fully mobilising, including ensuring compliance with the specification / Commissioning Policy, use of Mental Health Services data and indicative activity plans.
- An interim position from April 2026 in relation to shared care, whereby ADHD drugs are added into existing shared care arrangements (including existing funding arrangements) whilst a new standardised shared care arrangement is commissioned during 2026-27.
- Effective communication with local communities, referrers and stakeholders to ensure understanding of the new model.

1.2.3.7 Primary Care

General Practice

GP Patient Survey results for 2025-26 showed improvements across many areas. In line with national trends, more patients than ever are accessing their GP practice digitally, as well as in person and by telephone. In line with national contract requirements, all practices now offer online consultations during core operating hours - ensuring patients can make full use of available access routes.

GP practices across Cheshire and Merseyside are delivering more appointments across all methods of consultation. There were 16.19 million GP appointments in 2025/26 compared to 15.64 million in 2024/25.

In 2025-26, a further 34 practices were supported to access the national General Practice Improvement Programme, helping to drive service development and improvement. The workforce has also grown significantly, with 2,148 whole-time equivalent roles in the Additional Roles Reimbursement Scheme (ARRS), compared to 313 in 2018-19.

In 2025-26, the Cheshire and Merseyside Sustainability Team worked closely with Cheshire and Merseyside Greener Practice to support primary care clinicians and

staff to deliver locally led sustainability initiatives. 10 primary care projects were sponsored across Cheshire and Merseyside, spanning prevention, respiratory care, resource efficiency, estates and community wellbeing.

Projects included asthma and inhaler disposal initiatives, greener prescribing and diagnostics, community gardening and practice-level green plans. This work demonstrates how sustainability in primary care can be clinician-led and closely aligned with improved patient outcomes and population health.

Case Study – New NHS guidance helps GPs support families following the death of a child

In a pioneering move, NHS Cheshire and Merseyside published new guidance designed to equip general practice teams with the tools and understanding to support bereaved families following the death of a child.

When a Child Dies: An NHS Cheshire and Merseyside Framework for General Practice was produced in collaboration with The Alder Centre – a dedicated child bereavement centre based at Alder Hey Children's Hospital – and Claire House Children's Hospice.

Published to coincide with the inaugural Child Death Awareness Week (1 to 7 July), the framework recognises that, while healthcare professionals are experienced in dealing with loss, child deaths are deeply traumatic and often occur under sudden or complex circumstances, presenting unique clinical and emotional challenges.

Drawing on best practice and the lived experiences of bereaved parents, the framework provides a checklist for GP practices to follow, advice on communicating with and supporting bereaved parents and families, as well as signposting to further support.

The guidance was created in close consultation with bereaved parents, whose powerful testimonies are quoted throughout the document, serving as poignant reminders of the important roles GPs play as one of the few consistent healthcare touchpoints for families in the aftermath of such a loss.

Case Study – Cheshire and Merseyside primary care excellence on display at General Practice Awards 2025

Primary care teams across Cheshire and Merseyside were recognised at the 2025 General Practice Awards, winning three national categories and receiving a further commendation. Finalists from eight GP practices and primary care networks attended the ceremony, highlighting the strength of primary care across the region.

Award-winning work included the Sefton Mobile Cervical Screening Partnership, which brought screening into community settings to improve access for underserved groups. The initiative increased uptake among people who were overdue or had never been screened and has since been replicated across multiple areas and shared nationally as best practice.

In addition, South Sefton Primary Care Network's Medicines Management Team was named Pharmacist Team of the Year for its innovative, system-wide approach, improving patient safety, supporting vulnerable patients and reducing GP workload. These achievements demonstrate the impact of collaboration and innovation in improving outcomes and tackling health inequalities.

NHS Dentistry

NHS Cheshire and Merseyside continued to deliver the Local Dental Improvement Plan in 2025-26 to help tackle some of the challenges facing NHS dental care.

Built on national reforms, the plan is aimed at increasing access to both routine and unscheduled (urgent) NHS dental care and improving oral health in the local population - backed by an extra £15m of local funding to support the plan's delivery.

Working in close partnership with local professional networks such as the Local Dental Network, Local Dental Committees and NHS England's North West Dental Public Health team, the plan was also closely informed by feedback from Healthwatch, local authorities and other key stakeholders.
Two main areas of focus for this work have been:

- Incentivising contracts for providers of NHS Dentistry to encourage them to increase capacity for NHS patients
- Offering additional incentives to providers for supporting vulnerable patient groups.

Since 2020, an established network of dental practices has remained in place to provide unscheduled (urgent) care appointments for patients who are unable to access regular care - including via the local Dental Helpline.

Across Cheshire and Merseyside, 103 dental practices also signed up to deliver 'Urgent Care Plus' - a scheme which offers additional funded sessions as an extension to the urgent care pathway. This scheme enables patients who have attended an urgent care appointment to also receive a full examination and any further treatment required to help get them dentally fit again.

Between the UDC and UDC Plus local schemes, more than 80,000 appointment slots were commissioned to support access to urgent dental care for the Cheshire and Merseyside's residents in 2025-26.

Separately, a locally developed project has been developed to improve access for new dental patients across Cheshire and Merseyside, with a focus on supporting vulnerable groups. This includes encouraging practices to work with voluntary sector organisations such as homeless centres and family hubs and improving access for patients undergoing treatment for breast cancer, as well as looked after children and care leavers. A total of 68 dental practices signed up to the scheme.

NHS Business Services Authority (BSA) data shows that between April 2025 and January 2026, a total of 76,159 new adult patients and 35,816 new children were seen across practices delivering these schemes - 111,975 new patients over a 10-month period.

In order to address workforce challenges, NHS Cheshire and Merseyside has also been looking to address some of the longer-term workforce challenges in NHS dentistry and launched a recruitment incentive scheme to help tackle local dental workforce issues in more deprived areas, including areas of Liverpool and Knowsley.

Case Study – Transforming vacant premises into new dental services in Liverpool

In Liverpool, NHS Cheshire and Merseyside transformed vacant premises into a new dental service designed to improve access and attract and retain NHS dental staff. Serving communities across Liverpool, Knowsley, Sefton and St Helens, the model also uses a second nearby site to expand capacity and reach.

The service focuses on outcomes rather than activity, offering dedicated access pathways, urgent care provision, and ongoing support for vulnerable groups. This includes children, expectant mothers, care home residents and people referred from social care, hospitals and specialist services. The model also supports workforce development through training and career progression within a multidisciplinary team.

Between April and August 2025, 2,881 patients were referred to the service, including children and young people, demonstrating strong demand and improved access to dental care.

Community Pharmacy

During 2025-26, NHS Cheshire and Merseyside continued to strengthen its role as a strategic commissioner of community pharmacy services following the delegation of responsibilities in April 2023.

NHS Cheshire and Merseyside oversees a network of 559 community pharmacies - one of the most accessible elements of primary care - and works closely with Local Pharmaceutical Committees to ensure provision remains aligned to population need and statutory requirements.

Updated Pharmaceutical Needs Assessments across all nine local authority areas confirm that pharmacy provision across the system is both adequate and accessible, while also highlighting the opportunity to further expand prevention, public health services and support for long-term conditions.

NHS Cheshire and Merseyside has made significant progress in delivering national priorities and expanding the clinical role of community pharmacy. Services such as Pharmacy First, the Community Pharmacy Hypertension Case Finding Service and the Oral Contraception Service have improved access to care and reduced pressure on general practice.

Performance against national ambitions has been strong: the system delivered 6.6% of national blood pressure consultations against a target of 4.7%, ranking 1st out of 42 Integrated Care Boards, and achieved 5.7% of national oral contraception consultations (ranked 3rd), alongside strong delivery of Pharmacy First clinical pathways above target levels. These outcomes reflect effective mobilisation of national programmes at scale and demonstrate how community pharmacy is being used as a first point of contact for patients, improving timely access and supporting earlier diagnosis and prevention.

Community pharmacy continues to play a critical role in addressing health inequalities and supporting neighbourhood health models. Pharmacies are increasingly acting as local health anchors, offering extended opening hours, delivering prevention services such as smoking cessation and vaccinations and supporting system resilience, including during peak periods and Bank Holidays.

NHS Cheshire and Merseyside has embedded community pharmacy within its broader approach to population health management and within neighbourhood teams, with services tailored to meet the differing needs of local communities, including areas of high deprivation, rural isolation and ageing populations.

NHS Cheshire and Merseyside maintains a Pharmaceutical Services Regulations Committee that meets monthly in order to discharge its delegated responsibilities. The Committee Terms of Reference can be found here: https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/.

Where appropriate, decisions are taken with regard to the Pharmaceutical Needs Assessments. These are published by each Health and Wellbeing Board every three years with regard to the Joint Strategic Needs Assessments and determine the requirements for Pharmaceutical Services in each area.

NHS Optometry

NHS Cheshire and Merseyside continued to make significant progress in transforming optometry services in 2025-26 through a strong focus on integration, access improvement and community-based care delivery. A major milestone included the full rollout and expansion of the ‘Eye Care Navigation Service’ across all nine local authority footprints. Building on earlier pilots, this model introduced clinically-led triage of referrals and an informed patient choice process - ensuring patients are directed to the most appropriate provider and setting, thereby improving pathway efficiency and outcomes.

As referenced earlier in this report, NHS Cheshire and Merseyside successfully implemented a Single Point of Access (SPoA) in conjunction with Primary Eyecare Services (PES) for ophthalmology referrals across five local authority footprints, creating a streamlined and standardised referral management system across the region. This initiative has enabled faster access, reduced administrative burden and ensured more efficient use of hospital and community capacity.

NHS Cheshire and Merseyside has also strengthened its community optometry infrastructure, expanding and embedding a broad portfolio of enhanced services including Community Urgent Eyecare (CUES), glaucoma monitoring, cataract pathways and services for patients with learning disabilities such as 'Easy Eye Care'. These developments are reflective of a system-wide shift toward delivering care closer to home and targeting hard to reach groups such as the homeless population segment to ultimately improve population health outcomes.

Primary Care Complaints

During the 2025-26 period NHS Cheshire and Merseyside received 866 complaints regarding Primary Care services commissioned by the Integrated Care Board, with the majority of complaints in relation to GP Primary Care and Dentistry. The main complaint themes were in relation to:

- clinical care
- referral issues
- access to appointments
- access to services
- communication
- staff attitude.

The volume of complaints, themes and any lessons learned are reported to the Quality and Performance Committee.

Learning from primary care complaints has focused on strengthening communication with patients and between services, improving adherence to clinical assessment standards, reinforcing data protection and record-keeping practices, and enhancing staff training and governance processes (including significant event analyses, protocol reviews, and double-check systems). Collectively, these actions aim to improve patient safety, ensure timely and coordinated care, and promote more consistent, patient-centred service delivery across primary care.

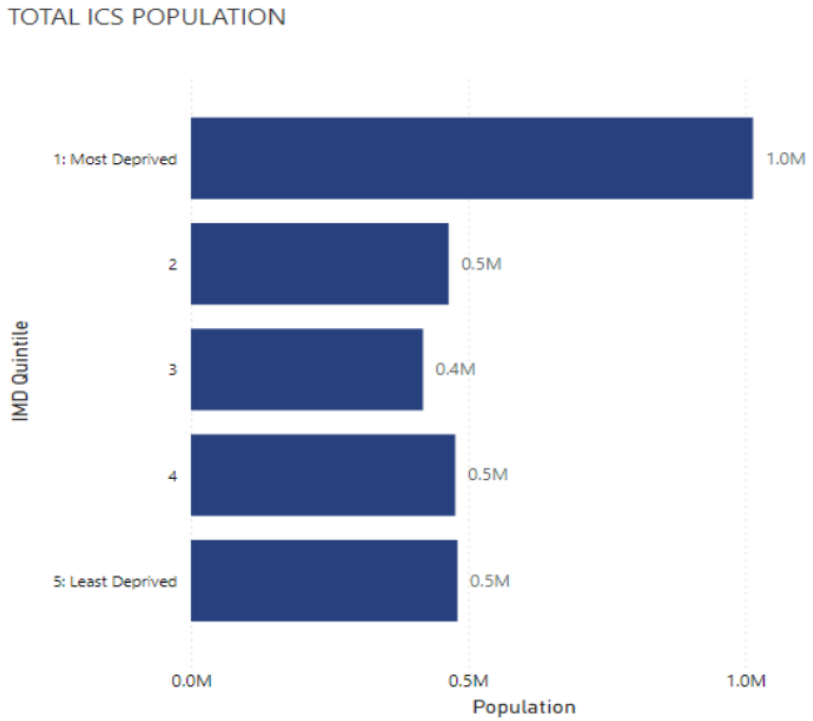
1.2.3.8 Reducing health inequalities

Reducing health inequalities is a core statutory responsibility of NHS Cheshire and Merseyside and is fundamental to the role of the Integrated Care Board as a strategic commissioner and system leader. Health inequalities are unfair and avoidable differences in people's health. They often affect certain groups more than others and are linked to factors such as income, housing, education and employment. These same factors can also make it harder for some people to access healthcare or get the support they need. As a result, people who face these challenges often experience poorer health outcomes.

In Cheshire and Merseyside there are 2.7 million people, with significant variation in deprivation levels as measured by the Index of Multiple Deprivation (IMD). Figure 5 shows the breakdown of the Cheshire and Merseyside population by deprivation quintile, with the highest number of people living in deprivation quintile one (most deprived).

Joint Strategic Needs Assessments (JSNAs), the Cheshire and Merseyside Integrated Needs Assessment and other sources of intelligence have been used to understand these patterns - providing an evidence base for prioritisation, including clear identification of conditions that contribute most significantly to premature mortality and avoidable ill health.

Figure 5. Cheshire and Merseyside population by deprivation quintile



NHS Cheshire and Merseyside has consistently consulted every relevant Health and Wellbeing Board on the development of plans to ensure alignment with each local authority's Health and Wellbeing Strategy.

With a focus on PLUS groups – population groups who experience poorer than average health access, experience and / or outcomes – priority has been given to understanding the health and wellbeing needs of PLUS and Health Inclusion groups. Local authority areas are also taking a targeted approach to PLUS and Inclusion Health groups based on specific needs identified via local engagement with people and communities to understand barriers to service access.

During 2025-26, the NHS Cheshire and Merseyside Board also maintained a clear focus on health inequalities as part of its wider oversight of population health improvement, quality and access. This included routine consideration of inequalities within Board and committee performance reports, with particular emphasis on priority clinical areas, variation between local authority areas and outcomes for communities experiencing the greatest disadvantage.

The Board assures delivery of statutory and policy expectations through a number of mechanisms referenced in this report:

Statutory/policy expectation	How the Board assures delivery	Evidence in this report
Section 13SA – reducing health inequalities	Routine Board and Committee review of Core20PLUS5 indicators; annual health inequalities dataset quarterly.	Section 1.2.3.8; Appendix One
Marmot Principles	Explicit use within All Together Fairer and Joint Forward Plan. It was the ICB that initially commissioned the Institute of Health Equity to become a Marmot community	Sections 1.1.2, 1.2.3.8
NHS Long Term Plan (three shifts)	Performance reports framed around hospital to community, sickness to prevention, analogue to digital	Sections 1.2.1–1.2.3

To support effective oversight and assurance, the NHS Cheshire and Merseyside Board agreed to focus on a defined set of health inequalities priorities during 2025-26, aligned to national expectations and the NHS Long Term Plan:

- Cardiovascular disease, as a major contributor to premature mortality and life expectancy gaps
- Smoking, as the single largest preventable cause of inequality
- Cancer, with a focus on early diagnosis and outcomes
- Core20PLUS5 priority areas for adults and children and young people
- Access to services across urgent, elective, community and mental health pathways

Application of data: from insight to action

Health inequalities analysis during the year focused not only on describing variation, but on informing commissioning, transformation and improvement activity. Where data quality and availability allowed, performance metrics were stratified by deprivation, geography and relevant population characteristics to support targeted decision-making.

For example, cardiovascular disease indicators were used to identify variation in detection and management of hypertension and lipid control across local authority footprints, informing prioritisation of prevention and early intervention programmes within primary care. Smoking prevalence data highlighted higher rates in more deprived communities, supporting targeted smoking cessation initiatives and the deployment of community-based interventions aligned to need.

These insights were integrated into programme-level governance and commissioning decisions, demonstrating how inequalities data was actively applied rather than reported solely for descriptive purposes.

Case Study: "Without that test my wife would have lost a husband, and my children would have lost their dad"

Mike Andrews, 45, from Tuebrook in Liverpool, discovered he had dangerously high blood pressure during a routine visit to the optician. After reading a leaflet in the consulting room, he agreed to a quick test, later reflecting: *"I'm not one for going to the doctor… but in that moment, something made me think: 'why not?'"*

The results were extremely high, prompting an urgent referral via NHS 111 and a repeat test at a local pharmacy, which confirmed a reading of 255/151. Mike was sent straight to Aintree Hospital, where he was admitted and underwent a series of scans and tests. He described the experience as involving *"some quite alarming conversations,"* after doctors told him that without treatment, a heart attack or stroke would have been inevitable.

Reflecting on what could have happened, Mike said that without the test, *"my wife would have lost a husband and my children would have lost their dad."* Now taking daily medication to manage his condition, he is *"eternally grateful"* the issue was identified when it was.

His story highlights the life-saving importance of early detection and accessible health checks in community settings

Partnership work with the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector to reduce health inequalities

NHS Cheshire and Merseyside invests in the Cheshire and Merseyside VCFSE Health and Care Transformation Programme in recognition of the sector's role as a key strategic partner and the role they play in shaping, improving and delivering services which tackle the wider determinants of health which are often drivers of health inequalities.

This investment has ensured that the VCFSE sector voice has been embedded across the Cheshire and Merseyside Health and Care Partnership.

The VCFSE sector are strongly represented across a number of All Together Fairer workstreams that have been established to reduce health inequalities through tackling the wider determinants of health. This includes representation at the Housing and Health partnership and the Health and Work partnership where the sector has supported NHS Cheshire and Merseyside to develop an expression of interest for Workwell funding - a programme designed to support people who are at risk of falling out of employment due to health related needs.

The sector has also been crucial in the design of NHS Cheshire and Merseyside's neurodiversity pathway. Through meaningful engagement and co-production, the

new pathway has been designed in a way that addresses systemic gaps in support and reduces the risk of health inequalities occurring across this patient group. The VCFSE sector was key in supporting children, young people and their families to have their voices heard throughout the process.

Case study – Fuel poverty scheme linked to reduction in GP appointments

A targeted programme in St Helens and Knowsley has shown how addressing fuel poverty can improve health and reduce pressure on NHS services.

The project supported adults with chronic obstructive pulmonary disease (COPD) through a coordinated package of care. This included medicines optimisation, referrals to pulmonary rehabilitation and stop smoking services, and practical support with financial challenges such as energy costs.

An evaluation by NHS Cheshire and Merseyside, working with Health Innovation North West Coast, found a 9.8% reduction in GP appointments in the 12 months following the intervention. Among 254 patients who received support, around 400 GP appointments were avoided compared to a matched group.

If scaled to over 1,000 patients, the programme could reduce demand by an estimated 1,575 GP appointments. This demonstrates how tackling the wider causes of ill health can both improve outcomes for patients and free up GP capacity for those most in need.

Focus on: Smoking

Smoking remains the leading cause of preventable illness and death in Cheshire and Merseyside, causing 20,562 hospital admissions and 3,435 early deaths every year. Smoking is also the leading cause of health inequalities accounting for half the difference in life expectancy between the richest and poorest in society. We know that smoking rates are highest among people who are homeless, people entering prison and those living in social housing. A total of 9,716 people are out of work in Cheshire and Merseyside due to smoking related illnesses.

All Together Smokefree is the Cheshire and Merseyside programme working to end smoking for everyone. The “What Will You Miss?” communications campaign, launched in December 2025, encourages smokers to consider quitting by highlighting the important life moments they could miss and signposts to the Cheshire and Merseyside Smoking Ends Here website.

Case Study: What will you miss

Shaun has recently come forward to talk about how the Treating Tobacco Dependency service in Mid-Cheshire Hospitals NHS Trust supported him to successfully quit his 60 a day habit. Shaun had his first cigarette at just eight years old and went on to develop lung cancer in 2024.

Following his lung cancer diagnosis and inspired by his wish to walk his daughter down the aisle Shaun was introduced to a Tobacco Addiction Specialist Nurse Jo who guided him through the process of quitting, developing a tailored plan that was specific to his motivations and needs.

Shaun said being told he had cancer was something he never thought would happen. His first thought was that he was a failure he felt he had caused this through decades of heavy smoking, and he couldn't bear the thought of not being by his daughter Holly's side on her wedding day.

He was put in touch with Jo who sat him down, asked why he wanted to quit and what his triggers were and with a lot of hard work he managed to stop. Shaun now hopes to inspire other smokers to follow in his footsteps with a simple message: *"Give it another go. You won't miss smoking as much as you'll miss those special moments."*

Focus on: Ethnicity data completeness, quality and use

Accurate and complete ethnicity data is essential to understanding and addressing inequalities in access, experience and outcomes. During 2025-26, the NHS Cheshire and Merseyside Board recognised that completeness of ethnicity recording remains variable across datasets and service areas, reflecting historic recording practices, system limitations and patient choice.

Completeness varies by setting and provider, reflecting historic coding practices and patient choice, but NHS Cheshire and Merseyside monitors data completeness by setting, provider and over time.

Table 7. Ethnicity recording data completeness for Cheshire and Merseyside compared to national averages.

Care Setting	Latest C&M % data completeness ethnicity recording (January 2026) C&M	National average	Comparison to national average
Admitted Patient Care	97.4%	87.0%	Better
Outpatients	94.2%	74.5%	Better
Community Services Data Set	74.6%	71.4%	Better
Emergency Care Data Set	95.5%	87.0%	Better
Improving Access to Psychological Therapies	97.0%	94.3%	Better
Mental Health Services Data Set	93.1%	69.8%	Better

Source: NHS Digital, Data Quality Maturity Index publication

Progress on improving data quality has been monitored through programme-level governance arrangements, particularly within mental health and health inequalities programmes. Further system-wide work is underway to strengthen completeness and consistency of ethnicity recording to improve future assurance and transparency.

More detail about the work of NHS Cheshire and Merseyside's Population Health Programme is available in the Health Inequalities appendix published alongside this Annual Report, which identifies key trends, caveats and actions against the NHS England indicators that NHS bodies are required to collect, analyse and publish as part of their duty under section 13SA of the National Health Service Act 2006.

1.2.3.9 Continuing healthcare

Spending on All Age Continuing Care remained under close scrutiny in 2025-26. Key objectives were identified using data, benchmarking, and identifying local and national best practice to ensure services operate efficiently, effectively and deliver best value for our population.

The introduction of a new way of delivering All Age Continuing Care, following the move away from outsourced services, has been affected by national changes to ICBs. Despite this, the team continues to work towards a consistent approach in line with the national framework for NHS Continuing Healthcare and NHS-funded Nursing Care.

The All Age Continuing Care service is one of the priority portfolio areas relating to NHS Cheshire and Merseyside's financial position with several efficiency schemes developed to support improvements. Savings have been made, but further work is

needed in 2026–27 to ensure services continue to deliver good value for money, while maintaining a strong focus on quality and safety.

In response to the 'Model ICB All Age Continuing Care) / NHS Continuing Healthcare Good Practice Document' the team is assessing digital opportunities within the service.

Plans are underway to introduce digital tools and voice technology to help reduce administrative workload in the All Age Continuing Care service. A more centralised way of working is expected to increase efficiency, alongside a new single digital case management system that will support greater consistency and flexibility across the service.

Alongside this work, progress is being made on developing Policies and Standard Operating Procedures to support consistent service delivery and strong governance. A pilot focused on the Fast Track process is showing positive results in both cost effectiveness and patient experience, helping people to die in their preferred place of care. Collaboration with Local Authorities will continue in 2026–2027 to develop and implement joint policies.

Case Study: New report shows personal health budgets transforming lives and supporting NHS ambitions across Cheshire and Merseyside

A new report highlighted the impact of personal health budgets (PHBs) across Cheshire and Merseyside, showing how they are improving quality of life by giving people greater choice and control over their care. PHBs enable individuals to design support around their needs, leading to more personalised and flexible care.

The report demonstrated benefits for both patients and families, including improved wellbeing, independence and overall experience, while also delivering value for money for the NHS. It drew on real-life experiences from people using PHBs, as well as input from health professionals and voluntary sector organisations.

Cheshire and Merseyside was highlighted as a leading example of good practice, with insights from the report helping to inform wider NHS ambitions to expand access to personal health budgets and support more personalised models of care.

1.2.3.10 Maternity, neonatal and women's health services

NHS Cheshire and Merseyside's commitment to safety and improving services continued to be at the forefront of the work of the programme during 2025-26.

The Women's Health and Maternity (WHaM) Programme incorporates the leadership of the Local Maternity and Neonatal System (LMNS) and the delivery of the local priorities set out in the national 10-year Women's Health Strategy.

Local Maternity and Neonatal System
During 2025–26, the Local Maternity and Neonatal System (LMNS) delivered key actions from the national three-year plan to improve maternity and neonatal safety.

This was achieved through focused programmes of work and regular checks on progress with local NHS trusts. Key achievements in 2025–26 include:

- The Cheshire and Merseyside Preterm Birth Network continues to operate as a well-established and collaborative network, with a focus on unit achievements and challenges, shared learning, and ongoing opportunities for education and training for clinicians, along with a focus on supporting women most at risk of preterm births. Furthermore, a successful funding bid has enabled expansion of cervical length scan training (to help identify women at higher risk of preterm birth early) across the region, directly supporting national ambitions to reduce preterm birth rates, optimise place of birth and improve timely administration of optimisation measures.
- Continued investment in the North West Maternal Medicine Network enabled delivery of a range of activities supporting the three North West Maternal Medicine Centres to improve care for complex maternal medicine pregnancies. The network supported the Cheshire and Merseyside Maternal Medicine Centre to manage complex referrals, provide access to timely specialist expertise, enable women to receive care locally and strengthen multidisciplinary pathways through additional Obstetric Physician and Maternal Medicine Nurse posts. Education and workforce development remained key priorities, with regional training, collaborative learning, and part funding for midwives to complete the Masters level Foundations of Maternal Medicine module. The Network also established a Regional Maternal Mortality Group to promote consistent review and prevention approaches and led initiatives including contraception training, enhanced postnatal follow-up for women with diabetes, and a pilot embedding a specialist maternity pharmacist within the Network.
- The continued provision of Perinatal Pelvic Health Services (PPHS) has strengthened the quality and consistency of perinatal pelvic health care. Enhanced specialist expertise and improved multidisciplinary working has resulted in clearer pathways and better outcomes for women recovering from third and fourth degree perineal trauma.
- Bereavement support remained a priority, with all maternity providers offering seven-day specialist services to ensure that families experiencing pregnancy loss or neonatal death receive timely, compassionate and equitable care. The Warrington and Halton Hospitals Butterfly Bereavement Team demonstrated exemplary continuity and compassion, with their work playing a pivotal role in shaping the creation of the Willow Tree Hub - a dedicated, supportive space for bereaved and Rainbow families.
- Progress continued in embedding personalised care through the rollout of the Cheshire and Merseyside Personalised Care Support Plan (PCSP). Launched in digital format and accessible in more than 100 languages, the PCSP supports shared decision making and preparation for maternity appointments. Trusts have adopted varied approaches to implementation, with Wirral University Teaching Hospital demonstrating best practice through integrating the PCSP booklet into core midwifery training and enhanced visibility across services through posters, QR codes and digital links. Engagement across midwifery teams, community services and Trust communications is helping embed personalised care into routine maternity practice.
- Smoking cessation in pregnancy continued to show a positive impact, due to the work of specialist maternity tobacco dependency teams embedded within trusts. As a result, the smoking at delivery rate fell to 4.8% in September 2025, contributing to improved outcomes for both mothers and babies.

- The Enhanced Midwifery Continuity of Carer (ECoC) model expanded in 2025-26 with the introduction of four additional teams, offering targeted support to women at highest risk of poor outcomes, including those living in deprived areas, from ethnic minority communities, and those with vulnerable or complex pregnancies.
- Breastfeeding rates also improved across the region. Several Trusts achieved or maintained UNICEF Baby Friendly Initiative accreditation, supported by the launch of the new Cheshire and Merseyside Breastfeeding and Infant Feeding Strategy.
- Workforce stability improved, with vacancy rates remaining low at 1.2% and reductions in temporary staffing, turnover and leavers. Professional Midwifery Advocates played an important role in supporting staff wellbeing and improvement, with 65 PMAs delivering 17 active projects across the region.
- Delivery of the Equity and Equality Action Plan remained central to reducing inequalities. Key initiatives included the refreshed Maternity Rights Advice Service, which provides free legal advice offer for pregnant women and new parents, the maternity health literacy pilot, which enhances the readability of information for pregnant women, the implementation of a new regional alcohol screening guideline enabling earlier identification and support for women, and a project to increase awareness of pregnancy risks among women of the global majority. The English for Speakers of Other Languages Baby Steps programme further strengthened communication and engagement for women with limited English, reducing barriers and improving access to safe care.
- Maternity and Neonatal Voices Partnerships have strengthened engagement with families and communities, ensuring that people's experiences help shape and improve services. This informed the development of trust action plans, enhanced communication materials, and drove improvements through Fifteen Steps walkarounds within maternity and neonatal units which drove improvements in communication – particularly for neurodivergent and non-English-speaking families – while ensuring signage was equally accessible. Targeted outreach increased engagement with underserved communities, while neonatal and bereavement initiatives further improved personalised, family-centred care.
- Trusts were supported to achieve the ten maternity safety actions set out in the national Maternity Incentive Scheme through a structured assurance process.
- NHS Cheshire and Merseyside met national preterm birth targets, maintained stillbirth rates in line with national averages, reported reductions in intrapartum brain injuries and saw lower neonatal mortality rates than the North West average.
- Compliance with the Saving Babies' Lives Care Bundle remained high, underpinned by structured assurance and sustained application of evidence-based practice
- System-wide safety work was strengthened through regular monitoring of maternity and neonatal safety metrics, shared learning from incident reviews and development of regional maternity and neonatal guidelines, while specialist pathways such as the regional MDT for Placenta Accreta Spectrum ensured co-ordinated and expert management of high-risk pregnancies.
- A key output from the Cheshire and Merseyside Maternity and Neonatal Safety Group was a system-wide review of maternity triage processes, which informed best practice recommendations for Trusts to improve timely assessment and escalation.

- The development and launch of the new Quality Improvement Learning Package by the LMNS has supported trusts to address recurring safety themes and strengthen provider-led improvement.
- Oversight through the Cheshire and Merseyside Maternity Safety SitRep has enabled early identification of service pressures and effective co-ordination of mutual aid across the region led by the LMNS. This support has helped trusts to remain open during critical incidents (avoiding unnecessary separation of women and babies or transfers far from home) and has contributed to a significant reduction in Induction of Labour (IOL) delays. Figures from the Liverpool Women's IOL project showed that delays reduced from 35% to 13%, and while two-hour delays (a national maternity red flag) have become rare since the IOL Suite opened.
- The Cheshire and Merseyside Joint Oversight and Support Framework has strengthened leadership, governance, and resilience across maternity services, enabling clearer escalation pathways, earlier risk identification, and sustained improvements in the quality of care.

Women's Health

The national Women's Health Strategy[1] highlights the need for sustained action to improve health and social outcomes for women, girls and those assigned female at birth. During 2025-26, the NHS Cheshire and Merseyside Women's Health and Maternity Programme continued to raise awareness of the inequity affecting 51.6% of the local population due to gender, while focusing on improving outcomes and narrowing gaps in life expectancy.

The national strategy is currently being refreshed to align with the NHS 10Year Plan, with a focus on:

- **Hospital to community:** elective gynaecology waits, neighbourhood good practice guides, clinical pathways and data dashboards
- **Analogue to digital:** NHS online, virtual group consultations, FemTech and other digital solutions
- **Illness to prevention:** contraception and preconception care, preventing long term conditions, cervical screening, and violence against women and girls.

Key achievements include:

- Women's Health Hubs remain a national priority, with all nine Cheshire and Merseyside local authority areas delivering at least six DHSC core services through integrated, community-based care. Early work focused on improving access to Long-Acting Reversible Contraception (LARC), with strong uptake supported by workforce upskilling and expanded provision. Four local authority areas now offer this as a recurrent service.
  Patients benefit from shorter waits, fewer referrals to secondary care, earlier management of menstrual conditions, and better access for underserved groups. Services have expanded to include menopause care, group consultations, complex menopause support, cervical screening, pessary fitting, and improved referral pathways.
- The Cheshire and Merseyside Women's Health and Maternity App continues to enhance communication and access to trusted health information. The app includes clinically approved content on menopause, endometriosis, cervical screening, fertility, pelvic health and pregnancy, and provides digital booking and

referral options. Acting a virtual one-stop-shop, the app is available in 100 languages.

- In partnership with NHS England North West and Axess Sexual Health, complex cervical screening training has been delivered to primary care clinicians, strengthening prevention and early detection, reducing unnecessary referrals into secondary and tertiary care, and supporting consistent, high quality screening provision across the system.
- Pan-North endometriosis pathways were launched across primary and secondary care to standardise the recognition, diagnosis and management of endometriosis. These pathways support earlier identification, improve consistency of care, and are underpinned by accessible patient information materials.
- A menopause education event for healthcare professionals across primary and secondary care, showcased successful community menopause pilot projects from across Cheshire and Merseyside.
- Community menopause pilots in Liverpool and Sefton successfully reduced pressure on hospital-based services, improved patient experience, and created opportunities for workforce upskilling. The Liverpool pilot reduced waiting times from 52 to 25 weeks, and a blueprint Standard Operating Procedure (SOP) has been developed to support system-wide adoption.
- The WHaM Programme continues to work with local, regional and national partners to improve support for vulnerable women, reduce harm and help women remain healthy, safe and well with a firm commitment to the national ambition to halve violence against women and girls in the next decade.
- A gynaecological cancer awareness webinar was delivered across Cheshire and Merseyside in collaboration with The Eve Appeal and the Cheshire and Merseyside Cancer Alliance.
- Access to hospital-based gynaecology care remains challenging, however, coordinated work through the Cheshire and Merseyside Gynaecology Network has led to improvements in waiting lists and pathway performance. System-wide work has included the development of referral optimisation standard operating procedures (SOPs) and Advice and Guidance processes to support timely and appropriate referrals and reduce avoidable delays. There has also been increased awareness of gynaecological conditions and cancers, with a focus on equity.
- Fifteen Steps walkarounds have been introduced in gynaecology services to identify quality improvement opportunities, alongside ongoing engagement across the women's health strategy, including work on heavy menstrual bleeding, the Menopause Equity Framework, and neighbourhood service specifications.
- A 'reason for referral' audit has identified the main conditions referred to secondary care, informing capacity planning and mutual aid.
- Targeted Network visits in 2025 have supported improvement plans, contributing to progress in key metrics: day case rates for HVLC hysterectomy increased to from 0% to 4.3%, outpatient hysteroscopy from 63.1% to 70.9%, length of stay for ectopic pregnancy reduced to 1.2 days, and minimally invasive cancer hysterectomy rose from 24.6% to 69.9%.

The continued strength of the Cheshire and Merseyside Gynaecology Network, the Women's Health Hub Forum, and the various special interest groups (Menopause, Endometriosis, Cervical Screening and Paediatric Gynaecology) remains central to progressing and delivering the women's health ambitions.

Case Study: New strategy launched to improve breastfeeding and infant feeding support across Cheshire and Merseyside

NHS Cheshire and Merseyside Local Maternity and Neonatal System (LMNS) launched a new Breastfeeding and Infant Feeding Strategy, developed in partnership with parents, carers, health professionals and community organisations across the region.

The strategy responds to the challenge of low breastfeeding rates, particularly the number of babies exclusively breastfed to six months, which impacts on health outcomes and contributes to inequalities.

Co-produced and shaped by lived experience, the strategy sets out a clear, shared vision to promote, protect and support optimal infant nutrition, ensuring parents are supported to breastfeed for as long as they choose. It is built around five key priorities: seamless support, improved information and education, greater equality and accessibility, stronger collaboration and workforce development, and a focus on implementation and continuous improvement.

By providing a coordinated, system-wide approach, the strategy has the potential to increase breastfeeding rates, improve outcomes for mothers and babies, reduce health inequalities, and lower long-term demand on health and care services.

1.2.3.11 Quality and Safety

Quality remains a key priority for NHS Cheshire and Merseyside. Quality, safety and experience are captured within the Clinical and Strategic Commissioning Plan for Board oversight. Specific areas of focus include; Infection Prevention and Control, Urgent Care Flow, Falls Prevention, Maternity Care and prevention of Never Events. The Integrated Performance Report captures metrics aligned to quality outcomes in these workstreams. During 2025-26 oversight of these core quality and safety metrics at committee and Board level have directed several pieces of quality improvement work.

Healthcare associated infections
A wide range of work has been delivered throughout 2025-26 to prevent healthcare-associated infections. A core example of this has been the launch of the Cheshire and Merseyside-wide Patient and Visitor Hand Hygiene Guide in February 2026, encouraging patients and visitors to act as partners in their own patient safety.

There has been a significant focus on rates of Clostridioides Difficile (CDI) and Escherichia Coli (E.Coli). These rates are tracked via the Integrated Performance Report at committee and Board level. The development and implementation of a CDI toolkit allowed coproduction with system partners through the system provider collaborative and set agreed expectations for actions to reduce rates of infection. Since implementation within Q2, rates of infection have reduced month on month.

The national tolerance level was not met this year; however, progress made has significantly improved performance heading into 2026-27, with expectations of remaining below tolerance.

Work on E. Coli has not been as dramatic, however has continued to progress. A deep dive into cases at one provider noted as an outlier has led to significant learning in relation to management of invasive lines and catheters as well as communication on transfer between organisations. This has led to improvement actions with results being monitored closely.

The work around E. Coli has also noted a need for a specific focus on community onset cases and will be a key focus moving into 2026-27.

In addition to the targeted work in relation to both CDI and E. Coli, the wider infection prevention and control agenda is recognising the importance of patients and carers as safety partners, which has seen a greater focus on patient education.
Alongside the Infection Prevention and Control work NHS Cheshire and Merseyside continues to support a targeted drive to improve antimicrobial stewardship.

This work has seen a continued reduction in total amounts of antimicrobials used and ensures an acceptable ratio of broad-spectrum antibiotics. This has been a key basis for the forthcoming targeted action required nationally during 2026-27 to commit to tackling Antimicrobial resistant.

Never Events
Never Events remain a key focus, with work ongoing to identify improvements in systems and processes to eliminate avoidable errors. NHS Cheshire and Merseyside has also contributed to the national review of Never Events and is awaiting updated guidance.

During the year there has been an increase in Never Events from 22 in 2024-25 to 29 in 2025-26. Analysis of the Never Events in-year identified 24 involved an invasive procedure. Work throughout the year has allowed a detailed reflection on implementation of the latest National Safety Standards for Invasive Procedures guidance (NatSSIPs 2). This has identified the progress made within each provider since the guidance was updated and allowed targeted support and oversight.

The understanding developed through targeted support has provided clear direction to reduce avoidable error in invasive procedures and is expected to have a positive impact on Never Event rates into 2026-27.

Mortality
Mortality rates remain a safety focus within the system, mainly through the observation of Standardised Hospital Mortality Index (SHMI) rates within performance metrics but with deeper understanding at provider level.

The SHMI position for the system remains within the expected range, however one provider has been consistently higher than expected. NHS Cheshire and Merseyside has worked closely with this provider throughout the year, including seeking direct assurance to the Quality and Performance Committee.

Work to date provides assurance on the quality of in-hospital care. However, higher mortality rates are seen in the 30-days following discharge, and further work is focused on improving care during this period.

Urgent and Emergency Care
During 2024-25 Cheshire and Merseyside developed a red lines tool kit to set clear expectations for all partners in relation to mandated standards of care during periods of pressure in Urgent and Emergency Care.

During 2025-26 this tool kit has been successfully implemented across Cheshire and Merseyside, with close oversight from NHS Cheshire and Merseyside to ensure standards were maintained. This has supported essential quality improvement within care provided across the Urgent and Emergency Care and particularly where this has been required outside of planned clinical environments.

Following its use, NHS Cheshire and Merseyside is now evaluating the toolkit and developing an updated version to provide further support to services.

Wound care formulary
Due to inefficiencies in prescribing and use of wound care products, NHS Cheshire and Merseyside worked with NHS Providers to launch a Wound Care Formulary across the Cheshire and Merseyside Provider Collaborative in January 2026. This formulary will support best practice for patients and ensure consistent use of cost-effective, efficient wound care products.

Community paediatric waiting times
In response to challenges with extended waiting times within several pathways for children and young people, a Cheshire and Merseyside working group of system leaders came together to agree a 90-day action plan, with support and oversight from Beyond (the children and young person transformation programme team).

The group has worked to improve how data is recorded and shared, enabling a more accurate understanding of waiting time pressures across the system.

This has led to actions to improve the visibility and accuracy of waiting times, including alignment with national guidance and validation of current waits. It has also supported efficiency improvements through neighbourhood integration, helping to release capacity, particularly for neurodiversity services.

Environmental sustainability
Environmental sustainability is an important factor in maintaining safe and resilient healthcare services. Climate-related risks such as heatwaves, flooding and extreme weather can affect service delivery and population health.

NHS Cheshire and Merseyside considers these risks through its Green Plan and wider resilience planning, while supporting initiatives such as improvements in inhaler prescribing and the reduction of high global warming potential anaesthetic gases.

Case Study: North Mersey Stroke Service hosts first hybrid national stroke prevention conference

The North Mersey Stroke Service hosted its first hybrid national Stroke Prevention Conference in Liverpool, bringing together over 160 clinicians, academics and health organisations to share best practice and the latest developments in stroke prevention. Delivered both in person and online, the event aimed to raise awareness of prevention and improve outcomes for patients.

The conference showcased collaborative work across Cheshire and Merseyside and the wider North West to better identify and manage cardiovascular risk factors, including initiatives in primary care and community settings. It also highlighted the importance of early detection, prevention, and reducing health inequalities through a more joined-up, system-wide approach.

Case Study – Community-based care in Warrington

In Warrington, partners are working together to deliver more accessible, community-based healthcare through the Living Well programme. Focused on prevention and supporting people to take greater control of their health, the programme has been recognised nationally, being shortlisted for Integrated Care Initiative of the Year at the HSJ Awards.

The programme brings together NHS, local authority and voluntary sector partners to improve access to services and tackle health inequalities, including a 10-year gap in life expectancy between the most and least deprived communities.

At the centre of the programme is the Living Well Hub, which offers a wide range of clinical and non-clinical support in a single, accessible location. Since opening in early 2024, more than 27,500 people have accessed services through the hub, demonstrating the impact of joined-up, neighbourhood-based care.

NHS Cheshire and Merseyside is committed to understanding the experience of the population in access and receipt of healthcare. In addition to published experience indicators that are utilised to support quality benchmarking, we work closely with partners (such as Healthwatch) to gain targeted understanding of service delivery. During the year we have gained specific feedback in relation to dental services that has supported direction in future commissioning and is viewed as an area of continued growth for NHS Cheshire and Merseyside to strengthen.

1.2.3.12 Children, Young People and Safeguarding

NHS Cheshire and Merseyside has continued to meet its statutory safeguarding duties throughout 2025-26 with safeguarding children, young people, and adults at risk.

Up until January 2026 the Executive Director of Nursing and Care held the statutory accountability for safeguarding and was supported by the Deputy Director of Nursing

and Care, Associate Director of Safeguarding and Head of Safeguarding. From February 2026 the statutory accountability was transferred to NHS Cheshire and Merseyside's Executive Clinical Director, who is supported by the posts outlined above. Statutory safeguarding responsibilities are delegated to Associate Directors of Quality and Safety, with delivery of statutory functions undertaken by the nine designated teams.

NHS Cheshire and Merseyside can demonstrate that there are appropriate safeguarding governance systems in place to meet it statutory safeguarding duties and functions in line with the key safeguarding legislation. Safeguarding governance is via the System Oversight Group, and quarterly assurance reports to the Quality and Performance Committee on how our statutory functions are being delivered.

The System Oversight Group has safeguarding system oversight to give assurance that NHS Cheshire and Merseyside is meeting its statutory duties and against the Safeguarding Children, Young People and Adults at Risk NHS: Safeguarding Accountability and Assurance Framework 2024 (SAAF).

During 2025-26, assurance of NHS commissioned services continues via quality schedules, safeguarding Key Performance Indicators, NHS England commissioning standards, Section 11 audits, action plans, and self-evaluation frameworks.

NHS England requires NHS Cheshire and Merseyside to submit a response to the requirements of the SAAF. NHS Cheshire and Merseyside has submitted its Safeguarding Self-Assessment to provide assurance of its arrangements and evidence how we meet the framework. The finding shows compliance with all measures except for safeguarding workforce capacity, which remains an area for progression, with an interim business continuity plan in place and plans to move to full compliance for 2026-27.

NHS Cheshire and Merseyside continues to contribute to safeguarding statutory safeguarding reviews and shares learning from national and local reviews across the organisation and the wider partnership.

Achievements this year include:

- Established the Corporate Parenting Steering Group to strengthen our response to proposed changes in legislation
- Supported the planning and delivery of Family First Partnership reforms.
- Supported the North West Multi-Agency Safeguarding Partnership by contributing as delegated safeguarding partners, helping lead regional priorities, and supporting shared learning through the NW Safeguarding Learning and Support Hub.

The Safeguarding Service will continue to support delivery of its statutory responsibilities and key priorities, ensuring a responsive, flexible approach and working closely with partners to maintain effective and robust safeguarding practice.

NHS Cheshire and Merseyside has contributed to each of the safeguarding partnership annual reports which outline key achievements and priorities for each local authority area. Each annual report and updated Multi-agency Safeguarding Arrangements (MASA) can be found on Local Authority websites

Table 8

Place	Safeguarding Children Partnership Multi agency annual reports link	Safeguarding Children Partnership Multi agency safeguarding arrangements link
Cheshire East	https://www.cescp.org.uk/about-us/annual-report.aspx	https://www.cescp.org.uk/homepage.aspx
Cheshire West and Chester	https://cheshirewestscp.uk/p/about-us/annual-reports	https://cheshirewestscp.uk/
Halton	https://haltonsafeguardingchildrenpartnership.org.uk/about-us/annual-report	https://haltonsafeguardingchildrenpartnership.org.uk/
Knowsley	https://knowsleyscp.co.uk/publications-and-reviews/annual-report/	https://knowsleyscp.co.uk/
Liverpool	https://liverpoolscp.org.uk/p/annual-report/lscp-annual-report-business-plan	https://liverpoolscp.org.uk/
Sefton	https://seftonscp.org.uk/scp/about-us/sefton-scp-annual-report	https://seftonscp.org.uk/
St Helens	https://sthelenssafeguarding.org.uk/p/about-us/annual-report	https://sthelenssafeguarding.org.uk/
Warrington	https://www.warringtonsafeguardingpartnerships.org.uk/p/about-the-wsp/annual-reports	https://www.warringtonsafeguardingpartnerships.org.uk/p/safeguarding-children/welcome-to-the-safeguarding-children-pages
Wirral	https://www.wirralsafeguarding.co.uk/the-partnership/annual-reports-business-plans/	https://www.wirralsafeguarding.co.uk/

1.2.3.13 Special educational needs and disabilities (SEND)

NHS Cheshire and Merseyside holds statutory responsibilities under the Children and Families Act 2014 and the SEND Code of Practice 2015 to ensure that children and young people aged 0–25 with Special Educational Needs and Disabilities (SEND) have their needs identified and met across education, health, and social care. Local Areas deliver this through Local Area SEND Partnerships (LASPs).

NHS Cheshire and Merseyside has a clear governance structure to comply with national SEND expectations:

- **Executive Lead for SEND:** Chris Douglas (Executive Director of Nursing & Care up until January 2026), Dr Fiona Lemmens (Executive Clinical Director – from February 2026)
- **Head of SEND (corporate)** providing strategic oversight.
- **Designated Clinical Officers (DCOs)** operating within each local authority area to deliver statutory functions.

Local Area SEND Partnerships are inspected under the Area SEND Inspection Framework (2023). Inspections lead to one of three outcomes:

1. **Positive experiences and outcomes** – improvement actions underway; full inspection usually within five years.
2. **Inconsistent experiences/outcomes** – partnership must make improvements; full inspection usually within three years.
3. **Significant concerns / widespread failings** – Priority Action Plan required; monitoring within 18 months; full reinspection within three years.

Table 9 Cheshire and Merseyside SEND inspections outcomes to date:

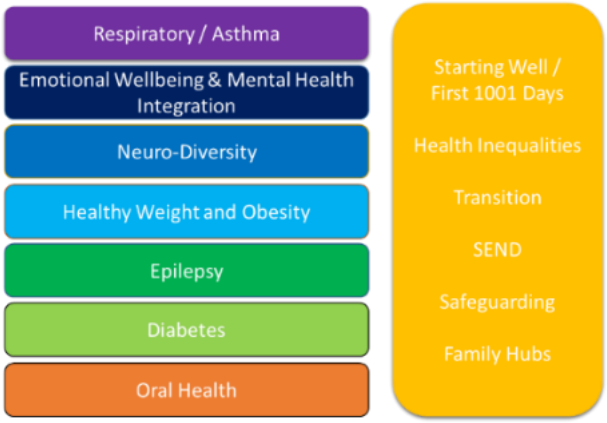
PLACE	INSPECTION DATE	INSPECTION FRAMEWORK APPLIED	OUTCOME	NEXT INSPECTION DUE
Cheshire West	April 2022 November 2025	2015 2023/5	No Written Statement of Action (WSOA) 2. Inconsistent	3 years ie. Autumn term 2028
Cheshire East	April 2018 May 2021 (Revisit)	2015 2015	WSOA WSOA Lifted	Inspection under 2023/5 framework predicted within the next 2 years
Knowsley	April 2021	2015	WSOA	Inspection under 2023/5 framework predicted within the next 2 years
Halton	Mar 2017 Nov 2023 January 2026	2015 2023 2023/5	No WSOA 3. Widespread and/or systemic failings	Monitoring inspection announced 12.1.26 Outcome currently embargoed
Liverpool	Feb 2019 June 2022 (Revisit)	2015 2015	WSOA WSOA lifted	Inspection under 2023/5 framework predicted within the next 2 years
Sefton	Dec 2016 June 2019 (Revisit)	2015 2015	WSOA WSOA lifted	Inspection under 2023/5 framework predicted within the next 2 years
St Helens	March 2018 February 2026	2015 2025	No WSOA	Full inspection announced 19.1.26 Outcome currently embargoed
Warrington	Feb 2019 Feb 2023	2015 2023	No WSOA 2. Inconsistent	3 years ie. Spring term 2026
Wirral	Dec 2021 Jan 2025	2015 2023	WSOA 3. Widespread and/or systemic failings	Monitoring inspection within 18 months ie. June 2026

Local authority-level SEND information can be found within the LASP's Local Offer. For health queries, Designated Clinical Officers for SEND are first point of contact.

Table 10

Local authority area	Local Offer	Designated Clinical Officer
Cheshire East	https://www.cheshireeast.gov.uk/livewell/local-offer-for-children-with-sen-and-disabilities/local-offer-for-children-with-sen-and-disabilities.aspx	Ingrid Bell
Cheshire West & Chester	https://www.livewell.cheshirewestandchester.gov.uk/Information/Local-offer	Gill Tyler (until 4.26) Jen Griffin (from 4.26)
Halton	https://localoffer.haltonfamilyhubs.co.uk/send-home	Kat Gater (Mat leave until 11.26) Beccy Emery
Knowsley	https://www.knowsleyinfo.co.uk/send-home	Charlotte Rees
Liverpool	https://liverpool.gov.uk/children-and-families/special-educational-needs-and-disabilities/send-local-offer/	Kerry Roberts
Sefton	https://www.seftondirectory.com/kb5/sefton/directory/localoffer.page?localofferchannel=0	Beckie Banks
St Helens	https://familyinfodirectory.sthelens.gov.uk/kb5/sthelens/directory/advice.page?id=LUHeqWQli0M	Charlotte Rees
Warrington	https://www.warrington.gov.uk/local-offer-send	Beccy Emery
Wirral	https://www.sendlowirral.co.uk/	Mike Banner

Children and Young People's Transformation Programme



Beyond has continued to bring partners together to deliver transformational improvements for children and young people across Cheshire and Merseyside

Progress has been aligned to the *three shifts* within the NHS Long Term Plan, with a strong focus on early intervention, prevention, and reducing health inequalities. Alongside delivery of established programme of work, Beyond has played a key role in enabling wider system transformation, strengthening multiagency collaboration, and embedding consistent, co-produced approaches to improving outcomes for children, young people and their families.

Participation
The Beyond Lundy Framework has been developed to provide a consistent regional approach for embedding the voices of children and young people in the planning, delivery, and evaluation of services. Building upon the established Lundy Model of Child Participation, the framework shifts practice from one-off engagement towards an ongoing, rights-based approach, ensuring young people's views remain central to everyday service delivery.

ISupport
Beyond is working with the iSupport team at Edge Hill University to pilot a region-wide approach to improving communication standards for staff working with children and young people. So far, 15 audits have been completed across a range of health settings. Young people are playing a key role in shaping this work, with two ambassadors helping to identify priority services and gather wider feedback from children and young people.

Case Study: Izzy, iSupport Young Ambassador

"Working alongside Lucy with the iSupport team has been an immense honour. At just 19, I've had the opportunity to collaborate with people and services that are making huge, positive differences to the way children and young people are treated, and it's been so rewarding to hear people's responses to the work that's being done as well as see these changes and their effects in action.

"It seems to me that as long as the iSupport team continues to be as dedicated and committed to the children and young people of Cheshire and Merseyside as they are currently, we are all in safe hands from now on."

Neighbourhoods

Beyond has provided strategic oversight for the implementation of Children and Young People's Neighbourhood MultiDisciplinary Teams (MDTs). Seed funding has been allocated to six of Cheshire and Merseyside's nine local authority areas to support the development of neighbourhood MDT models, with the aim of establishing one MDT in each area by end of Q1 2026-27.

Respiratory

The workstream focus remains on the delivery of the Asthma Bundle of care with significant improvements being seen in over-dispensing of Short-Acting Beta Agonist (SABA) inhalers. This reflects targeted system-wide respiratory work, including the development of the "Too Much Blue, Get a Review" programme.

So far 621 primary care colleagues have completed training on asthma in children and are now identifying those at higher risk based on their use of short-acting bronchodilators (SABA). This supports a shift towards Maintenance and Reliever Therapy (MART) for children and young people where appropriate, helping to reduce reliance on SABA.

Case Study: Too Much Blue – Get a Review

A new campaign launched across Cheshire and Merseyside in autumn 2025 to help children and young people better manage their asthma.

Developed by Beyond, 'Too Much Blue - Get a Review' launched in autumn 2025 to promote early review and support children and families to better manage asthma through education, practical tools and community-based support.

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

Intent programme
The Intent programme has been further rolled out in schools, with 8,000 children and young people accessing smoking prevention sessions, while 350 children and young people attended vaping prevention sessions delivered.

328 schools are working towards Asthma Friendly Schools accreditation with 16 schools now fully accredited to improve asthma safety and reduce missed school days. 71.95% of schools working towards accreditation have completed training.

Emotional wellbeing and mental health
The Appropriate Places of Care (APoC) programme has continued to strengthen support for children and young people with the most complex multiagency needs. Convened by Beyond and the Directors of Children's Services Forum, the work has united system partners to develop a consistent regional response. NHS Cheshire and Merseyside has agreed to jointly fund the revenue costs for four additional APoC homes across the region.

Neurodiversity
The Knowing Me NeuroInclusive Profiling Tool has been launched as a strengths-based approach that helps young people explain how they experience the world, the support they need, and what matters to them. Training began in September 2025, with over 850 colleagues trained within the financial year.

Healthy Weight and obesity
Beyond has supported the rollout of a Whole System Approach to healthy weight, with colleagues trained in systems thinking, leadership, mapping, and evaluation to drive change across sectors.

The Health, Exercise, Nutrition in the Really Young (HENRY) programme received an additional year of funding, enabling 176 professionals to complete training and supporting 882 families over the course of the programme.

Epilepsy
The epilepsy bundle of care continues to be delivered regionally. Integrated Epilepsy Specialist Nurses have:

- Improved access to specialist neurology advice
- Strengthened medicines governance
- Enhanced data quality
- Reduced variation in care

This work has enabled timely access to tertiary expertise through monthly case reviews and supported the establishment of the Complex Epilepsy Panel.

Diabetes
Transition teams and pathways have been established across pilot sites at Aintree Hospital, The Royal Liverpool University Hospital, and Southport and Ormskirk Hospitals. Access to diabetes technology is being closely monitored, with uptake continuing to rise, particularly among families living in the most deprived areas. Median HbA1c levels have also shown sustained improvement, indicating better diabetes management and improved outcomes.

Oral Health
The All Together Smiling supervised toothbrushing programme has been rolled out across the region, with 60,000 toothbrush and fluoride toothpaste packs distributed so far. A total of 290 early years settings, childminders and primary schools are now participating, supporting 12,000 children.

The programme has successfully reached over 52% of settings in the most deprived communities, helping to improve oral health and reduce inequalities.
(Evidence[1] shows that at least 50% reach will enable a positive reduction in tooth decay amongst children.)

Case Study: All Together Smiling - Supervised Tooth Brushing Programme

At Kensington Life Bank Nursery in Liverpool, more than 120 children take part in daily supervised toothbrushing. The programme was introduced in response to increasing levels of visible tooth decay in very young children, including cases requiring hospital treatment. Limited access to local NHS dental services meant many children were not receiving regular oral health checks.

With support from the All Together Smiling programme, the nursery has delivered workshops for parents on good oral health and the sugar content of food and drink. Toothbrushing is reinforced throughout the setting through displays and learning activities, helping children understand healthy choices. Staff also provide toothpaste to families and use social media to share updates and encourage consistent routines at home.

The approach has become embedded in daily practice, with staff reporting that children now look forward to toothbrushing as part of their routine.

Case Study – Primary school pupils make healthy lifestyle pledge

Primary school pupils in Cheshire and Merseyside took part in the ‘School’s Pledge for a Healthy and Active Future’, supporting healthier lifestyles through a whole-school approach to wellbeing. At The Oaks Community Primary School in Ellesmere Port, pupils were encouraged to eat well, stay active and build healthy habits for life.

The school introduced practical changes including healthier food and drink policies, increased physical activity throughout the day, and initiatives to promote nutritious meals and free school meal uptake. Pupils were actively involved, helping to shape activities such as daily exercise and healthier choices.

Funded by NHS Cheshire and Merseyside and delivered in partnership with the Health Equalities Group and local authorities, the programme is being rolled out across schools in more deprived areas. It supports a wider shift towards prevention by embedding healthy behaviours early and helping reduce long-term health inequalities.

Children and Young People's Alliance
Launched in November 2025, the Paediatric Clinical Advisory Service (PCAS) operates seven days a week across Cheshire and Merseyside. Between November and January 2,491 calls were accepted by PCAS, with a 57% call closure rate (1,420). As a result of the launch of PCAS, there has been a 36% decrease in the number of children advised to contact their GP, and a 60% decrease in the number of children referred onwards to Walk in Clinics or Urgent Treatment Centres. For children previously advised to contact primary care there has been a 50% reduction in the number of attendances to emergency department.

1.2.3.14 Engaging people and communities

As an integrated care board, NHS Cheshire and Merseyside has a statutory duty to involve the public in its work. The full details of the legal requirements are set out in section 14Z45 of the NHS Act 2006 and described in NHS England's *Working in partnership with people and communities: statutory guidance*.

NHS Cheshire and Merseyside's involvement plan
2025-26 was the second year of our two-year involvement plan, which was approved by the Board in summer 2024.

This plan sets out NHS Cheshire and Merseyside's overall approach to involving the public and wider stakeholders in our work. It acts as a foundation for more tailored activity based around specific projects and programmes.

The plan outlines the following ten objectives, which continued to inform NHS Cheshire and Merseyside's involvement focus during 2025-26:

1.	Ensure that involvement is embedded in our governance and decision-making as an organisation.
2.	Ensure that a focus on hearing underrepresented voices underpins our involvement plans.
3.	Provide a range of different routes for people and communities to be involved in the work of NHS Cheshire and Merseyside.
4.	Identify barriers to participation, and design communication and engagement mechanisms which recognise different needs, preferences, and styles.
5.	Ensure that tailored plans are developed for involving people in specific programmes and pieces of work, including service change.
6.	Ensure that our staff understand our involvement duties and recognise the benefits that come from working with people and communities. Support and empower staff to be proactive in identifying opportunities to embed involvement, including co-production, through their own roles.
7.	Actively find opportunities to share involvement skills and best practice amongst our provider organisations.
8.	Demonstrate how feedback is used to develop services and influence plans.
9.	Work with partners to develop and deliver involvement activity, so that we make the most of skills and expertise across the system, while utilising different routes for reaching our audiences.
10.	Look for ways to share the insights we gather with system partners, to maximise the impact of the feedback our local population gives us.

The involvement plan is due to be updated during 2026-27.

How NHS Cheshire and Merseyside involved people during the past 12 months
During 2025-26 we delivered our public involvement duties through engagement and consultation activity covering a range of different themes and issues. These included:

Gluten free prescribing
In early 2025, NHS Cheshire and Merseyside held a six-week public consultation on a proposal to end the prescribing of gluten free bread and bread mixes, with more than 1,000 people sharing their views.

Feedback from the consultation was considered by the Board of NHS Cheshire and Merseyside in May 2025, when the decision was made to end gluten free prescribing for adults aged over 18. Prescribing for under 18s continued until November 2025, when it also came to an end.

Shaping Care Together
From 04 July to 03 October 2025, the Shaping Care Together Programme ran a public consultation into where A&E services should be located in Southport, Formby and West Lancashire. More than 5,000 people shared their views during the consultation, with feedback set out in an independent report.

In March 2026, a joint committee made up of the integrated care boards of NHS Cheshire and Merseyside and NHS Lancashire and South Cumbria decided to relocate the children's A&E from Ormskirk Hospital to Southport Hospital and extend it to a 24-hour service, together with the existing 24-hour adult A&E.
For more information visit yoursayshapingcaretogether.co.uk

Women's Hospital Services in Liverpool
To support the Women's Hospital Services in Liverpool programme, NHS Cheshire and Merseyside set up a Lived Experience Panel for people who have used gynaecology or maternity services, either as patients, carers or family members. During summer 2025, members of the panel took part in workshops to develop potential options for how gynaecology and maternity services in the city could look in the future.
At a meeting on 29 January 2026, the Board of NHS Cheshire and Merseyside was presented with the findings of this options process and agreed to progress a proposal for a range of service improvements to improve safety in the medium term. This involves steps to increase resources at Liverpool Women's Hospital on Crown Street, and to deliver a number of very high-risk births and complex gynaecology operations at the Royal Liverpool University Hospital, rather than Liverpool Women's Hospital.

It is expected that public engagement on the proposal will take place during summer 2026, ahead of final decision-making.
For more information visit www.gynaeandmaternityliverpool.nhs.uk

Fertility treatment policies
In May 2025, the Board of NHS Cheshire and Merseyside approved a plan to hold a six-week public consultation on proposed changes to local fertility treatment policies.

The public consultation took place from 3 June to 15 July 2025, attracting more than 2,100 responses.

Following the consultation, and having received a report into the feedback received, the Board of NHS Cheshire and Merseyside made the decision to adopt a new, single policy. This was introduced in February 2026.

Previously, there were ten NHS subfertility policies being used across Cheshire and Merseyside, meaning people had varying access to NHS-funded fertility treatment, depending on where they lived.

Neonatal Service Review
NHS England and the three ICBs for the region – NHS Cheshire and Merseyside, NHS Greater Manchester and NHS Lancashire and South Cumbria are looking at how to improve neonatal care for babies and their families across the North West.

A case for change has been developed which describes the challenges facing the region's neonatal services, and a staff engagement process was undertaken during January and March 2026 to gain views and feedback. During March 2026 there will also be discussions with parents, carers and family members who have used neonatal services to hear about their experiences of care - including what currently works well, and what could be better for babies and their families.

Feedback gathered from staff, parent and carer discussions will be used to help inform the next phase of planning for improving neonatal services, which includes developing potential options for how neonatal services could look in the future. These would be set out in a Pre-Consultation Business Case which is likely to be drafted later in 2026.

1.2.3.15 Environmental matters

NHS Cheshire and Merseyside remains committed to embedding sustainability at the heart of health and care planning and delivery, in line with the *NHS Long Term Pla*n and *Delivering a Greener NHS*.

Climate change presents a significant and growing risk to population health and to health and care services, with vulnerable populations disproportionately affected by environmental hazards. To tackle this, our approach focuses on reducing the environmental impact associated with service delivery, improving health outcomes, tackling health inequalities, and ensuring the system is resilient to current and future climate risks.

The NHS Cheshire and Merseyside Green Plan (2025-2028) came into effect on 1 April 2025 and sets out our system-wide approach to delivering a sustainable, net zero health service by 2040. Developed collaboratively with system partners, the Green Plan builds on progress made during the 2022-2025 period.

Case Study – NHS trusts in Cheshire and Merseyside secure £8.3 million for clean energy upgrades

Eight NHS trusts across Cheshire and Merseyside secured £8.3 million in national funding to deliver clean energy upgrades, reducing carbon emissions and generating long-term savings that can be reinvested into patient care. The funding supports improvements such as solar panels, battery storage, LED lighting and more efficient building systems.

As part of the NHS net zero programme, these upgrades will cut energy use, lower running costs and support more sustainable healthcare delivery, while strengthening the resilience of NHS services across the region.

Progress and highlights

Key environmental highlights during the year include:

- Delivery and evaluation of green primary care pilot projects, with learning informing wider rollout across general practice. Areas of focus included active travel, biodiversity, staff and patient engagement, medicines optimisation, deprescribing, waste reduction and lifestyle-based prevention.
- Continued embedding of environmental sustainability within planning and decision-making processes.
- Strengthening of system co-ordination and assurance through the Sustainability Board and supporting governance structures, enabling greater consistency of approach with partners.

Social value and Anchor Institutions

As a recognised Social Value Accelerator site since 2018, NHS Cheshire and Merseyside has continued to embed social value principles across the system. This leadership and impact in delivering social, economic and environmental value was recognised through the award of the Silver Social Value Quality Mark for Health.

Social value activity highlights include:

- More than 100 organisations have signed the Social Value Charter
- 98 organisations have achieved the Social Value Award
- In total, £824,794,000 of social value was delivered across Cheshire and Merseyside during the reporting period.

In addition, the Cheshire and Merseyside Anchor network has continued to expand, with 49 organisations now signed up to the Anchor Charter.
Highlights from the Anchor Charter include:

- 99% of employees are paid the Real Living Wage
- 86% of the workforce resides within Cheshire and Merseyside
- 32% of employees live in the 20% most deprived neighbourhoods, supporting inclusive local recruitment
- 54% of contracts and grants are awarded locally, contributing to the regional economy

- 10 organisations support VCSE partners through free use of buildings
- All Anchor organisations deliver initiatives addressing health inequalities.

Anchor organisations are also contributing to environmental sustainability, with 17 organisations having a Net Zero or Green Plan in place and all committing to reducing environmental impact and work towards net zero by 2040 or sooner.

Taskforce on climate-related financial disclosures (TCFD)

Local NHS bodies are not required to directly report Scope 1, 2 and 3 greenhouse gas emissions under TCFD, as these are calculated nationally by NHS England.

Recommended disclosures will be implemented on a phased basis up to the 2025-26 financial year. For 2024-25, the phased approach incorporates the disclosure requirements of: Governance, Strategy, Risk Management and Metrics and Targets.

Governance

NHS Cheshire and Merseyside has overall accountability for environmental sustainability and climate-related matters. The Board receives regular updates on delivery of the Green Plan (2025-2028), including progress against key priorities, risks and system-level performance indicators.

Climate-related issues are formally reported to the Board and are considered within strategic planning, estates strategy, financial planning, and service transformation.

Progress against goals and targets is monitored through:
- Oversight of Green Plan delivery via the Sustainability Board
- Review of system-level performance indicators
- Reporting into regional Net Zero governance arrangements
- Integration of relevant risks into the corporate risk management framework.

Executive accountability for sustainability sits with the Assistant Chief Executive Officer. Operational leadership is provided by a dedicated sustainability function within the Assistant Chief Executive Officer directorate, led by the Associate Director of Partnerships and Sustainability.

Below Board level, responsibility for delivery is distributed across management structures including estates, procurement, finance, population health, emergency planning and transformation teams.

Strategy
Climate-related risks have been identified through strategic planning processes, risk assessments, and reference to HM Treasury TCFD guidance (including physical and transition risks as outlined in Table 11).

Table 11

Physical risks (acute and chronic)	Transition risks	Identified opportunities
• Increased frequency and intensity of heatwaves • Flooding and extreme weather events • Impacts on infrastructure, supply chains and service continuity • Increased demand for services linked to heat, air pollution and climate-sensitive conditions.	• Policy and regulatory changes associated with net zero commitments • Withdrawal or variability of capital funding (e.g., decarbonisation schemes) • Reputational risk associated with failure to demonstrate progress • Workforce and capability constraints.	• Improved population health through prevention-focused, low-carbon models of care • Energy efficiency and operational cost savings • Innovation in digital care pathways reducing travel and estate demand • Strengthened community resilience through Anchor and social value approaches.

NHS Cheshire and Merseyside's strategy is evolving to address these risks through:
- Delivery of the Green Plan 2025–2028
- Integration of adaptation into estates and emergency planning
- Promotion of prevention and population health approaches
- Strengthening system-wide governance and assurance.

Use of the NHS Climate Change Risk Assessment Tool supports identification of localised physical risks and informs prioritisation.

Risk Management

The Climate Change Committee's 2025 progress assessment highlights increasing exposure of UK public services to heat, flooding, infrastructure disruption and interdependent system risks. NHS Cheshire and Merseyside has considered the themes and risk areas identified within this report when reviewing system resilience and adaptation priorities.

Risk identification during the reporting period has largely been led by the Sustainability function. Climate-related risks are identified through policy review, programme development, analysis of national evidence and engagement with system sustainability forums.

Mitigation and adaptation activity during the reporting period has been driven primarily through the Green Plan programme rather than through a stand-alone climate risk management framework.

Metrics and Targets

Key metrics used to assess climate-related risks and opportunities include:
- Energy consumption (kWh) and associated emissions (tCO_2e)

- Greenhouse gas emissions (Scopes 1 and 2 where applicable locally, with Scope 3 reported nationally)
- Inhaler prescribing data
- Anaesthetic gas usage
- Waste generation and diversion rates
- Social value and anchor metrics.

Targets and Performance Against Targets

NHS Cheshire and Merseyside and system partners contribute to the NHS commitment to achieve:

- Net Zero for NHS Carbon Footprint emissions by 2040
- Net Zero for NHS Carbon Footprint Plus emissions by 2045.

The Cheshire and Merseyside Green Plan (2025-2028) includes system-wide objectives relating to:

- Reduction in carbon emissions from estates and operations
- Increased uptake of low-carbon models of care
- Reduction in high-carbon inhaler prescribing
- Improved waste segregation and recycling
- Increased embedding of sustainability within organisational decision-making.

During 2025–2026, progress against these objectives included:

- Continued delivery of green primary care pilot schemes
- Ongoing delivery of estates decarbonisation schemes across partner Trusts
- Expansion of sustainability governance and reporting arrangements
- Increased participation in Anchor and Social Value initiatives supporting environmental sustainability.

NHS Cheshire and Merseyside recognises that maturity of system-wide emissions reporting and target monitoring continues to develop. Further work is planned during 2026-2027 to strengthen quantitative performance reporting and climate-related target tracking across the system.

Figure 6

	Low Carbon Skills Fund (LCSF)	Public Sector Decarbonisation Scheme (PSDS)	NHS Energy Efficiency Fund (NEEF) / NHS Decarbonisation Fund	GB Energy	Energy Submetering	NHS Chargepoint Accelerator Scheme	Other	All Schemes total by year
2020/21	£95,340.00							**£95,340.00**
2021/22		£10,206,366.00						**£10,206,366.00**
2022/23								**£0.00**
2023/24	£622,114.00	£832,984.00	£2,117,399.41					**£3,572,497.41**
2024/25	£99,921.00		£3,781,000.00	£6,303,000.00	£23,000.00			**£10,206,921.00**
2025/26		£34,663,706.00	£8,288,215.81	£4,763,160.00	£188,472.00	£220,696.00		**£48,124,249.81**
All years total by scheme	**£817,375.00**	**£45,703,056.00**	**£14,186,615.22**	**£11,066,160.00**	**£211,472.00**	**£220,696.00**	**£0.00**	**£72,205,374.22**

Figure 6 - Greener NHS programme Trust Estates Funding by Scheme and Year Awarded

Figure 7

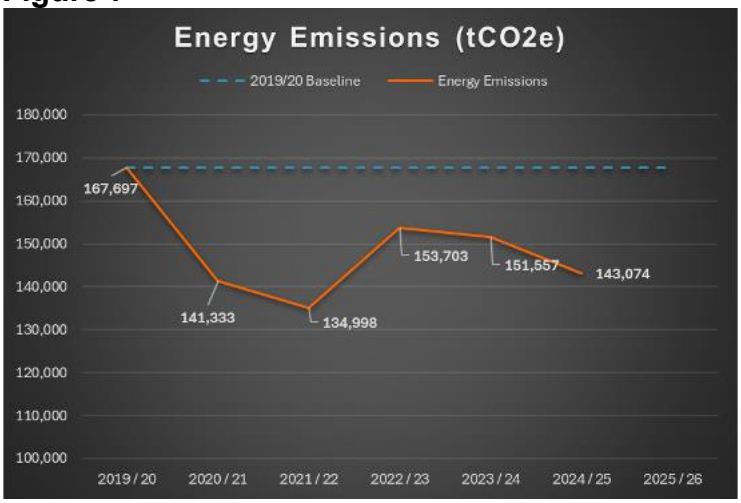


***Figure 7** - Trust energy (electricity, gas and oil) emissions*

1.2.3.16 Equality, diversity and Inclusion

Discrimination and disadvantage contribute to unequal access, experience and outcomes for patients and can also affect staff experience and opportunity. Equality, diversity and inclusion therefore remain central to how NHS Cheshire and Merseyside carries out its role as a commissioner, employer and system leader.

NHS Cheshire and Merseyside remains committed to meeting its duties under the Equality Act 2010 and to reducing inequalities in access, experience and outcomes. During 2025 to 2026, this work continued in the context of financial recovery, organisational reform and significant system pressure.

As a result, a substantial proportion of EDI capacity was required to respond to live service change, policy, workforce and governance issues, while maintaining statutory assurance and support to decision making.

Strategic EDI leadership sits within the central NHS Cheshire and Merseyside director and senior leadership structures. The Chief People Officer has acted as the Senior Responsible Officer for EDI, workforce and organisational development at Board level. From a patient and commissioning perspective, the Senior Responsible Officer for EDI has been the Assistant Chief Executive. The Associate Director of EDI provides strategic leadership across the organisation.

A full Equality, Diversity and Inclusion Annual Report for 2025 to 2026 is in development and, once finalised, will be published on the NHS Cheshire and Merseyside Equality, Diversity and Inclusion webpage: *https://www.cheshireandmerseyside.nhs.uk/about/equality-diversity-and-inclusion/*

That report will provide fuller detail on how the organisation is meeting its Public Sector Equality Duty, promoting equality of service delivery, publishing equality information, and reporting progress in relation to workforce, patients, accessibility and the Equality Delivery System.

During the year, NHS Cheshire and Merseyside continued to apply equality considerations across commissioning, transformation, workforce and corporate governance. This included equality advice and challenge into service change and financial recovery proposals, support for equality and health inequality impact assessments, oversight of provider equality assurance, staff support, and collaborative work with partners to improve accessibility, inclusion and the use of evidence in decision making. The year also demonstrated the need to strengthen the shift from reactive support to earlier and more strategic EDI involvement, with stronger links between equality, involvement, quality, risk and performance oversight.

NHS Cheshire and Merseyside's work has continued to be informed by national equality requirements and improvement frameworks, including the NHS EDI Improvement Plan and associated success metrics. Workforce equality reporting has continued through the established national standards.

Publicly available information on the NHS Cheshire and Merseyside website shows that the Workforce Race Equality Standard report for 2024 to 2025 was published through People Committee papers in September 2025 and the Workforce Disability Equality Standard report for 2024 to 2025 was published through People Committee papers in October 2025. Gender Pay Gap reporting was also published through the relevant national reporting route.

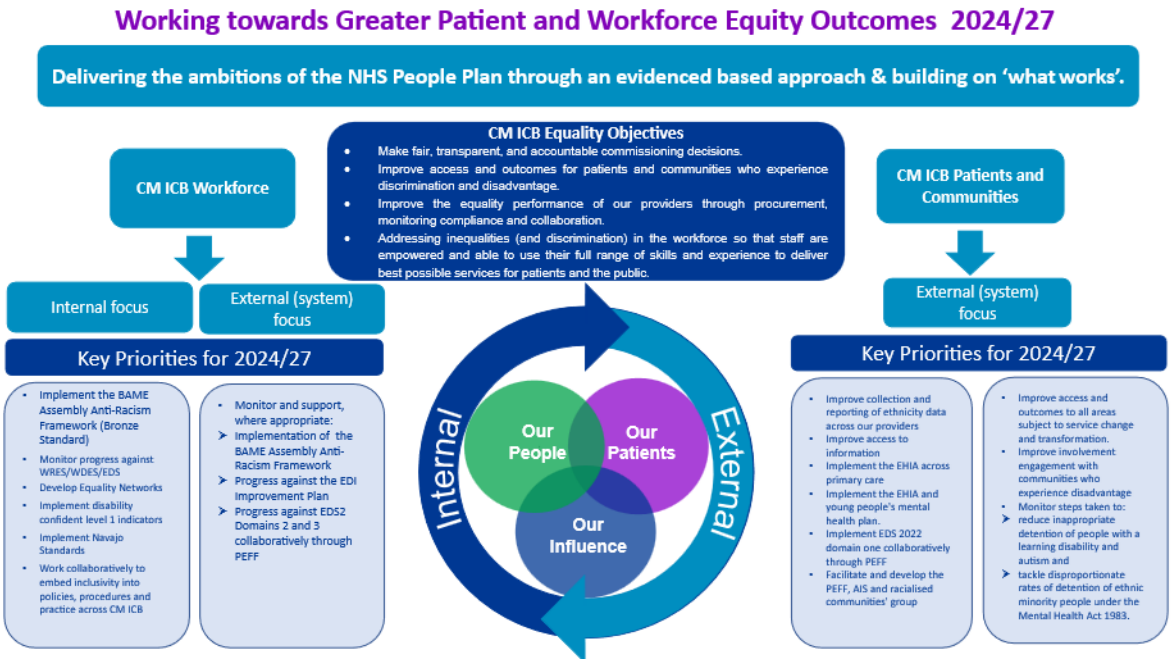
Health Objectives

NHS Cheshire and Merseyside's Equality Objectives for 2024 to 2027 are to

- Make fair, transparent and accountable commissioning decisions
- Improve access and outcomes for patients and communities who experience discrimination and disadvantage
- Improve the equality performance of providers through procurement, oversight and collaboration
- Address workforce inequalities so that staff are supported and able to use their full range of skills and experience to deliver the best possible services for patients and the public.

To support delivery of these objectives, NHS Cheshire and Merseyside has developed a plan on a page . These include supporting fair and evidence based financial recovery decisions, embedding equality and inclusion within organisational reform, improving the quality and use of ethnicity data, and strengthening implementation of the Accessible Information Standard and the Reasonable Adjustment Digital Flag across secondary and primary care.

These priorities are aligned to wider system aims, including the All Together Fairer strategy, the Cheshire and Merseyside Health and Care Partnership agenda and the Joint Forward Plan.



Key areas of progress during the year included, equality input into Individual Funding Request processes where the Public Sector Equality Duty may be engaged, ongoing EDI awareness activity, and partnership work to improve implementation of the Accessible Information Standard. The AIS partnership has supported development of a primary care pilot involving commissioners, providers, local authority partners, Healthwatch, informatics leads, equality officers, accessibility specialists and experts by experience.

Equality Delivery System

The Equality Delivery System remains an important part of NHS Cheshire and Merseyside's assurance approach. EDS supports NHS organisations to review services, workforce and leadership through evidence and engagement, and to identify where improvement is required.

For 2024 to 2025, NHS Cheshire and Merseyside reported an overall mean Domain 1 rating of Achieving across the provider trusts reviewed in Cheshire and Merseyside. Domain 1 considers whether service users have appropriate access to services, whether health needs are met, whether people are free from harm when using services, and whether service users report positive experiences.

For 2025 to 2026, publicly available provider information indicates a mixed picture, with several providers continuing to demonstrate Achieving ratings and some showing areas where further improvement is required. NHS Cheshire and Merseyside will continue to use EDS findings, alongside wider equality, quality and performance information, to inform provider oversight and improvement discussions. The full EDI Annual Report will provide a fuller account of EDS performance, evidence and next steps.

Priorities for 2026 to 2027 will include strengthening early EDI input to decision making, improving the consistency and quality of equality and health inequality evidence, ensuring clear and timely workforce equality reporting, using EDS findings more systematically in provider oversight, refreshing equality objectives in line with

organisational reform, and demonstrating more clearly the impact of mitigating actions on patients, communities and staff.

1.2.3.17 Medicines and prescribing

Prescribing is the most common intervention in healthcare, and strong medicines management, pharmacy expertise and medicines optimisation are essential to delivering safe, effective care while ensuring best value. Prescribing activity also underpins many of the other workstreams described throughout this Annual Report, reflecting its central role in improving quality, safety and sustainability across the system.

Of the prescribing costs of £561 million shown in the accounts, GP practices in Cheshire and Merseyside spend around £527 million each year on prescriptions, while total prescribing across the system, including specialist services, exceeds £1 billion. Effective medicines optimisation is therefore critical not only to improving patient outcomes but also to ensuring that NHS resources are used wisely. Savings achieved through appropriate prescribing enable resources to be redirected to support delivery of high-quality care for all patients.

In 2025-26, a cost-effective prescribing programme is expected to deliver over £35 million in savings, aligned to the principles of medicines optimisation: improving patient experience, supporting evidence-based use of medicines and ensuring safe prescribing. This work is delivered through close collaboration with clinicians across primary and secondary care, pharmacy professionals and allied health professionals, supporting consistent, high-quality prescribing decisions.

In primary care, prescribing programmes have focused on supporting shared decision-making between clinicians and patients, ensuring that changes to medicines are clearly understood and clinically appropriate. Clear, patient-facing communications, alongside the sharing of key projects, objectives and supporting documentation on the NHS Cheshire and Merseyside website, have improved patient confidence in prescribing decisions. This has supported safer optimisation of medicines, while enabling financial efficiencies to be delivered alongside improved patient experience and clinical outcomes.

Targeted programmes have delivered quality and efficiency improvements in areas such as high-cost hospital medicines and antimicrobial stewardship, with joint working between hospitals and general practice contributing to reductions in inappropriate antibiotic use.

The polypharmacy programme has proactively identified and reviewed patients at risk of medicine-related harm across hospitals and general practice and will remain a priority in 2026-27, alongside continued communications campaigns such as *Only Order What You Need*, supporting sustained patient and clinician engagement.

Case Study: 'Five double-decker buses' of medication saved in Cheshire and Merseyside

Residents in Cheshire and Merseyside have supported their local NHS to successfully reduce medicines waste in the region, saving approximately 60 tonnes of prescription medicines last winter – the weight of five double-decker buses.

A total of 641,000 prescription medicine items were saved during a five-month period from November 2024 to March this year, compared to forecasted numbers for dispensed medicine items, which would have otherwise cost the local NHS around £5 million.

The campaign was viewed approximately 2 million times across the region - via online platforms, local radio, and on 200 local buses - and is being relaunched this November in time for #MedSafetyWeek, with NHS leaders asking the public to 'only order what you need' to continue helping reduce medicines waste and stockpiling.

1.2.3.18 Emergency Preparedness, Resilience and Response

NHS Cheshire and Merseyside is classified as a Category 1 responder under the Civil Contingencies Act (2004) and is subject to the following set of civil protection duties:

- Assess the risk of emergencies occurring and use this to inform emergency planning;
- Put in place emergency plans;
- Put in place business continuity management arrangements;
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency;
- Share information with other local responders to enhance coordination; and
- Cooperate with other local responders to enhance coordination and efficiency.

Emergency Preparedness, Resilience and Response (EPRR) is a core function of the NHS and is a statutory requirement of the Civil Contingencies Act (2004). Responding to emergencies is also a key function within the NHS Act (2005) as amended by the Health and Social Care Act (2012).

During 2025-26, the Director of Performance and Planning was the Accountable Emergency Officer up until March 2025, when the role was transferred to the Executive Director of Strategy and Transformation.

The Accountable Emergency Officer is supported by the Head of Emergency Preparedness, Resilience and Response for the delivery of the Emergency Preparedness, Resilience and Response Work Programme. In order to meet its statutory duties as a Category 1 responder, NHS Cheshire and Merseyside holds a portfolio of emergency and business continuity plans which have been developed in consultation with Corporate Teams and key stakeholders.

As per the Emergency Preparedness Resilience and Response Framework (2022), a self-assessment was performed by NHS Cheshire and Merseyside against the EPRR Core Standards in September 2025. A position of substantially-compliance was declared, with only four out of 47 standards requiring further action to meet full compliance. The EPRR Team endeavours to deliver against each Core Standard and there continues to be opportunities for the organisation to further improve over the coming year, through the implementation and monitoring of effective action plans.

The EPRR Team supported Tactical and Strategic Commanders in the use of prepared plans to effectively respond to and recover from a variety of incidents during 2025-26. This included:

Water Street Liverpool RTC Major Incident	May 2025
Industrial Action	July 2025
Manchester Synagogue Attack (Supporting NHS GM)	October 2025
Wirral University Teaching Hospital Sterile Services Critical Incident	October 2025

The aim was to minimise disruption and support patient care across the system. The Incident Coordination Centre was activated with a Command and Control Structure in place, while debriefs were also undertaken following each incident to highlight lessons identified and notable practice. Where appropriate, the subsequent reports from these incidents have been shared with multi-agency partners to inform the planning and response arrangements for potential future incident response.

The Emergency Preparedness, Resilience and Response team also performed a crucial role in the multi-agency planning arrangements for significant events across Cheshire and Merseyside during 2025-26 which included:

Grand National	April 2025
Liverpool Football Club Trophy Parade	May 2025
Southport Airshow	August 2025
Creamfields	August 2025
Labour Party Conference	September 2025

This year saw the approval and ratification of multiple policies and plans, including the Business Continuity Policy, Incident Response Plan and Adverse Weather Plan. The EPRR Team continue to support all services in the production of their individual Business Impact Analyses and subsequent Service Area Business Continuity Plans. All of these elements contribute to the Business Continuity Management System for NHS Cheshire and Merseyside and support progress in addressing one of the two identified EPRR risks.

To test and validate plans, NHS Cheshire and Merseyside has developed and delivered three exercises and participated in 39 multi-agency exercises.

The Team has delivered 22 EPRR specific training sessions in relation to Commander Training, Loggist Training and Resilience Direct Training. These sessions benefit Strategic Commanders, Tactical Commanders and EPRR Specialists within Cheshire and Merseyside. An additional 15 specific training

sessions were also provided on specific areas including Legal Awareness and Media Training.

NHS Cheshire and Merseyside continues to lead the health sector in multi-agency preparedness and planning for emergencies through the Local Health Resilience Partnership and is a core member of both the Cheshire Resilience Forum and Merseyside Resilience Forum. The Local Resilience Forums identify potential risks and produce emergency plans to either prevent or mitigate the impact of any incident on their local communities, for which NHS Cheshire and Merseyside represents the whole health sector and Providers within Cheshire and Merseyside.

EPPR and environmental factors
During 20252/6, the ICS Sustainability Team continued its work to develop and consolidate understanding of climate change as a strategic risk to health, service continuity, and population vulnerability. This included ongoing preparation and analysis relating to climate adaptation and its relevance to emergency preparedness, resilience, and response. While this work has established a strong evidence base and clarity on emerging risks, progress towards embedding climate adaptation within established EPRR planning, governance and assurance processes is now dependent on broader system cooperation and alignment.

1.2.3.19 Research and Innovation

The National Institute of Health Research (NIHR) published accounts for 2023/24 estimate that for every £1 invested in health research, society receives over £13 in return. This return comes from direct health benefits, profits to UK firms undertaking research, and spillover effects to the wider economy.

In 2024, NHS Cheshire and Merseyside approved the establishment of an Integrated Research and Innovation System (IRIS) to fulfil its statutory responsibility to deliver research and innovation under the Health and Social Care Act 2022. This aligned with NHS England's guidance for ICBs on Maximising the Benefits of Research.

The Cheshire and Merseyside Integrated Research and Innovation System (IRIS) has added considerable value to the Cheshire and Merseyside health and care ecosystem by attracting considerable external research investment, strongly supporting innovation and enabling the Cheshire and Merseyside Integrated Care System (ICS) to evolve into a national leader in research and innovation excellence that sets us apart and ahead in areas such as research and innovation in the primary and community setting.

The Model ICB Blueprint reinforces the need for strong strategic partnerships with academia and industry to support the population health strategy. It also highlights the need for robust evaluation methodologies, as well as evidence synthesis using both qualitative and quantitative data, feedback, and insights to inform the development of care pathways and neighbourhood delivery models.

Cheshire and Merseyside has a strong foundation in primary and community research, with 349 practices engaged, 131 actively recruiting, and 53 involved in commercial studies—more than twice the national average (15% vs 6%). The region ranks among the top three nationally for total primary care recruitment, alongside North West London and Oxford, and leads all ICBs for research recruitment in the

most deprived communities. It also tops the country for the total number of primary care studies opened and for recruitment in the most deprived communities demonstrating its commitment to inclusive and impactful research.

The universities across Cheshire and Merseyside - Edge Hill University, Liverpool John Moores University, University of Chester, and University of Liverpool play a vital role in supporting research and innovation within the region's Integrated Care System. These institutions bring together world-leading expertise in public health, primary care, and social care research, directly aligning with the proposed priorities to improve population health and develop health neighbourhoods.

The Cheshire and Merseyside region benefits from strong links with a wide range key NIHR infrastructure, including the NIHR Applied Research Collaboration (ARC), NIHR Academy, NIHR School for Public Health Research, NIHR Health Determinants Research Collaboration, NIHR Mental Health Leadership Award and NIHR Coastal Communities Awards. Edge Hill University and the University of Chester- both home to new and growing medical schools - are expanding opportunities for health and social care researchers from diverse professions, backgrounds, and research interests.

Cheshire and Merseyside organisations, including primary care, social care, voluntary groups, and ten secondary care providers, are working together to support the NHS 10-year health plan through participation in the new £5.7M NIHR Cheshire and Merseyside Commercial Research Delivery Centres (CRDCs), which aim to promote better patient outcomes and a healthier population, support UK economic growth, and contribute to a financially sustainable NHS. The NHS University Hospitals of Liverpool Group has been named one of 21 UK CRDCs, giving patients faster access to innovative clinical trials and treatments. This recognition highlights the strength of collaboration within the region's healthcare research ecosystem, supported by Liverpool Health Partners—a partnership between research-intensive universities and NHS trusts.

The Cheshire and Merseyside region is home to one of the largest bio-manufacturing clusters, and its scientists are driving breakthroughs in infection prevention and control, therapeutics, mental health, and the use of data and AI to improve lives. The CRDC will provide a vital link to connect this industry to the NHS.

Supported by ICB-directed NIHR Research Capability Funding, several Research and Innovation Collaborations have been established, including the Wirral Research Collaborative, Halton Research Alliance, and the St Helens Research and Innovation Academy. The Wirral Research Collaborative is a partnership of health and care providers across the Wirral, united in their commitment to improving outcomes for the local population through high-quality evaluation and research. By fostering synergy between primary care, secondary care, and wider health and care agencies, the collaboration supports a thriving research and innovation ecosystem across the community.

The Liverpool City Region's Life Sciences Investment Zone supports initiatives that create high-tech facilities, drive business innovation, and develop future talent. A key example is Alder Hey Children's NHS Foundation Trust, awarded over £4 million as part of a £9.44 million investment by the Combined Authority to establish the Paediatric Open Innovation Zone (POIZ). This initiative enhances the region's

leadership in children's healthcare innovation. Alder Hey, home to the UK's largest hospital-led innovation centre, has a proud legacy of pioneering paediatric care. POIZ will develop and deploy cutting-edge technologies to tackle health challenges facing children and young people. It will also enable collaboration with local innovators, giving them access to Alder Hey's clinical teams and expertise. The initiative supports businesses in testing healthcare solutions and provides training to embed innovation-led care across the region. It will also help NHS and industry partners benefit from Alder Hey's experience and global reputation.

1.2.3.20 Capital resources

Joint Capital Resources Plan
The National Health Service Act 2006, as amended by the Health and Care Act 2022 sets out that an Integrated Care Board and its partner NHS Trusts and Foundation Trusts:

- must before the start of each financial year, prepare a plan setting out their planned capital resource use
- must publish that plan and give a copy to their integrated care partnership, Health and Wellbeing Boards and NHS England
- may revise the published plan - but if they consider the changes significant, they must re-publish the whole plan; if the changes are not significant, they must publish a document setting out the changes.

The Joint Capital Resources Plan for 2025-26 was published on the NHS Cheshire and Merseyside website (https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/finance-procurement-and-contracting/joint-capital-resource-plan/) and sets out the £497m capital plans for 2025-26. The key priorities identified within the Plan included to:

- enable secondary care and primary care and GP Practices to maintain their equipment and premises safe
- investing in a number of key strategic objectives across urgent care and mental health; and delivering on local and national priorities supporting recovery of constitutional standards.

The completion of existing schemes covering urgent care upgrades, elective recovery and mental health dormitory eradication was identified as a key priority, as well as the eradication of Reinforced Autoclaved Aerated Concrete (RAAC) from Trust premises (Countess of Chester, Aintree Hospitals and Mid Cheshire Hospital).

Further investment in electronic patient records at Warrington and Halton Hospitals, Southport and Ormskirk and Liverpool University Teaching Hospitals remained a key objective for 2025-26.

For the 2025-26 period, the following programmes were identified to be prioritised:

- Estates Safety infrastructure proposals (c£18m) which were developed based on the scale of our most critical infrastructure issues with the aim of reducing the high and significant risk backlog reported by organisations in the Estates Returns Information Collection (ERIC).

- The ICS Mental Health Programme team led a prioritisation task and finish group with mental health providers to ascertain the system priorities for managing out of area placements.
- c£6.3m has been received linked to national bids for net zero (GB energy solar scheme).
- c£62m has been allocated nationally to tackle the RAAC challenges, most notably Leighton Hospital (Mid Cheshire Hospital NHS FT) and Aintree Hospital (Liverpool University Hospitals NHS FT).
- Capital to expedite improvements against the constitutional standards (c£67m) supported by the Cheshire and Merseyside Provider Collaborative and Cheshire and Merseyside Diagnostics Network focused on diagnostics, elective and urgent care (covering both physical and mental health).
- c£54m capital to accelerate digitisation for those trusts with the lowest digital maturity through additional digital infrastructure and implementation of electronic patient records.
- Mid Cheshire have been allocated £27m to start to develop the New Hospital on the Leighton site as part of the national New Hospital Programme.

Changes to Joint Capital Resources Plan and outcome

The figure in this plan are for items that NHS Cheshire and Merseyside manages on behalf of the whole system and none of the capital spend is accounted for in the finance statements of the ICB.

Changes to the plan were not significant and therefore it was not necessary to publish a revised plan. During the year, the Cheshire and Merseyside system invested £454m in capital, £33m less than the original plan. This was principally a result of delays in approval and delivery of projects linked to capital to expedite improvements in constitutional standards which amounts to £28.2m of the system variance.

Work on constitutional standards and other improvement programmes will continue in 2026-27 supported by further capital resource.

1.3 Financial review

1.3.1 Statutory Duties

NHS Cheshire and Merseyside has a number of financial duties under the NHS Act 2006 (as amended) **Table 12**

Table 12

Duty	Achieved
Expenditure not to exceed income	Yes
Revenue resource use does not exceed the amount specified in Directions	Yes
Revenue administration resource use does not exceed the amount specified in Directions	Yes

NHS Cheshire and Merseyside achieved its financial duties in the year ended 31 March 2026.

1.3.2 Financial Performance

Table 13 summarises NHS Cheshire and Merseyside's financial performance for the year to 31 March 2026

Table 13

Area of Expenditure	2025-26		
	In Year Allocation £000s	Expenditure £000s	Surplus/ (Deficit) £000s
Programme	8,328,458	8,328,484	(26)
Running Costs	61,035	60,979	56
Total	**8,389,493**	**8,389,463**	**30**

Each year NHS Cheshire and Merseyside is given a spending allocation for programme costs and running costs and formulates its spending plan against the allocation. NHS Cheshire and Merseyside delivered a surplus (underspend) of £30k against its spending allocations for the year ended 31st March 2026.

As explained elsewhere in this report, NHS Cheshire and Merseyside ICB did not meet the financial targets in its original plan, which set an ICB target surplus of £50m, within an Integrated Care System (ICS) control total of £178m deficit excluding Deficit Support Funding (i.e. a control deficit of £178m for the ICB and the NHS providers in the Cheshire and Merseyside system). The system agreed an adjusted control total of £288m deficit (excluding Deficit Support Funding) in the year, which was £110m adverse to the original plan. The ICB is currently subject to formal NHS England enforcement undertakings, reflecting the challenges of ICB and wider system financial delivery.

A system-wide recovery programme is underway. This included a revised 2026/27 Financial Plan, strengthened financial governance and controls, and enhanced oversight arrangements. External support for the system was provided in 2025-26 by a large accountancy firm to help drive financial recovery and sustainable improvement. It was agreed with NHS England that the cost of the support, which amounted to approximately £5.6m including VAT for the ICS system, would be met by the ICB on behalf of the system.

Net programme expenditure increased by £446m reflecting uplifts in funding for pay and non-pay inflation, increases in spend for the elective recovery and other NHS priorities.

NHS Cheshire and Merseyside did not require a capital allocation for 2025/26. Capital expenditure for ICBs consists of renewals of leases for buildings capitalised as Right of Use assets less disposals of leases no longer required. Lease arrangements are treated as capital items under accounting standards. The impact of changes to ICB leases in 2025-26 did not result in a requirement for capital funding.

1.3.3 Financial Analysis

The analysis in Table 14 provides further information on NHS Cheshire and Merseyside's net expenditure for the year ended 31 March 2026.

Table 14

Expenditure Area	**2025/26 £000s**
Acute Provision	3,821,329
Community Services	729,716
Primary Care Other	127,557
Prescribing incl. Associated Costs	564,679
Primary Care Delegated	923,312
Specialist Commissioning	765,437
Mental Health Services	824,912
Continuing Healthcare	486,028
Other	85,514
Total Programme Expenditure	**8,328,484**
Running costs	60,979
Total Expenditure	**8,389,463**

Figure 8 shows the relative percentage of NHS Cheshire and Merseyside expenditure against the reporting categories.

Figure 8

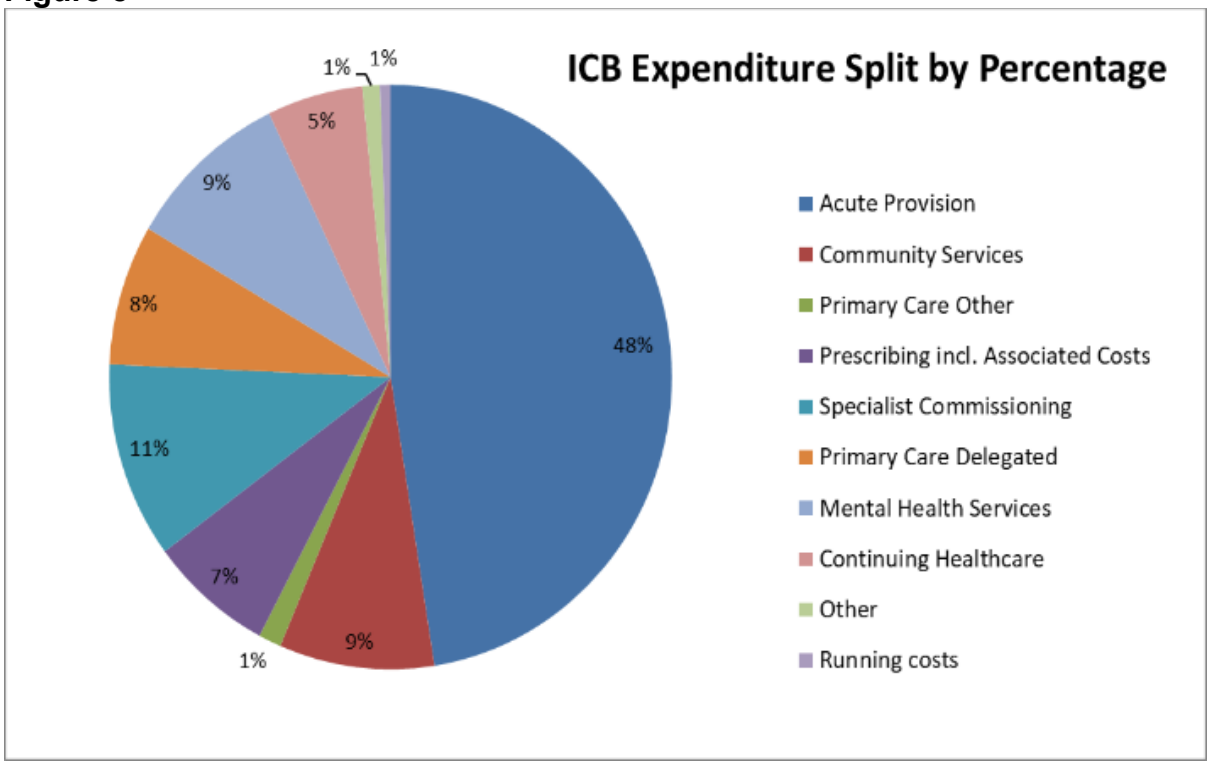


Table 15 provides information on NHS Cheshire and Merseyside's programme expenditure with the top 15 NHS providers for the year ended 31st March 2026. These providers account for £5.16 bn or 62% of NHS Cheshire and Merseyside Programme expenditure.

Table 15

Provider	**£000s**
Liverpool University Hospital NHS Foundation Trust	988,768
Mersey & West Lancashire Teaching Hospitals NHS Trust	750,384
Mersey Care NHS Foundation Trust	576,558
Wirral University Teaching Hospital NHS Foundation Trust	444,142
Mid Cheshire NHS Foundation Trust	393,843
Warrington NHS Foundation Trust	327,089
Countess of Chester Hospital NHS Foundation Trust	317,148
Cheshire and Wirral Partnership NHS Foundation Trust	245,406
Alder Hey Children's NHS Foundation Trust	244,323
East Cheshire NHS Foundation Trust	181,669
North West Ambulance Service NHS Trust	159,957
Liverpool Women's NHS Foundation Trust	146,222
Clatterbridge Cancer Centre NHS Foundation Trust	144,818
Liverpool Heart and Chest Hospital NHS Foundation Trust	130,118
Walton centre NHS Foundation Trust	109,151
Total Programme Expenditure Top 15 NHS providers	**5,159,597**
Other Programme Net Expenditure	3,168,887
Total Programme Expenditure	**8,328,484**
Running costs	60,979
Total Net Expenditure for the Year	**8,389,463**

1.3.4 Mental Health

The percentage of mental health spend (as defined by the Mental Health Investment Standard) as a proportion of spend can be seen in not 24 to the accounts and in **Table 16.**

Table 16

Financial Years	**Current year (2025/26)**	**Prior year (2024/25)**
	£'000	**£'000**
Minimum expenditure in mental health services to meet the Mental Health Investment Standard as notified by NHS England	667,310	581,602
Mental Health Expenditure	673,970	591,031
Mental health expenditure above minimum investment required	6,660	9,429
Mental Health Spend as a proportion of total expenditure	8%	7%

Liz Bishop

Liz Bishop
Chief Executive
18th June 2026

Accountability Report

- Corporate Governance Report
- Remuneration and Staff Report
- Parliamentary Accountability and Audit Report

2. Accountability Report

2.1 Accountability Report

This Annual Report has been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2025 - 26.

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

- The **Corporate Governance Report** sets out how we have governed the organisation during the period 01 April 2025 to 31 March 2026 including membership and organisation of our governance structures and how they supported the achievement of our objectives.

- The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

- The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

2.2 Corporate Governance Report

2.2.1 Members Report

2.2.1.1 Chair and Chief Executive

Raj Jain was the Chair of NHS Cheshire and Merseyside since 01 July 2022 until 12 October 2025, with Sir David Henshaw becoming the Chair from 13 October 2025. Cathy Elliott was the Chief Executive of NHS Cheshire and Merseyside from 01 June 2025 until 17 November 2025, with Liz Bishop becoming the Chief Executive from 18 November 2025.

2.2.1.2 Board

The Board of NHS Cheshire and Merseyside directs and controls the major activities of the organisation and is collectively accountable for the performance of its functions.

The Membership of the Board during the 2025-26 period is set out in **Table 17.**

Table 17

Name	Position	From	To
Raj Jain	Chair	01 July 2022	12 Oct 2025
Sir David Henshaw	Interim Chair	13 Oct 2025	Present
Tony Foy	Non-Executive Member	01 July 2022	Present
Erica Morriss	Non-Executive Member	01 July 2022	Present
Prof Hilary Garratt CBE	Non-Executive Member	03 July 2023	Present
Dr Ruth Hussey CB, OBE, DL	Non-Executive Member	01 Nov 2023	Present
Mike Burrows	Non-Executive Member	27 March 2025	Present
Sue Lorimer	Non-Executive Member	05 Nov2025	Present
Adam Irvine	Partner Member	01 July 2022	Present
Dr Naomi Rankin	Partner Member	31 Jan 2023	Present
Ann Marr OBE	Partner Member	01 July 2022	08 Sept 2025
Trish Bennett MBE	Partner Member	01 November 2024	Present
Janelle Holmes	Partner Member	25 Sept 2025	Present
Warren Escadale	Partner Member	01 Oct 2026	Present
Andrew Lewis	Partner Member	01 Oct 2024	Present
Stephen Broomhead MBE	Partner Member	01 July 2022	30 June 2025
Delyth Curtis	Partner Member	01 July 2025	Present
Graham Urwin	Chief Executive	01 July 2022	31 May 2025
Cathy Elliott	Chief Executive	01 June 2025	17 Nov 2025
Liz Bishop	Interim Chief Executive	18 Nov 2025	Present
Prof Rowan Pritchard-Jones	Medical Director	01 July 2022	27 Jan 2026
Chris Douglas MBE	Executive Director of Nursing and Care	01 July 2022	11 Jan 2026
Mark Bakewell	Interim Director of Finance	09 Dec 2024	14 Sept 2025
Andrea McGee	Interim Director of Finance and Contracting	15 Sept 2025	01 Feb 2026
Andrea McGee	Executive Director of Finance and Contracting	02 Feb 2026	Present
Dr Fiona Lemmens	Executive Clinical Director	02 Feb 2026	Present
Clare Watson	Executive Director of Health and Integrated Care Commissioning	02 Feb 2026	Present
Jude Adams	Interim Executive Director of Strategy and Partnerships (Turnaround	02 Dec 2025	Present
Ben Vinter	Executive Director of Corporate Services and Governance	02 Mar 2026	Present

2.2.1.3 Directors

NHS Cheshire and Merseyside's directors, in addition to those on the Board listed 2.2.1.2, for the 2025-26 period are set out in Table 18.

Table 18

Corporate Directors			
Name	**Position**	**From**	**To**
Clare Watson	Assistant Chief Executive	1 July 2022	01 Feb 2026
Mike Gibney	Chief People Officer	13 Jan 2025	Present
Anthony Middleton	Director of Performance and Planning	1 July 2022	31 March 2025
Dr Fiona Lemmens	Deputy Medical Director	1 July 2022	01 Feb 2026
John Llewellyn	Chief Digital Officer	17 Oct2022	Present
Jude Adams	Interim Executive Director of Strategy and Partnerships (Turnaround)	02 Dec 2025	Present
Place Directors			
Name	**Position**	**From**	**To**
Mark Wilkinson	Place Director – Cheshire East	1 July 2022	29 June 2025
Richard Burgess	Interim Place Director – Cheshire East	08 Sept 2025	Present
Laura Marsh	Interim Place Director – Cheshire West	22 Nov 2023	Present
Anthony Leo	Place Director – Halton	01 July 2022	31 March 2026
Anthony Leo	Interim Place Director - Liverpool	18 Dec 2024	31 March 2026
Alison Lee	Place Director – Knowsley	01 July 2022	30 Aug 2025
Jenny Woods	Interim Place Director – Knowsley	01 Sept 2025	Present
Deborah Butcher	Place Director – Sefton	01 July 2022	28 Sept 2025
Tracey Jeffes	Interim Place Director – Sefton	29 Sept 2025	Present
Mark Palethorpe	Place Director – St Helens	01 July 2022	31 March 2025
Jamaila Hussein	Place Director – St Helens	01 April 2025	Present
Carl Marsh	Place Director – Warrington	01 July 2022	28 Sept 2025
Amanda Ridge	Interim Place Director – Warrington	29 Sept 2025	31 March 2026
Simon Banks	Place Director – Wirral	01 July 2022	Present

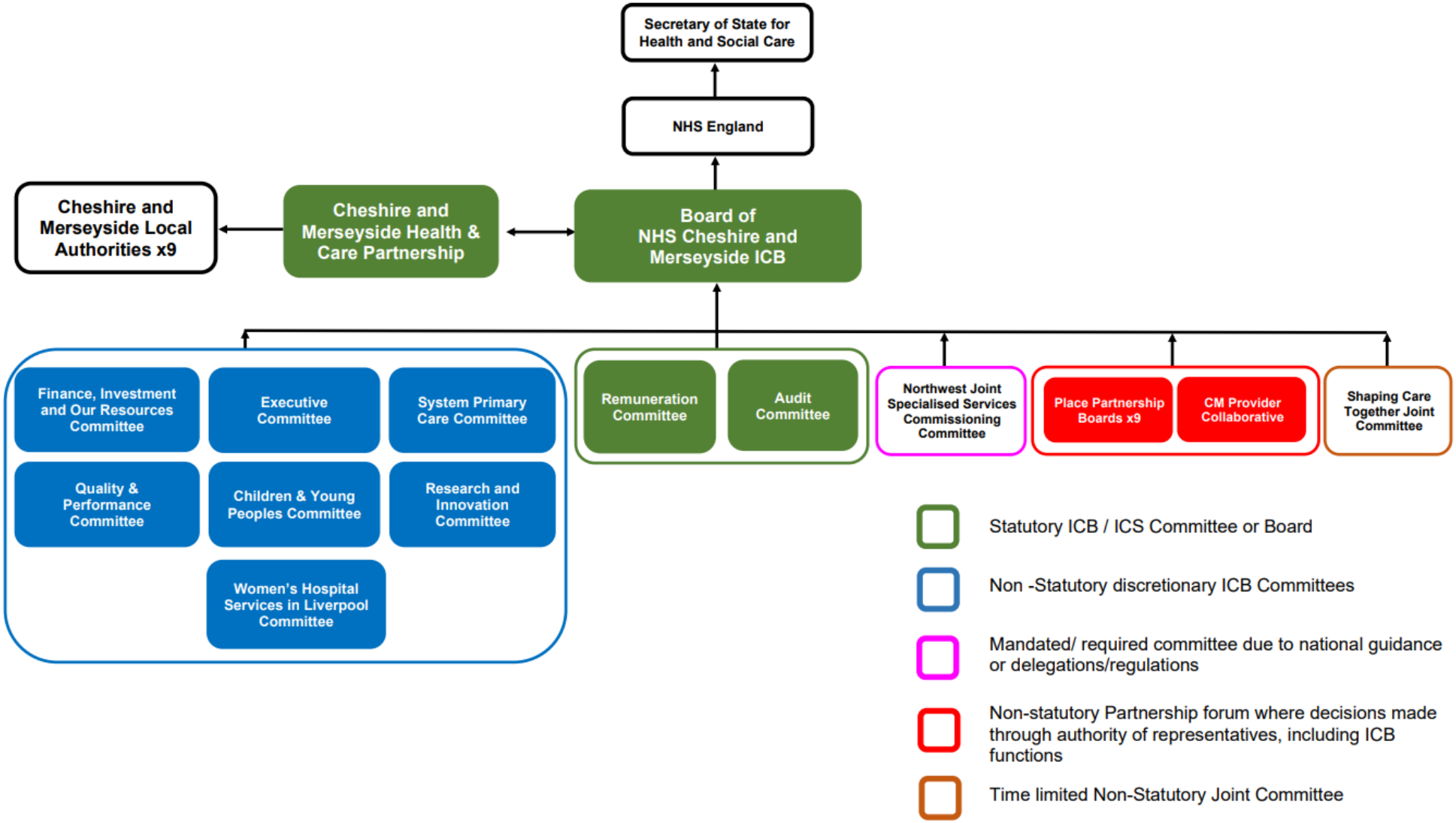
Further information regarding NHS Cheshire and Merseyside's current Board members and directors can be found on our website here

2.2.1.4 Committee(s), including Audit Committee

The members of the Audit Committee during the period covered by this report are set out in Appendix One.

NHS Cheshire and Merseyside's governance and committee structure is set out in Figure 9. The membership of, and attendance at each committee is provided in Appendix One.

Figure 9


Secretary of State for Health and Social Care
NHS England
Cheshire and Merseyside Local Authorities x9
Cheshire and Merseyside Health & Care Partnership
Board of NHS Cheshire and Merseyside ICB
Finance, Investment and Our Resources Committee
Executive Committee
System Primary Care Committee
Quality & Performance Committee
Children & Young Peoples Committee
Research and Innovation Committee
Women's Hospital Services in Liverpool Committee
Remuneration Committee
Audit Committee
Northwest Joint Specialised Services Commissioning Committee
Place Partnership Boards x9
CM Provider Collaborative
Shaping Care Together Joint Committee
Statutory ICB / ICS Committee or Board
Non -Statutory discretionary ICB Committees
Mandated/ required committee due to national guidance or delegations/regulations
Non-statutory Partnership forum where decisions made through authority of representatives, including ICB functions
Time limited Non-Statutory Joint Committee

2.2.1.5 Register of Interests

NHS Cheshire and Merseyside is committed to maintaining high standards of transparency and integrity in its decision-making. The ICB hosts a dedicated Conflicts of Interest section on its website, which provides clear information on how conflicts are identified, declared and managed. This includes access to key policies and publicly available registers detailing declarations of interest, gifts, hospitality and sponsorship.

Robust governance arrangements are in place to support this, including the appointment of an independent Conflicts of Interest Guardian (a Non-Executive Director on the ICB Board and Chair of the Audit Committee) who provides advice, oversight and a safe point of contact for raising concerns. These arrangements help ensure that any actual or perceived conflicts are appropriately managed and handled in line with national guidance.

The ICB uses the Civica Declare platform to capture and publish declarations electronically, enabling both staff and the public to access up-to-date information in a transparent and consistent way. This approach supports compliance with NHS requirements and reinforces public confidence in how decisions are made and resources are used.

All ICB Staff complete as part of their Annual Statutory and Mandatory training the NHS England approved Managing Conflicts of Interest Module One.

A review of the ICBs arrangements for managing conflicts of interest last featured on the 2023-24 Internal Audit Plan. The completed review provided the ICB with a Substantial Audit opinion. A further review of the ICBs arrangements has been incorporated within the 2026-2027 Internal Audit Plan.

Further details on how the ICB manage conflicts of interest, including its Conflicts of Interest Policy can be found at:
https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/managing-conflicts-of-interest/

During 2025-26 there were no reported breaches of the NHS Cheshire and Merseyside's Conflicts of Interest policy and procedures.

2.2.1.6 Personal data related incidents

NHS Cheshire and Merseyside's arrangement for information governance are described in the Governance Statement on page 99.

There were no personal data related incidents during the year which required formal reporting to the Information Commissioner's Office (ICO).

2.2.1.7 Modern Slavery Act

NHS Cheshire and Merseyside fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the period ending 31 March 2026 is published on our website.

2.2.2 Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of NHS Cheshire and Merseyside and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The National Health Service Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer and that Officer shall be appointed by NHS England.

NHS England has appointed the Chief Executive to be the Accountable Officer of NHS Cheshire and Merseyside. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding NHS Cheshire and Merseyside's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS Cheshire and Merseyside's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Liz Bishop

Liz Bishop
Chief Executive
18th June 2026

2.2.3 Governance Statement

2.2.3.1 Introduction and context

NHS Cheshire and Merseyside is a body corporate established by NHS England on 01 July 2022 under the National Health Service Act 2006 (as amended).

NHS Cheshire and Merseyside's statutory functions are set out under the National Health Service Act 2006 (as amended).

NHS Cheshire and Merseyside's general function is arranging the provision of services for persons for the purposes of the health service in England. It is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.

In November 2025, NHS England determined that Financial and Quality Enforcement Undertakings would be applied to NHS Cheshire and Merseyside. Section 14Z61 of the Act gives NHS England powers to direct ICBs when it is satisfied that an ICB (a) is failing or (b) is at risk of failing to discharge its functions. In its correspondence, NHS England indicated to NHS Cheshire and Merseyside that it has reasonable grounds to suspect that the ICB is failing or has failed to discharge one or more of its functions properly, or that there is a significant risk that it will fail to do so, in particular, its functions under sections 3, 14Z33, 14Z34, 14Z43, and 223L and 223M of the NHS Act 2006. NHS enforcement guidance is published **here** and sets out the steps NHS England will follow when considering its ICB enforcement powers under the NHS Act 2006.

2.2.3.2 Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of NHS Cheshire and Merseyside's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in the NHS Cheshire and Merseyside's Accountable Officer Appointment Letter.

I am responsible for ensuring that NHS Cheshire and Merseyside is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within NHS Cheshire and Merseyside as set out in this governance statement.

2.2.3.3 Governance arrangements and effectiveness

The main function of the Board is to ensure that NHS Cheshire and Merseyside has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically, and complies with such generally accepted principles of good governance as are relevant to it.

NHS Cheshire and Merseyside's governance arrangements described below have been designed, developed and embedded to ensure that:

- through the membership of the Board, its committees and underpinning network of partnership, programme, clinical and other advisory networks, there is access to a broad range of professional expertise in the prevention, diagnosis or treatment of illness, and the protection or improvement of public health.
- it is appropriately informed and clear on the impacts of decisions, and responsive to the 'triple aims' of health and wellbeing of the people of England, quality of healthcare services for the purposes of the NHS and sustainable and efficient use of resources by NHS bodies.

The ICB constitution commits NHS Cheshire and Merseyside to, at all times, observe generally accepted principles of good governance. This includes the Nolan Principles of Public Life and any governance guidance issued by NHS England. NHS Cheshire and Merseyside has agreed standards of business conduct. These set out the expected behaviours that members of the Board and its committees will uphold while undertaking NHS Cheshire and Merseyside business, and principles that will guide decision making.

The constitution commits NHS Cheshire and Merseyside to demonstrating its accountability to local people, stakeholders, and NHS England in a number of ways. These include a set of principles for involving people and communities, meetings and publications, the appointment of non-executive members to the Board, transparent decision-making, compliance with procurement rules and the publication of an annual report and accounts.

The constitution describes the arrangements for the exercise of its functions, which may be through delegation internally, externally or jointly with another body, where permitted by legislation.

NHS Cheshire and Merseyside has published a functions and decision map on its website which provides a high-level structural chart setting out which decisions are delegated and taken by which parts of the system.

NHS Cheshire and Merseyside has also published a scheme of reservation and delegation on its website which sets out those decisions which are reserved to the Board and those which have been delegated.

NHS Cheshire and Merseyside's Governance Structure Chart is in the Members Report on page 96. Details of the membership and attendance at the Board and each of its committees is provided in Appendix One. The key responsibilities of the Board and each of its committees, highlights of their work, and assessment of their performance and effectiveness over the year is provided in sections 2.2.3.4 to 2.2.3.14.

2.2.3.4 Board of NHS Cheshire and Merseyside

NHS Cheshire and Merseyside sets out to use its resources and powers to achieve demonstrable progress against the four core purposes of Integrated Care Systems. These are as follows and are set by NHS England:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access

- enhance productivity and value for money
- help the NHS support broader social and economic development.

The Board of NHS Cheshire and Merseyside remains accountable for all of the functions of the Integrated Care Board, including those that it has delegated and therefore, appropriate reporting and assurance mechanisms are in place forming part of agreed terms of delegation. Each NHS Cheshire and Merseyside committee provides a frequent assurance update to the Board on the areas it has considered and which are within the scope and authority of each respective committee terms of reference.

During the financial year 2025-2026, the Board has held its meetings in public seven times and was quorate on each occasion. Key activities of the Board included the approval and oversight of NHS Cheshire and Merseyside's significant strategies, plans and financial plan / budget; making decisions in relation to major change programmes such as Gynaecology and Maternity Hospital Services in Liverpool; making decisions around service changes such as the cessation of NHS Funded Gluten free prescribing and the harmonisation of sub-fertility policies across the region, and making other key decisions in relation to items reserved to the Board; and receiving assurance reports in relation to key strategic issues and risks from committees and leadership.

2.2.3.5 Audit Committee

The Audit Committee is accountable to the Board and provides an independent and objective view of NHS Cheshire and Merseyside's compliance with its statutory responsibilities. The Committee is responsible for arranging appropriate internal and external audit.

The Committee provides oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within NHS Cheshire and Merseyside. The Terms of Reference for this Committee can be found on our website at: https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/.

During 2025-26, the Committee has met five times and was quorate on each occasion. Key activities of the Committee included scrutinising and recommending to Board NHS Cheshire and Merseyside's Annual Report and Accounts and receiving associated audit opinions and reports; approving policies where delegated to the committee; and oversight and assurance to the Board in relation to audit activity, anti-fraud, conflicts of interest, risk management, information governance, procurement waivers and freedom to speak up.

2.2.3.6 Remuneration Committee

The Remuneration Committee is accountable to the Board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to NHS Cheshire and Merseyside. The Terms of Reference for this Committee can be found on our website at: https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/.

During 2025-2026, the Committee has met 10 times and was quorate on each occasion. Key activities of the Committee included approving contractual changes in respect of very senior manager roles; approving recruitment arrangements and appointments to the NHS Cheshire and Merseyside Board and executive roles; approving policies where delegated to the committee.

2.2.3.7 Integrated Care Board Executive Committee

The NHS Cheshire and Merseyside Executive Committee is responsible for effective operational management of NHS Cheshire and Merseyside, through the provision of effective leadership and direction to the work of the organisation. It also supports the Board in setting the vision and the organisations' strategic objectives. The Terms of Reference for this Committee can be found on our website at: https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/.

In addition, the NHS Cheshire and Merseyside Executive Team Committee will provide direction, as a category one responder and that NHS Cheshire and Merseyside supports its partners with system and borough-wide planning and activity. It will also make decisions in respect of system quality innovation productivity and prevention (QIPP) and financial recovery, any such decision shall be reported to the next meeting of the Board for ratification.

During 2025-2026, the Committee has met weekly. Key activities of the Committee included approving commissioning, decommissioning and funding decisions as delegated by the Board, reviewing and endorsing significant strategies, plans and financial plan / budget prior to submission for Board approval; and oversight and assurance to the Board in respect of key strategic programmes and activity of NHS Cheshire and Merseyside, finance, performance, quality, workforce, key issues and risks.

2.2.3.8 Finance, Investment and Our Resources Committee (FIRC)

The Finance, Investment and Our Resources Committee (FIRC) provides NHS Cheshire and Merseyside with a vehicle to support assurance, risk management, system engagement, delivery and collaborative resolution in finance and investment, including capital and resources, for NHS Cheshire and Merseyside as an employer. The Terms of Reference for this Committee can be found on our website at: https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/.

During 2025-26, the Committee has met 12 times and was quorate on each occasion. Key activities of the Committee included decisions on budgets, capital plan and financial plan submissions, and procurements; endorsing the Infrastructure Strategy prior to Board approval; and oversight and assurance to the Board in respect of the long-term financial strategy, ongoing financial position, recovery programmes and delivery of efficiencies, procurement and risks.

2.2.3.9 Quality and Performance Committee

The Quality and Performance Committee provides the Board with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality (safe, effective, person-centred,

well-led, sustainable and equitable), set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021.

The Committee scrutinises the robustness of, and gains and provides assurance to the Board, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care. The Committee focuses on quality performance data and information and considers the levels of assurance that NHS Cheshire and Merseyside can take from performance oversight arrangements within the Integrated Care System and actions to address any performance issues. The Terms of Reference for this Committee can be found on our website at: https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/.

During 2025-2026, the Committee has met 11 times and was quorate on each occasion. Key activities of the Committee included oversight and assurance to the Board in relation to the quality and performance of the range of services commissioned by NHS Cheshire and Merseyside, the SEND, All Age Continuing Care Programme and Safeguarding functions of NHS Cheshire and Merseyside, quality issues and concerns, patient safety incidents, complaints and risks; and approving policies where delegated by the Board.

2.2.3.10 System Primary Care Committee

The System Primary Care Committee has been established to enable collective decision-making on the review, planning and procurement of primary care services in relation to GP primary medical services, community pharmacy, primary dental and primary ophthalmic services as part of NHS Cheshire and Merseyside's statutory commissioning responsibilities across Cheshire and Merseyside under delegated authority from NHS England. The Terms of Reference for this Committee can be found on our website at: https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/.

During 2025-2026, the System Primary Care Committee has met 10 times and was quorate on each occasion. Key activities of the Committee included oversight and assurance to the Board in relation to delivery of primary care strategies and access improvement plans; response to national commissioning and contract policy, local system pressures, GP Patient Survey and Healthwatch reports on access improvement and patient experience.

2.2.3.11 Women's Hospital Services in Liverpool Committee

The Women's Hospital Services in Liverpool Committee was established, following the Liverpool Clinical Services Review report published in January 2023, to oversee a programme of work to address the clinical sustainability of hospital services for women and the clinical risk in the current model of care. The Terms of Reference for this Committee can be found on our website at: https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/.

During 2025-2026, the Committee has met four times and was quorate on each occasion. Key activities of the Committee included approving programme plans; endorsing the draft case for change; and oversight and assurance in relation to the

delivery of the programme, stakeholder engagement and risks. Following a review of NHS Cheshire and Merseyside Committees, the Women's Hospital Services in Liverpool Committee was disestablished after its last meeting in December 2025, with its ICB duties transferring to the Executive Committee.

2.2.3.12 Children and Young People's Committee

The Children and Young People's Committee oversees, shapes and provides assurance to the Board of NHS Cheshire and Merseyside regarding its responsibilities and functions for children and young people (aged 0 to 25), children and young people with special educational needs and disabilities, and safeguarding (children and young people), including looked after children.

The Committee has overseen the development and delivery of the Cheshire and Merseyside Children and Young People's Strategy and ensures effective system focus on Children and Young People as a population cohort. The Committee is also responsible for oversight of the delivery of the ambitions and priorities within the Cheshire and Merseyside Joint Forward Plan, in relation to Children and Young People. The Terms of Reference for this Committee can be found on our website at: https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/.

During 2025-2026, the Committee has met four times and was quorate on each occasion. Key activities of the Committee included engagement with children and young people and relevant services; endorsing key strategies, plans and consultation responses; and considering reports on high risk, high-cost children and young peoples' placements, the neurodiversity pathway and child poverty. Following a review of NHS Cheshire and Merseyside Committees, the Children and Young Peoples Committee was disestablished after its last meeting in October 2025, with its duties transferring to the Executive Committee.

2.2.3.13 Cheshire and Merseyside Health and Care Partnership

The Cheshire and Merseyside Health and Care Partnership (HCP) is formally a joint Committee between NHS Cheshire and Merseyside and the nine Local Authorities of Cheshire and Merseyside. However, it is a broad alliance of a diverse range of organisations and representatives concerned with improving the care, health, and wellbeing of the population. Its meetings are jointly convened by local authorities and the NHS as equal partners in order to facilitate joint action to improve health and care outcomes and experiences, influence the wider determinants of health, and plan and deliver improved integrated health and care.

The HCP, as an Integrated Care Partnership, has a statutory responsibility to prepare, approve and publish an Integrated Care Strategy for the Cheshire and Merseyside Integrated Care System, setting out how the assessed needs in relation to Cheshire and Merseyside are to be met by the exercise of functions of the Integrated Care Board, NHS England, and the nine local authorities whose areas coincide with the Cheshire and Merseyside area. The Terms of Reference for this Committee can be found on our website at: https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/.

During 2025-26, the Health and Care Partnership has met on one occasion.

2.2.3.14 Joint Committees

Under s65Z5 of the act, NHS Cheshire and Merseyside is able to jointly exercise its functions with other relevant bodies and in 2025-26 the Board has been a member of two joint Committees.

2.2.3.15 North-West Specialised Services Joint Committee

Specialised services support people with a range of rare and complex conditions. They often involve treatments provided to patients with rare cancers, genetic disorders or complex medical or surgical conditions. The North-West was one of three regions in England where NHS England approved plans to delegate the commissioning of a number of specialised services, to ICBs from 01 April 2024. These arrangements are underpinned by a Delegation Agreement, which can be found on our website.

These services consist of ‘delegate 1’ services which are planned at a single-ICB level with decision being taken by the ICB, and ‘delegate 2’ services which are planned and commissioned jointly at a multi-ICB level.

In order to facilitate the delegate 2 decision making a Specialised Services Joint Committee has been established between the three North West ICBs (Cheshire and Merseyside, Greater Manchester, and Lancashire and South Cumbria). The role of the Joint Committee is to carry out the strategic decision-making, leadership and oversight functions relating to the commissioning of specified Delegated Services as set out in the NHS England Delegation Agreement.

As a Joint Committee of the three ICBs, the Joint Committee is accountable to the respective Boards of NHS Cheshire and Merseyside ICB, NHS Greater Manchester ICB and NHS Lancashire and South Cumbria ICB. The NHS Cheshire and Merseyside representatives at this Committee are made up of one Non-Executive Member and one Executive director. The Terms of Reference for this Committee can be found on our website at: https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/.

The ICB has also established a Specialised Commissioning Oversight Group to oversee the commissioning and delivery of the 59 single-ICB Specialised (delegate 1) services that have been delegated from NHS England to NHS Cheshire and Merseyside. The group brings together the leadership of the ICB with the NHS England Nort West hub and subject matter experts with a commitment to ensure that we commission effective, high-quality care in relation to delegated specialised commissioning functions within the resources available.

A specialised services audit was included on the 2025-26 internal audit plan. The objective of this audit was to assess the effectiveness of the ICB’s governance, risk management, financial control and operational delivery arrangements relating to specialised commissioning. The audit provided a ‘substantial’ assurance opinion.

2.2.3.16 Shaping Care Together Joint Committee

The Shaping Care Together programme is a health and care transformation programme operating across Southport, Formby and West Lancashire. Its aim is to

improve the quality of care for local residents by exploring new ways of delivering services and utilising staff, money and buildings to maximum effect.

As the commissioners for the programme, NHS Cheshire and Merseyside and NHS Lancashire and South Cumbria agreed to form a Joint Committee for the Urgent and Emergency Care decisions in scope of the Shaping Care Together Programme. As a Joint Committee of the two ICBs, the Joint Committee is ultimately accountable to the respective Boards of NHS Cheshire and Merseyside and NHS Lancashire and South Cumbria. NHS Cheshire and Merseyside are the lead commissioner in this arrangement. The Terms of Reference for this Committee can be found on our website at: https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/.

During 2025-26 the Shaping Care Together Joint Committee met on three occasions and was quorate on each occasion. Key activities of the Committee included the approval of the Pre-Consultation Business Case and the start of a comprehensive public consultation, receipt of the outcome of the consultation and the approval of the final Decision Making Business Case, which was approved to agree the future location of A&E services in Southport, Formby and West Lancashire. More information regarding this programme can be found here: Your Say Shaping Care Together.

2.2.3.17 UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance.

2.2.3.18 Discharge of Statutory Functions

NHS Cheshire and Merseyside has reviewed all the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that NHS Cheshire and Merseyside is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of NHS Cheshire and Merseyside's statutory duties.

2.2.3.19 Risk management arrangements and effectiveness

NHS Cheshire and Merseyside's Risk Management Strategy sets out its statement of intent, organisational arrangements, systems and processes for risk management and assurance. It has been developed based on best practice and subject to consultation within NHS Cheshire and Merseyside and with its internal auditors.

Risks arise from a range of external and internal factors, and the identification of risks is the responsibility of all NHS Cheshire and Merseyside staff. This is done proactively, via regular planning and management activities and reactively, in response to inspections, alerts, incidents and complaints.

All risks are assessed to determine:

- a clear description identifying the cause, effect and impact on NHS Cheshire and Merseyside

- ownership of the risk including operational and executive leadership and overseeing committee
- strategic objective or function that will be impacted by the risk
- controls that are currently in place to mitigate the risk and an assessment of their effectiveness
- an evaluation of the impact and likelihood of the risk using NHS Cheshire and Merseyside's risk matrix to arrive at an inherent and current risk rating
- risk proximity indicating whether the impact will be immediate, within or beyond the current year
- appropriate risk treatment and further mitigation action based on risk tolerance and cost effectiveness
- sources of assurance in respect of key control measures.

The control framework and mechanisms aim to provide a holistic system for prevention, deterrence and management of risks including:

- governance structures, with clearly defined terms of reference, roles and explicit responsibilities for scrutiny and assurance
- an accountability and reporting framework, with clearly defined roles and responsibilities
- clear strategies and plans with associated monitoring and review mechanisms
- policies, procedures and guidance, supported by communication, training and development
- robust contracts and service level agreements and effective contract management processes
- robust and effective performance, financial, risk, and project management
- an internal control framework, including independent, external assurance.

During 2025-26, the ICB's Internal Auditors, as part of the Internal Audit Annual workplan, undertook a review of the ICBs risk management controls. Findings from the audit identified that there was a good system of internal controls operating at the ICB for risk management, which included a clear risk escalation process which set out the formal procedure for managing and escalating risk. The ICB was provided with a substantial assurance rating with four recommendations for improvement, which included mandatory risk training for staff, formatting improvements to the risk register and a clear process for managing risks which are shared with Third Party Organisations.

The Board has developed and agreed the following core statement of risk appetite:

'NHS Cheshire and Merseyside's overall risk appetite is OPEN – we are willing to consider all delivery options and may accept higher levels of risk to achieve improved outcomes and benefits for patients.

NHS Cheshire and Merseyside has no tolerance for safety risks that could result in avoidable harm to patients.

Our ambitions to improve the health and wellbeing of our population and reduce inequalities can only be realised through an enduring collaborative effort across our system. We will not accept risks that could materially damage trust and relationships with our partners.

We will pursue innovation to achieve our transformational objectives and are willing to accept higher levels of risk which may lead to significant demonstrable benefits to our patients and stakeholders, while maintaining financial sustainability and efficient use of resources. We will support local system / providers to take risks in pursuit of these objectives within an appropriate accountability framework.'

NHS Cheshire and Merseyside has implemented a comprehensive strategy and robust processes for risk management. All of which can be found on a dedicated risk management section on the NHS Cheshire and Merseyside website.

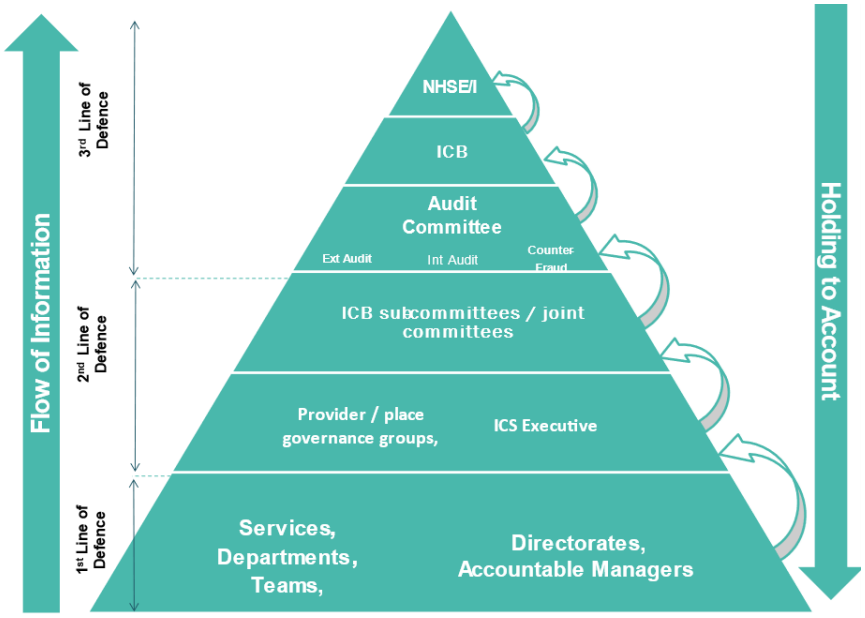
2.2.3.20 Capacity to Handle Risk

NHS Cheshire and Merseyside's Risk Management Strategy sets out specific accountabilities, roles and responsibilities for risk management and provides a structure that supports the integrated approach to risk and governance. These include the responsibilities of:

- **the Board** for providing the resources and support systems necessary and for assuring itself that the organisation has properly identified the risks it faces and has processes in place to mitigate those risks and the impact they have on the organisation and its stakeholders
- the **Audit Committee** for providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within NHS Cheshire and Merseyside
- all **committees and sub-committees** for providing assurance on key controls and ensuring that risks associated with their areas of responsibility are identified, reflected in the relevant corporate and / or place risk registers, and effectively managed
- NHS Cheshire and Merseyside's governance lead for the development and delivery of the Risk Management Strategy and associated operational procedures
- a senior responsible lead for each identified risk accountable to the Chief Executive, the relevant committee and the board for ensuring that the risk is appropriately managed.

NHS Cheshire and Merseyside's Risk Management Strategy incorporates the three lines of defence model as illustrated in **Figure 10**.

Figure 10



This includes:

- 1st line - Senior Responsible and Operational Leads have ownership, responsibility and accountability for directly assessing, controlling and mitigating risks.
- 2nd line - strategic leadership and oversight through the Board, its committees, place boards and reporting groups, leadership teams, and corporate monitoring and reporting activity.
- 3rd line - external review and oversight, including reporting, by auditors to the Audit Committee and the Board as appropriate, and supplemented through NHS England oversight and/or regulatory returns and reporting

The Board Assurance Framework 2026-26 was presented to the Board at its meetings in May 2025, September 2025, November 2025, and March 2026. At its meeting in September 2025 the Board approved refreshed strategic risks for the period 2025-2028, and which were refined and approved at its March 2026 meeting.

The committees of the Board of NHS Cheshire and Merseyside receive regular risk reports for review and consideration of the level of assurance that can be provided to the Board. Their actions and conclusions are reported to the Board through committee highlight reports. Operational risks rated as extreme or critical are escalated to the Board through the quarterly Corporate Risk Register.

2.2.3.21 Risk Assessment

NHS Cheshire and Merseyside's Board Assurance Framework (BAF) identifies 10 principal strategic risks to the delivery of NHS Cheshire and Merseyside's strategic objectives, the most significant of which are summarised in **section 1.1.4** of the performance report. The 2025-2028 BAF is summarised in **Figure 11**.

Figure 11

BAF ID	Strategic risk title	Risk appetite	Current score	Target Score
P4	Quality & Safety failures in commissioned services	Minimal	20	10
P11	Digital and Cyber Resilience Gaps	Open	16	8
P12	Failure to reduce health inequalities and improve population health	Cautious to open	15	10
P13	Inability to achieve financial sustainability and productivity	Minimal	20	10
P14	Failure to Recover Access and Performance Standards	Cautious	20	10
P15	System Fragmentation and Provider Sustainability	Cautious to open	12	8
P16	Failure to Deliver the Shift to Neighbourhood and Community-Based Care	Open	15	10
P17	Workforce Capacity, Capability, and Morale	Open	16	8

The refreshed BAF was approved at the November 2025 meeting of the Board with principal risks aligned against the four national ICB 'core purposes'.

Risks to the ICB's governance, risk management and internal control are summarised in Table 19.

Table 19

Risk	Risk Rating
Incident arising from unsafe working practices or environment leads to death or injury for which ICB is liable resulting in financial loss and / or reputational damage	High (12)
Commissioning support or other data processors acting on ICB's behalf breach statutory or regulatory requirements resulting in financial loss and / or reputational damage	Moderate (6)
Inconsistent adherence to core set of governance, financial and operational policies and procedures across NHS Cheshire and Merseyside leads to control failures, poor audit outcomes and reputational damage	High (12)
Business continuity incident impairs ICB's ability to deliver statutory duties and functions resulting in reputational damage and / or financial loss	High (8)
Non-compliance with the public engagement framework may lead to a breach of the ICB's statutory duty to involve and consult resulting in financial penalties and reputational damage	Moderate (8)
Major Incident causes disruption to ICB and commissioned services	High (8)

Fraud risk - this risk area covers any fraud and corruption risks that are carried out by individuals engaged by the ICB but are not payroll related.	Moderate (4)
Non-compliance with information governance policies leads to reportable data security and protection incident resulting in financial loss and / or reputational damage	Moderate (6)
Business continuity incident impairs ICB's ability to deliver statutory duties and functions resulting in reputational damage and / or financial loss	High (8)
Internal controls are insufficient to prevent fraudulent activity by ICB staff, contractors, patients or other third parties resulting in financial loss and / or reputational damage	High (8)

Controls have been put in place for each risk which focus on policy development, improvement of processes, dissemination of communications plans, development of bespoke and organisational-wide training strategies and reviews of information security systems). Assurance is provided through regular scrutiny and reporting at the Audit Committee and NHS Cheshire and Merseyside ICB Executive Committee.

Further development of the BAF will continue in 2026/27 as we review our strategic objectives against commissioning intentions, the Single Improvement Plan and our 5-year forward plan.

Our response to our undertakings is set out within our Single Improvement Plan. An update on our approach – which is being developed with oversight from NHS England – was received by NHS Cheshire and Merseyside's Board on 26th March 2026. The ICB has since approved a SIP framework that provides leadership, oversight and reporting on SIP activities (including key risks to delivery):

- Recognises the established executive leadership for each domain
- Monthly RAG-rated reporting covering scope, milestones, risks and dependencies
- PMO-led synthesis with Executive oversight prior to external reporting.

We will use this approach, coupled with Boad oversight and regular dialogue with NHSE to manage risks and jointly assess outcomes. Our progress in responding to undertakings will be subject to regular NHSE oversight with assurance and any exit being subject to nationally consistent processes.

2.2.3.22 Internal Control Framework

A system of internal control is the set of processes and procedures in place in NHS Cheshire and Merseyside to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

NHS Cheshire and Merseyside's internal control framework comprises:

- the Board Assurance Framework, which is framed around NHS Cheshire and Merseyside's strategic objectives. This is reviewed and managed by NHS Cheshire and Merseyside's Executive Team and reported quarterly to the Board.
- an internal audit service commissioned from Mersey Internal Audit Agency (MIAA) and delivering a comprehensive and balanced audit plan which is approved and monitored by the Audit Committee. This provides an objective challenge and valuable insight into risks, control weaknesses and opportunities for improvement
- anti-fraud arrangements described in paragraph 2.2.3.31
- the governance framework described in paragraphs 2.2.3.3 to 2.2.3.17
- the NHS Cheshire and Merseyside Executive Team and Non-Executive Members
- the application of agreed policies and procedures, principally the corporate governance handbook including schemes of reservation and delegation and standing financial instructions.

This internal control framework is informed and assured by external scrutiny and review, including the NHS England System Oversight Framework and External Audit.

2.2.3.23 Data Quality

The importance of data quality is well recognised by NHS Cheshire and Merseyside and is critical in the production of accurate analysis which underpins and influences commissioning decisions, priorities, contractual performance and assurance activities. NHS Cheshire and Merseyside has specified the data requirements for both effective monitoring of the performance, quality and safety of commissioned services and to support its plans to redesign and recommission services. These form the basis of regular reporting to NHS Cheshire and Merseyside, and its committees.

Data quality standards and requirements from commissioned providers are set out in information and quality contract schedules. The service agreements with NHS Cheshire and Merseyside's commissioning support providers include requirements for data validation and quality control.

NHS Cheshire and Merseyside has worked in partnership with its commissioning support providers to further develop the quality and design of reports and other business intelligence products. Performance data has been supplemented by intelligence from patient feedback, quality monitoring visits, audits, and contract monitoring activity to provide a broader view of performance than solely quantitative metrics.

The NHS Cheshire and Merseyside Business Intelligence team produces a routine data quality briefing report. This reviews the key contractual and performance data sets required to be submitted by providers either to meet national data requirements e.g., Secondary Users Services (SUS), Community Services Data Set (CSDS) or any local data requirements to support contracts e.g. SLAM. The monthly report includes the timeliness of data submissions, data quality, data validity e.g., a recent focus on the ethnicity coding to enable analysis to support targeted action to reduce health inequalities.

The report provides benchmarking of the national datasets against peers in addition to a regular overview of the Data Quality Maturity Index which provides an overview of data quality in the NHS by provider across the numerous data sets submitted. Actions to pick up on the findings from the report are led by the Business Intelligence

team, through a departmental data quality logging process. This ensures known issues are identified and communicated appropriately, with actions assigned to key personnel to address them, including clear escalation routes to resolution. Resolution most commonly involves working with providers through the respective information subgroups, which form part of the contractual governance structure.

2.2.3.24 Information Governance

NHS Cheshire and Merseyside has a robust information governance framework, which includes:

- the roles of Senior Information Responsible Officer (SIRO), Caldicott Guardian, and the Information Governance Lead, who advise and support NHS Cheshire and Merseyside's Executive Team in relation to information governance matters
- the roles of Deputy SIRO and Deputy Caldicott Champion for each of our nine places, who advise and support place teams in relation to information governance matters
- the Information Governance Management Group whose purpose is to support and drive the broader Information Governance agenda and provide the Audit Committee, and ultimately the Board with assurance that effective IG is in place within the organisation
- an information governance handbook and code of conduct, data protection and security policy, supported by briefings and training for all Board members and staff, and resources on our Staff Hub
- an information asset register, and data flows map which record the nature and security arrangements for the data held and transmitted, including sensitive and confidential data, and the risks and security arrangements, which are regularly assessed and reviewed
- access to specialist expertise and advice, including scrutiny, challenge and spot checks, through commissioning support arrangements
- quarterly reports on compliance which are reported to the Audit Committee and an annual review by internal audit.

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to NHS Cheshire and Merseyside, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

In September 2024, the Data Security and Protection Toolkit (DSPT) changed to adopt the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and IG assurance. This led to NHS Trusts, CSUs, ALBs and ICBs seeing a different interface, which sets out CAF-aligned requirements in terms of objectives, principles and outcomes. The scope of the 24-25 DSPT includes additional cyber and information governance requirements compared to the 2023-24 DSPT.

The new CAF-aligned DSPT is split into 47 contributing outcomes, each of which are supported by indicators of good practice, grouped into levels of achievement – 'Not Achieved', 'Partially Achieved' or 'Achieved'. To achieve Standards Met, NHS organisations will have to meet the expected achievement level set by NHS England

(NHSE) for each outcome. It has been recognised that the move to a CAF-aligned DSPT is a significant change and will be a considerable challenge for many NHS organisations as it represents an increase in the data security and cyber requirements for organisations. There is understanding nationally that this may take a year or more to meet all the requirements.

NHS Cheshire and Merseyside completed the CAF-aligned Data Security and Protection Toolkit (DSPT) self-assessment in 2024-25 providing evidence to demonstrate that it meets the Data Security and Protection Standards for health and care relevant to Integrated Care Boards. The 2024-25 DSPT audit conducted by Mersey Internal Audit Agency (MIAA) followed the CAF-aligned DSPT Independent Assessment Framework and Guidance published by NHS England, and 12 outcomes across the 5 objectives in the Cyber Assessment Framework were reviewed. The Audit delivered 3 outcomes with findings and recommendations for management response and follow up, in total; 3 High Risk. 9 outcomes were assessed as meeting the NHS England minimum profile, and which did not require management responses but recommendations were made to strengthen evidence or controls further.

Additionally, in reviewing the evidence submitted for the 12 outcomes, MIAA found that, for 9 outcomes, their rating aligned with the ICBs self-assessment. However, it was noted that, for the remaining 3 outcomes, MIAA rating did not align with the ICBs self-assessment, resulting in a high level of deviation between the independent and self-assessment.

NHS Cheshire and Merseyside has an Improvement Plan to respond to the recommendations made by MIAA. An update of the 2024/25 DSPT Improvement Plan was submitted to NHSE in December 2025, and all actions are due to be completed by the end of June 2026. Upon completion the ICB's 2024/25 DSPT will be amended to 'Standards Met'.

NHS Cheshire and Merseyside will submit the CAF-aligned DSPT for 2025-2026 at the end of June 2026.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures, and a programme will be established to fully embed an information risk culture throughout the organisation against identified risks.

2.2.3.25 Business Critical Models

The data and intelligence provided through NHS Cheshire and Merseyside's commissioning support provider to inform needs analysis and service commissioning is subject to robust quality assurance both internally by the provider and by NHS

Cheshire and Merseyside. NHS Cheshire and Merseyside's plans and forecasts are also subject to external scrutiny and sign-off by NHS England.

2.2.3.26 Third party assurances

During 2025-26 NHS Cheshire and Merseyside has relied on a number of third-party service provider organisations such as Capita (for primary care support / payments), NHS Shared Business Services Limited (for the provision of general ledger finance and accounting services - including invoice payment), Mersey and West Lancashire Teaching Hospitals NHS Trust (for payroll services), NHS Midlands and Lancashire Commissioning Support Unit (for Human Resources Support).

Typically, each area except for the Capita primary care support services and NHS Shared Business Services Limited, which are the responsibility of NHS England and Improvement, has a lead officer who maintains a client relationship with the service provider.

Those relations extend to regular contact and meetings with the providers, participation in client satisfaction ratings and where required intervention where performance falls below a satisfactory level. As appropriate, external standards and service delivery levels are monitored and by exception any assurance failings brought to the immediate attention of NHS Cheshire and Merseyside.

Assurance on these services is gained by independent service audits on the controls operated by these service providers which is commissioned directly by the contract holder, in most cases NHS England. NHS Cheshire and Merseyside reviews the independent audit reports for control issues at those service providers to assess whether there are adequate compensating controls to mitigate any risks to NHS Cheshire and Merseyside that might arise. After reviewing compensating controls operated by the NHS Cheshire and Merseyside, the issues identified in reports relating to the period to 31 March 2026 do not present a significant risk that would impact on NHS Cheshire and Merseyside directly.

2.2.3.27 Control Issues

The ICB is subject to formal NHS England enforcement undertakings in relation to:

- due to sustained challenges in meeting statutory financial duties. A system-wide recovery programme is underway, including a revised 2026/27 Financial Plan, strengthened financial governance and controls, enhanced oversight, and external support to support financial recovery and sustainable improvement.
- leadership and governance arrangements. Action is being taken to strengthen executive and Board capacity, refresh governance structures, enhance leadership development, and redesign organisational arrangements to ensure clear accountability for the effective delivery of statutory responsibilities.
- quality governance capability. A comprehensive improvement programme is in place, including benchmarking against national guidance, strengthened quality oversight and intelligence, and delivery of system-wide actions to improve mental health urgent and emergency care outcomes.

Additional control issues also include:

- Following significant failures in urgent and emergency mental health care, the ICB has implemented a system-wide Urgent and Emergency Mental Health Improvement Plan. This includes enhanced crisis and assessment services, closer

partnership working across agencies, and strengthened operational oversight to improve patient experience and reduce waiting times.

- Urgent and emergency care services have experienced sustained pressure during the year. While challenges remain, ambulance handover performance has improved, and patient safety has been supported through the implementation of minimum safety standards within emergency departments, with ongoing assurance through the ICB's Quality and Performance Committee.
- Performance against the four-hour A&E standard remains below trajectory, reflecting continued pressure across the urgent and emergency care system. System and trust-level improvement plans are in place, supported by daily operational oversight and coordinated recovery activity through established system governance arrangements.
- Significant progress has been made in reducing long elective waits across the system, though a small number of waits over 65 weeks remained at the end of December 2025. Continued improvement is being driven through the provider collaborative elective recovery programme, supported by targeted NHS England oversight where required.

2.2.3.28 Review of economy, efficiency and effectiveness of the use of resources

NHS Cheshire and Merseyside's constitution requires it to ensure that it receives value for money. To ensure that resources are used economically, efficiently and with effectiveness:

- the Board provides active leadership of the organisation within a framework of prudent and effective controls that enable risk to be assessed and managed.
- the Audit Committee, as a committee of the Board, is pivotal in advising the Board on the effectiveness of the system of internal control. Any significant issues would be reported to the Board via the Audit Committee.
- NHS Cheshire and Merseyside's committees' responsibilities include overseeing the development and review of: strategy and commissioning plans, annual commissioning intentions, financial plans (including delivery), undertaking detailed scrutiny of performance, contract monitoring and financial management on behalf of NHS Cheshire and Merseyside, and also reviewing and monitoring the organisational improvement plan. NHS Cheshire and Merseyside's committees formally report to the Board, escalating issues as required.
- Directors' roles and responsibilities are aligned to ensure systems of internal control are in place and implemented effectively throughout the organisation.
- the constitution includes a Scheme of Reservation and Delegation which sets out the procurement processes and financial limits that are delegated to management.
- a procurement strategy and procurement processes have been developed that include securing quality services and value for money as key criteria, whilst also ensuring compliance with the new Procurement Act 2023, which came into force on February 24, 2025.
- as explained throughout this report, extensive partnership working with local authorities and with service providers is undertaken through our place structure which helps ensure that local services are designed and delivered with economy, efficiency and effectiveness as a key priority.
- processes are monitored through risk assessment and through regular reports on procurement, including any tender waivers together with the reasons for those waivers.

- Internal Audit provides reports to each meeting of the Audit Committee and full reports to the Executive Director of Finance. The Audit Committee also receives details of any actions that remain outstanding from the follow up of previous audit work. The Executive Director of Finance and Associate Director of Governance and Corporate Affairs also meets regularly with the Audit Manager.
- External Audit provides external audit annual management letter and progress reports to the Audit Committee.

External auditors are required to be satisfied whether the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. On 19 June 2025, our external auditors provided a report on the arrangements to deliver value for money in the year to 31 March 2025 covering arrangements for financial sustainability, governance, and improving economy, efficiency, and effectiveness.

In the June 2025 report our external auditors identified no significant weaknesses in arrangements identified for financial sustainability, governance, and improving economy, efficiency, and effectiveness. Two improvement recommendations were provided around financial sustainability:

- IR1: The ICB should continue to develop the Cheshire and Merseyside system medium-term financial plan with system partners in order to set out a detailed and quantified plan to deliver financial sustainability over the medium term.
- IR2: The ICB should work with system partners to develop robust, deliverable and worked-up recurrent savings schemes to assure the delivery of annual and medium-term system financial plans. Adequate governance structures should be put in place to identify, deliver and closely monitor savings delivery, including where stretch targets and targets to reduce expenditure are included in system plans but are not yet fully developed.

The NHS Oversight assurance framework is aligned to the ambitions set out in the NHS Long Term Plan and in operational planning and contracting guidance issued for 2025-26. Metrics in relation to Finance and Use of resources include ensuring NHS Cheshire and Merseyside meets its financial duties and an assessment of capabilities on Strategy and Planning; Commissioning; Assuring performance, Quality and Delivery; and Effective Governance and People. These are also areas of focus for the Board.

Integrated Care Systems are required to demonstrate how, as organisations, we unite to reduce inequalities. NHS Cheshire and Merseyside is committed to use the scale and funding of partners to improve how our local economies flourish. Sustainability leaders throughout Cheshire and Merseyside are working with social value experts to do just this. All procurement includes a 10% social value requirement, based on a set of co-produced target operating models aligned with our Marmot principles.

Our procurement processes facilitates connections between prospective bidders and our voluntary sector as the recipient of this added value to ensure this goes directly into our communities.

2.2.3.29 Commissioning of delegated services (Primary Care and Specialised services)

NHS Cheshire and Merseyside has signed delegation agreements with NHS England for the commissioning of delegated primary care services and specialised services and held full commissioning responsibilities for delegated services during the 2025-26 reporting period.

To the best of the ICB leadership's knowledge, all delegated services were commissioned in accordance with 2025-26 delegation agreements and national service specifications.

The ICB leadership is able to provide the necessary evidence of compliance with the delegation agreements, any associated developmental requirements and national service specifications, and to show how effectively the delegated function is operating (either directly or via multi-ICB working arrangements) should NHS England or a third party (e.g. external auditors) ask for such evidence.

During 2025-26, Internal Audit undertook a review of the ICBs governance, risk management, financial control and operational delivery arrangements relating to specialised commissioning. The ICB received a substantial assurance rating from Internal Auditors and received five recommendations for improvements against identified control weaknesses. These recommendations centred on strengthening Terms of References for the North West Specialised Services Joint Committee, as well as ICB Finance and Quality Committees to reflect their responsibilities around delegated specialised services, recording of conflicts of interest in key meetings, review of risks relating to single and multi-ICB services for internal escalation and improvements in the effectiveness of the assessment process of provider compliance and single service specifications.

2.2.3.30 Delegation of Integrated Care Board functions

NHS Cheshire and Merseyside has delegated responsibility for some of its functions to its committees and Joint Committees and this is set out in the Committees terms of reference and the ICB scheme of reservation and delegation. The Board remains accountable for these functions and has put in place reporting and assurance arrangements requiring all committees to:

- submit regular reports of their business to the Board of NHS Cheshire and Merseyside
- make minutes of their meetings available to the Board of NHS Cheshire and Merseyside
- prepare an annual report outlining how it has delivered its responsibilities and submit this to the Board of NHS Cheshire and Merseyside.

NHS Cheshire and Merseyside has also entered into individual Section 75 arrangements with each of the nine local authorities across Cheshire and Merseyside. Through these individual arrangements NHS Cheshire and Merseyside has delegated decision making authority to each place through the formation of Section 75 Joint Committees with the local authorities, and authority given to NHS Cheshire and Merseyside representatives on budgets and functions that fall under the individual Section 75 Agreement, for example in relation to the Better Care Fund.

NHS Cheshire and Merseyside has also discharged significant decision-making authority to several key posts within the organisation which enables these individuals to have the authority to make decisions on behalf of NHS Cheshire and Merseyside on functions and budgets within a number of forums across Cheshire and Merseyside.

This authority is outlined within the NHS Cheshire and Merseyside Scheme of Reservation and Delegation, Operational Scheme of Reservation and Delegation and Standing Financial Instructions.

2.2.3.31 Counter fraud arrangements

The NHS Counter Fraud Authority currently estimates that the NHS is vulnerable to £1.346 billion worth of fraud each year, taxpayers' money lost out of the system that would otherwise pay for more doctors, more nurses, and much more else. Fraud has a significant impact on the NHS. It is not a victimless crime.

NHS Cheshire and Merseyside is fully committed to promoting an anti-fraud, bribery and corruption agenda and takes a zero-tolerance approach towards it.

NHS Cheshire and Merseyside contracts Mersey Internal Audit Agency (MIAA) to deliver anti-fraud, bribery and corruption services on its behalf. A nominated Local Counter Fraud Specialist (LCFS) delivers a programme of work in collaboration with key stakeholders to help raise staff and public knowledge and awareness of fraud, bribery and corruption, prevent and detect it, maintain strong governance arrangements around it and, where appropriate, investigate concerns, and seek sanction and redress outcomes. The Executive Director of Finance and Contracts is the senior responsible officer for fraud, bribery and corruption at NHS Cheshire and Merseyside and, together with the Audit Committee, has responsibility for approving, monitoring and reviewing the programme of work delivered. The Associate Director of Finance – Planning and Reporting is the nominated ICB Counter Fraud Champion and, along with named Counter Fraud Ambassadors at Place Level, provides support to the LCFS. All anti-fraud, bribery and corruption work undertaken by NHS Cheshire and Merseyside is completed in compliance with the Government Functional Standard 013 for Counter Fraud.

In 2025-2026, the LCFS conducted a number of activities to raise awareness, including the delivery of training on cyber mandate fraud, the circulation of articles and newsletters, and the promotion of International Fraud Awareness Week. Additionally, all staff are required to complete a fraud e-learning module, provisioned through ESR, every two years, as part of mandatory training.

Regarding prevention and detection, a number of activities were undertaken, including participation in the National Fraud Initiative 2024/25 data-matching exercise to identify fraud, circulation of local and national alerts in relation to specific identified fraud threats and a local proactive exercise focussed on the new corporate fraud offence of 'failing to prevent fraud', which came into effect on 01 September 2025 as part of the Economic Crime and Corporate Transparency Act 2023.

All allegations of fraud, bribery and corruption received by NHS Cheshire and Merseyside are dealt with and, where appropriate, investigated in line with the organisation's Anti-Fraud, Bribery and Corruption Policy and Response Plan and all staff are actively encouraged to report any concerns or suspicions to the LCFS,

MIAA's dedicated Investigation Team or the National Fraud and Corruption Reporting Line / online reporting form. Progress against any fraud, bribery or corruption investigations is reported to the ICB Audit Committee.

2.2.3.32 Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1st April 2025 to 31st March 2026 for NHS Cheshire and Merseyside, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the organisation's system of risk management, governance and internal control.
The Head of Internal Audit concluded that:

*"**Moderate Assurance*** can be given that there is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some of the organisation's objectives at risk*."*

This opinion is provided in the context that the ICBs like other organisations across the NHS is continuing to face a number of challenging issues and wider organisational factors particularly with regards to the changes to national and local bodies and the corresponding uncertainty this causes, ongoing elective recovery response, workforce challenges, financial challenges and increasing collaboration across organisations and systems. Enforcement Undertakings were also issued in 2025-26.

As at Month 11 the ICB was reporting year to date surplus of £16m (plan £46m surplus). It was noting continued pressures with Primary Care Prescribing, ADHD, Acute Sector and All Age Continuing Care. The ICB was slightly behind on efficiencies targets at Month 11, YTD £111.1m delivered vs £116.6m plan. The wider C&M ICS system remains challenged financially, as at month 11 reporting a deficit of £177.8m against a planned deficit of £79.4m.

The ICB has had a number of Board level changes in year; including the appointment of a new Chair, new Audit Committee Chair, and senior executive appointments at Interim Chief Executive, Executive Director of Finance, Executive Clinical Director, Executive Director of Heath & Integrated Care Commissioning, Executive Director of Corporate Services & Governance and Interim Executive Director of Strategy and Transformation. In addition, the ICB has also been impacted by the reorganisation of ICBs during 2025/26. The challenging start to the year, including leadership turnover, system reconfiguration and capacity pressures, impacted the delivery of planned internal audit activity; stability improved in the second half of the year as senior leadership arrangements settled. This supported more effective oversight regarding the delivery and progress of the internal audit plan.

MIAA has considered its sources of assurance, having regard to the scope and limitations of the internal audit work undertaken during the year, the overall opinion for 2025/26 is assessed as Moderate assurance. This reflects that whilst the ICB has an established and generally adequate framework of governance, risk management and internal control, there remain a number of areas where weaknesses in control design and consistency of operation increase the risk to the achievement of some strategic objectives. Our reviews have highlighted issues with control design in areas identified for inclusion in the internal audit plan for 2025-26 not subject to prior review. We have also noted issues with effective and consistent operation of controls

in Page | 5 Key Area Summary some established processes and also note that some recommendations relating to 2024-25 remain outstanding which could both be a result of the operational pressures the ICB has been facing particularly in light of the ICB reorganisation.

In particular, further attention is required to fully embed strengthened end-to-end operation of strategic risk management arrangements, including continuation of improved Board-level visibility and use of the Board Assurance Framework and clearer articulation and application of risk appetite, which we noted as of an appropriate frequency in Q3 and Q4. The profile of risk-based internal audit reviews completed during the year presents a varied picture, with assurance opinions broadly split between Substantial and Moderate, alongside one Limited assurance review and a High Risk outcome arising from the Data Security and Protection Toolkit assessment.

The delivery of the internal audit plan was impacted by organisational capacity pressures, resulting in the deferral of a number of planned reviews and the continued deferral of All Age Continuing Care for a third consecutive year, with assurance instead derived from targeted external PWC support.

Whilst management has made reasonable progress in implementing agreed internal audit actions, there needs to be continued focus on implementation given the volume of recommendations and significant recent organisational change.

These factors have been taken into account in forming this opinion and indicate that, while core controls remain in place and areas of good practice are evident, further improvement is required to enhance the robustness and consistency of the overall system of internal control. We have not been made aware of any Service Auditor reports that have been issued to the ICB at the time of writing this opinion.

In providing this opinion we can confirm continued compliance with the definition of internal audit (as set out in your Internal Audit Charter), code of ethics and professional standards. We also confirm organisational independence of the audit activity and that this has been free from interference in respect of scoping, delivery and reporting.

The purpose of our Head of Internal Audit (HoIA) Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of Internal control. As such, it is one component that the Board takes into account in making its Annual Governance Statement (AGS).

The basis for forming our opinion is in Table 20 as follows:

Table 20

Basis for the Opinion
1. An assessment of the design and operation of the underpinning Assurance Framework, risk management systems and supporting processes.
2. An assessment of the range of individual assurances arising from our risk-based internal audit assignments that have been reported throughout the period. This assessment has taken account of the relative materiality of systems reviewed and management's progress in respect of addressing control weaknesses identified.
3. An assessment of the organisation's response to Internal Audit recommendations, and the extent to which they have been implemented.

Commentary

The commentary in Table 21 provides the context for our opinion and together with the opinion should be read in its entirety. Our opinion covers the period 1st April 2025 to 31st March 2026 inclusive and is underpinned by the work conducted through the risk based internal audit plan.

Assurance Framework (AF)

Table 21

Opinion

Structure	The organisation's BAF is structured to meet the NHS requirements of assurance best practice model, noting that the BAF was updated and approved during the 2nd half of the year following a review of the ICB's strategic objectives.
Risk Appetite	The organisation has defined its risk appetite; however, this has not been reviewed since 2023. Risk appetite is not used to inform the management of the BAF.
Engagement	There could be greater visibility of the use of the BAF by the organisation.
Quality and Alignment	The updated BAF clearly reflects the risks discussed by the Board.

Core and Risk-Based Reviews Issued

We issued:

0 high assurance opinions:	n/a
4 substantial assurance opinions:	• Delegated Services (Specialised Commissioning) • Risk Management Core Controls • CIP Governance • Key Financial Controls
2 moderate assurance opinions:	• Quality of Commissioned Services • Equality, Diversity & Inclusion
1 limited assurance opinions:	• IT Supplier Management
0 no assurance opinions:	N/A
2 reviews without an assurance rating	• POD Delegations • Risk Appetite Briefing

Data Security and Protection Toolkit (DSPT)

As required by NHS England our work aimed to assess and provide assurance based upon the validity of the organisation's intended final DSPT submission, and consider compliance with the NHS CAF aligned Data Security and Protection Toolkit (DSPT) profile for 25/26 for the in-scope security and governance of information control environment outcomes and the level of risk / wider risk associated with weak or failing controls and security and governance of information objectives not being achieved.

The organisation was assessed against the NHSE profile for the mandatory and additional outcomes as agreed by the organisation.

Overall Assurance Rating	
Across the CAF DSPT our assurance is based on the number of in-scope outcomes rated as meeting / not-meeting the minimum achievement levels as profiled by NHS England. As a result of this our overall assurance level across the in-scope outcomes and indicators of good practice is rated as:	**High Risk**
Veracity of the organisation's self assessment	
In or view, the organisation's self-assessment for the in-scope outcomes partially aligned with that of the Independent Assessor and as such, the confidence-level in the veracity of the organisation's CAF DSPT self-assessment is:	**Medium Confidence**

Follow Up

During the course of the year, we have undertaken follow up reviews and can conclude that the organisation has made reasonable progress with regards to the implementation of recommendations. We will continue to track and follow up outstanding actions.

Themes

Through delivery of your internal audit plan, we noted the following thematic areas:

- Our reviews have highlighted issues with control design in areas identified for inclusion in the internal audit plan for 2025-26 not subject to prior review. We have also noted issues with effective and consistent operation of controls in some established processes and also note that some recommendations relating to 2024-25 remain outstanding.

Third Party/Other Assurance

We have not been made aware of any Service Auditor reports that have been issued to the ICB at the time of writing this opinion."

Chris Harrop
Managing Director, MIAA
March 2025

Louise Cobain
Assurance Director, MIAA
March 2025

2.3.33 Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within NHS Cheshire and Merseyside who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to NHS Cheshire and Merseyside achieving its principal objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- the Board of NHS Cheshire and Merseyside
- the Audit Committee
- the Quality and Performance Committee
- the NHS Cheshire and Merseyside Integrated Executive Committee
- Internal Audit.

The role and conclusions of each have been considered in the Corporate Governance Report from 2.2.

During the year, the Board and Audit Committee have kept under regular review the application of the system of internal control. With the support of Internal Audit where areas for improvement have been identified, prompt appropriate actions have been taken to address any gaps in control and changes made to ensure that the systems in place remain robust and effective.

2.2.3.34 Conclusion

The receipt of a Moderate Assurance opinion from our Internal Auditors reflects a position of overall sound and established governance, risk management and internal control arrangements across the ICB, while being candid about the areas where further strengthening is required. This judgement sits within the context of a particularly challenging year for the organisation and the wider system, including significant leadership change, system reconfiguration, financial pressures and increasing demands on services. Despite this, it is important to recognise that core controls remain in place, areas of good practice are evident, and the foundations for effective oversight and assurance continue to be strengthened.

As referenced elsewhere within this report, NHS Cheshire and Merseyside formally accepted enforcement undertakings with NHS England, In November 2025. This means that the Integrated Care Board (ICB) has committed to delivering rapid improvement work and providing additional assurance in a number of key areas, including:

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

Our response to our undertakings is set out within our Single Improvement Plan. We will use this approach, coupled with Board oversight and regular dialogue with NHSE to manage risks and jointly assess outcomes. Our progress in responding to undertakings will be subject to regular NHSE oversight with assurance and any exit being subject to nationally consistent processes.

We fully accept the findings of the 2025-26 Internal Audit review programme and the recommendations made. These provide a clear and constructive roadmap for improvement, particularly in relation to strengthening the consistency of control application, enhancing the end-to-end operation of our risk management arrangements, and ensuring greater visibility and maturity in our use of the Board Assurance Framework and risk appetite.

We are committed to maintaining momentum in delivering these improvements and will prioritise the timely implementation of all agreed actions, with the ambition of completing the majority by Quarter 3 of 2026 - 2027.

Looking ahead, the Board and Executive are resolute in their focus on continuous improvement, recognising that strong governance and effective internal control are critical enablers of delivering high-quality care and sustainable system performance. Building on the progress made in the latter part of the year, we will continue to embed stability, strengthen organisational capacity and enhance our assurance processes. Through this, we aim not only to address the areas identified but to move the organisation back towards a position of Substantial Assurance, underpinned by a culture of accountability, openness and continuous learning.

2.3 Remuneration and Staff Report

The remuneration and staff report sets out NHS Cheshire and Merseyside's remuneration policy for directors and senior managers, reports on how that policy has been implemented and sets out the amounts awarded to directors and senior managers.

2.3.1 Remuneration Report

The Government Financial Reporting Manual requires NHS bodies to prepare a Remuneration Report containing information about directors' remuneration. In the NHS, the report will be in respect of the Senior Managers of the NHS body. 'Senior Managers' are defined as: *'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of NHS Cheshire and Merseyside as a whole, rather than the decisions of individual directorates or departments.'* For the purposes of this report, this includes NHS Cheshire and Merseyside's Board.

This report:

- sets out the process under which the Chair, Executive Directors, Directors and Non-Executive Members were remunerated for the financial year to 31 March 2026
- sets out tables of information showing details of the salary and pension interests of all directors for the financial year to 31 March 2026.

In compliance with Article 21 of the General Data Protection Regulation (GDPR) each member of the Board, detailed in the tables 2.3.1.2 to 2.3.1.6, have given their consent for their information to be included.

2.3.1.1 Remuneration Committee

The Remuneration Committee is established as a Committee of the Board in accordance with its Constitution. The Remuneration Committee is responsible for determining the remuneration and terms and conditions of the Chief Executive, Executive Directors and non-voting directors. The Committee is chaired by a Non-Executive Member and membership comprises all other NHS Cheshire and Merseyside Non-Executive Members.

The Chair undertakes the annual appraisal of the Non-Executive Members and the Chief Executive, who in turn is responsible for assessing the performance of the Executive Directors.

Further details of the activity of the Committee during the year is provided in the Governance Statement at 2.2.3, and of its membership is provided at Appendix One.

2.3.1.2 Fair Pay Disclosure - Audited

Percentage change in remuneration of highest paid director

The percentage change in remuneration of the highest paid director (based on that director's midpoint banding on a Full-Time equivalent basis) in comparison to the previous financial year is set out below together with the average percentage change from the previous financial year in respect of employees of the entity, taken as a whole.

Table 22

	2025-26		2024-25	
	Salary and allowances	**Performance pay and bonuses**	**Salary and allowances**	**Performance pay and bonuses**
The percentage change from the previous financial year in respect of the highest paid director	-4%	N/A	5%	N/A
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	4%	N/A	5.5%	N/A

Pay is made in accordance with the NHS very senior manager pay framework, and the highest paid director was appointed at the bottom of the pay band in accordance with that framework.

Pay ratio information
Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director in NHS Cheshire and Merseyside in the year to 31st March 2026 was £272,500 (2024-2025 - £272,500). The relationship to the remuneration of the organisation's workforce is disclosed in Table 23.

Table 23

2025-26	**25th percentile pay ratio**	**Median pay ratio**	**75th percentile pay ratio**
Total remuneration (£)	37,796	50,273	63,191
Salary component of total annual remuneration (£)	37,796	50,273	63,191
Pay ratio information	**7.21 : 1**	**5.42 : 1**	**4.31 : 1**
2024-25			
Total annual remuneration (£)	36,483	48,526	62,215
Salary component of total annual remuneration (£)	36,483	48,526	62,215
Pay ratio information	**7.74 : 1**	**5.82 : 1**	**4.54 : 1**

During the reporting period 2025-26, no employee received remuneration in excess of the highest-paid director (2025-26 - no employee). Remuneration ranged from £24,465 to £272,500 (2024-25 - £21,169 to £272,500).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

As can be seen, pay multiples for the highest paid director against 25th Centile, the median pay centile and 75th centile decreased. The biggest factor was that employees were awarded an average pay rise of 3.6% and the highest paid employee was appointed in year.

2.3.1.3 Policy on the remuneration of senior managers

In determining and reviewing remuneration for Executive Directors, NHS Cheshire and Merseyside's Remuneration Committee considers relevant benchmarking with other NHS organisations, guidance from NHS England, national inflationary uplifts recommended for other NHS staff and any variation or change to the responsibilities of Directors and the financial circumstances relating to NHS Cheshire and Merseyside.

For the purposes of the Annual Report, Senior Managers are defined as those in Board level positions. Senior managers at NHS Cheshire and Merseyside do not receive performance-related pay or bonuses. All Executive Directors / Other Board Directors have employment contracts which are usually awarded on a permanent

basis unless the post is for a fixed period of time. Executive Directors (including the Chief Executive) have a 6-month notice period within their contracts of employment.

2.3.1.4 Remuneration of Very Senior Managers

NHS Cheshire and Merseyside complies with the NHS very senior managers pay framework (VSM framework) jointly produced by NHS England and the Department of Health and Social Care. During the year, national approval was sought and received for three board members pay that had been calculated in accordance with the VSM framework.

2.3.1.5 Senior manager remuneration (including salary and pension entitlements) - Audited

Table 24

1st April 2025 to 31st March 2026							
Name	**Title**	**Salary (bands of £5,000)[1]**	**Expense payments (taxable) to nearest £100****	**Performance pay and bonuses (bands of £5,000)**	**Long term performance pay and bonuses (bands of £5,000)**	**All pension-related benefits (bands of £2,500)[2]**	**TOTAL (bands of £5,000)**
		£000	**£**	**£000**	**£000**	**£000**	**£000**
Raj Jain[3]	Chair to 12 Oct 2025	35 - 40	-	-	-	-	35 - 40
Sir David Henshaw[3]	Interim Chair from 13 Oct 2025	30 - 35	1,600	-	-	-	30 - 35
Tony Foy	Non-Executive Member	15 - 20	100	-	-	-	15 - 20
Erica Morris	Non-Executive Member	10 - 15	300	-	-	-	10 - 15
Prof Hilary Garratt CBE	Non-Executive Member	15 - 20	300	-	-	-	15 - 20
Ruth Hussey CB, OBE, DL	Non-Executive Member	15 - 20	-	-	-	-	15 - 20
Mike Burrows	Non-Executive Member	15 - 20	800	-	-	-	15 - 20
Sue Lorimer[3]	Non-Executive Member from 5 Nov 2025	5 - 10	-	-	-	-	5 – 10
Dr Naomi Rankin	Partner Member	10 - 15	-	-	-	-	10 - 15
Dr Janelle Holmes[3,4]	Partner Member from 25 Sep 2025	-	-	-	-	-	-
Adam Irvine	Partner Member	10 - 15	-	-	-	-	10 - 15
Delyth Curtis[3,4]	Partner Member from 1 Jul 2025	-	-	-	-	-	-
Prof Stephen Broomhead MBE[3,4]	Partner Member to 30 Jun 2025	-	-	-	-	-	-
Ann Marr OBE[3,4]	Partner Member to 8 Sep 2025	-	-	-	-	-	-
Andrew Lewis	Partner Member	-	-	-	-	-	-
Warren Escadale	Partner Member	-	-	-	-	-	-
Trish Bennett	Partner Member	-	-	-	-	-	-
Graham Urwin[3,4]	Chief Executive to 31 May 2025	45 - 50	-	-	-	7.5 - 10	55 - 60
Cathy Elliott[3,4]	Chief Executive from 1 Jun 2025 to 15 Nov 2025	115 - 120	-	-	-	22.5 - 25	140 - 145
Dr Liz Bishop[3,4]	Chief Executive from 18 Nov 2025	90 - 95	-	-	-	-	90 - 95

1st April 2025 to 31st March 2026							
Name	**Title**	**Salary (bands of £5,000)[1]**	**Expense payments (taxable) to nearest £100****	**Performance pay and bonuses (bands of £5,000)**	**Long term performance pay and bonuses (bands of £5,000)**	**All pension-related benefits (bands of £2,500)[2]**	**TOTAL (bands of £5,000)**
		£000	**£**	**£000**	**£000**	**£000**	**£000**
Mark Bakewell[3,4]	Interim Executive Director of Finance to 14 Sep 2025	80 - 85	200	-	-	60 – 62.5	140 - 145
Andrea McGee[3,4]	Executive Director of Finance from 15 Sep 2025	95 - 100	-	-	-	55 – 57.5	150 – 155
Prof Rowan Pritchard-Jones[3,4]	Medical Director to 31 Jan 2026	155 - 160	-	-	-	22.5 - 25	175 – 180
Dr Fiona Lemmens[3]	Executive Clinical Director from 1 Feb 2026	20 - 25	-	-	-	10 – 12.5	30 - 35
Christine Douglas MBE[3]	Executive Director of Nursing & Care to 31 Jan 2026	150 - 155	500	-	-	-	150 – 155
Clare Watson[3]	Executive Director of Health and Integrated Care Commissioning from 2 Feb 2026	25 - 30	-	-	-	2.5 - 5	30 - 35
Ben Vinter[3]	Executive Director of Corporate Services and Governance from 2 Mar 2026	10 - 15	-	-	-	0 – 2.5	10 - 15
Jude Adams[3]	Interim Executive Director of Strategy and Transformation (Turnaround) from 1 Dec 2025	60 - 65	-	-	-	17.5 – 20	80 – 85

***Note: Taxable expenses and benefits in kind are expressed to the nearest £100.*

1. Where an executive member sacrifices salary which is used to lease a motor vehicle, the salary sacrificed is included within salary because the ICB considers this as salary earned that has been used by the employee to lease motor vehicles.
2. The value of pension benefits accrued during the period is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. The value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.
3. This table includes salary and benefits for the period of appointment as a member of the board as stated above. Cathy Elliott, Prof Rowan Pritchard-Jones and Christine Douglas remained employed by the ICB. Graham Urwin remained employed to 30 June 2025.
4. Dr Janelle Holmes, Delyth Curtis, Professor Stephen Broomhead MBE, Ann Marr OBE, Andrew Lewis, Warren Escadale, Trish Bennett were not remunerated in the year as they represent partner bodies.

Table 25

1st April 2024 to 31st March 2025							
Name	**Title**	**Salary (bands of £5,000)[1]**	**Expense payments (taxable) to nearest £100****	**Performance pay and bonuses (bands of £5,000)**	**Long term performance pay and bonuses (bands of £5,000)**	**All pension-related benefits (bands of £2,500)[2]**	**TOTAL (bands of £5,000)**
		£000	**£**	**£000**	**£000**	**£000**	**£000**
Raj Jain	Chair	75 - 80	100	-	-	-	75 - 80
Tony Foy	Non-Executive Member	15 - 20	500	-	-	-	15 - 20
Erica Morris	Non-Executive Member	15 - 20	600	-	-	-	15 - 20
Neil Large MBE[6]	Non-Executive Member	15 - 20	800	-	-	-	15 - 20
Hilary Garratt CBE	Non-Executive Member	15 - 20	-	-	-	-	15 - 20
Ruth Hussey CB, OBE, DL	Non-Executive Member	15 - 20	200	-	-	-	15 - 20
Dr Naomi Rankin	Partner Member	10 - 15	-	-	-	-	10 -15
Adam Irvine	Partner Member	10 - 15	-	-	-	-	10 -15
Professor Stephen Broomhead MBE[5]	Partner Member	-	-	-	-	-	-
Cllr Paul Cummins[6]	Partner Member	0 - 5	-	-	-	-	0 – 5
Ann Marr OBE[5]	Partner Member	-	-	-	-	-	-
Joe Rafferty CBE[5,6]	Partner Member	-	-	-	-	-	-
Andrew Lewis[5]	Partner Member	-	-	-	-	-	-
Warren Escadale[5]	Partner Member	-	-	-	-	-	-
Trish Bennett[5]	Partner Member	-	-	-	-	-	-
Graham Urwin[3,4,7]	Chief Executive	270 - 275	100	-	-	60 – 62.5	335 – 340
Claire Wilson[3,4]	Executive Director of Finance	130 - 135	-	-	-	35 -37.5	165 - 170
Mark Bakewell[3,4]	Interim Executive Director of Finance	55 - 60	300	-	-	17.5 - 20	70 - 75
Professor Rowan Pritchard-Jones[3]	Medical Director	185 - 190	200	-	-	25 -27.5	210 - 215
Christine Douglas MBE[3,4]	Executive Director of Nursing & Care	175 - 180	700	-	-	-	175 - 180

***Note: Taxable expenses and benefits in kind are expressed to the nearest £100.*

1. Where an executive member sacrifices salary which is used to lease a motor vehicle, the salary sacrificed is included within salary because the ICB considers this as salary earned that has been used by the employee to lease motor vehicles.
2. The value of pension benefits accrued during the period is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. The value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.
3. The Chief Executive, Executive Director of Finance (including interim), Executive Director of Nursing and Care and Executive Medical Director are engaged under contracts of services and are employees.
4. Claire Wilson left the ICB on 8 December 2024. Mark Bakewell took up the role as Interim Executive Director of Finance on 9 December 2024. Graham Urwin retired on 18 October 2024 and returned on 4 November 2024. Christine Douglas MBE retired on 31 October 2024 and returned on 18 November 2024.

1st April 2024 to 31st March 2025							
Name	Title	Salary (bands of £5,000)[1]	Expense payments (taxable) to nearest £100**	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)[2]	TOTAL (bands of £5,000)
		£000	£	£000	£000	£000	£000

5. Ann Marr OBE, Joe Rafferty CBE, Professor Steven Broomhead MBE, Andrew Lewis, Warren Escadale and Trish Bennett are Partner Board Members and are not remunerated by the ICB for their work as partner members. Ann Marr's employer charges the ICB for other services as executive lead for Cheshire and Merseyside Acute Specialist Trust Alliance and in the year these charges fell in the range £30k -£35k.
6. Cllr Paul Cummins left on 31 May 2024, Professor Joe Raffety left on 30 September 2024 and Neil Large left on 28 February 2025.
7. As explained in the pensions table in section 2.3.1.6 below, Graham Urwin retired and returned in the year. He contributes to the 2015 section of the NHS Pension Scheme, having retired from the other parts of the scheme, and therefore the pension benefit is based on that section of the scheme only.

2.3.1.6 Pension benefits as at 31st March 2026 - Audited

All salaried Board members, except for our Non-Executive Members, had access to the NHS Pension Scheme. See note 4 to the Annual Accounts for further information.

Table 26

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age 31 March 2026 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 31 March 2025	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2026	(h) Employers Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Graham Urwin – Chief Executive	2.5 – 5	-	10 – 15	-	161	41	213	-
Cathy Elliott Chief Executive	2.5 – 5	-	0 – 5	-	-	29	56	-
Mark Bakewell - Interim Executive Director of Finance	5 - 7.5	10 - 12.5	50 – 55	120 - 125	878	120	1,032	-
Andrea McGee Executive Director of Finance	5 - 7.5	15 - 17.5	70 - 75	195 - 200	1,498	136	1,672	-
Professor Rowan Pritchard-Jones – Medical Director	2.5 - 5	-	65 – 70	160 - 165	1,394	31	1,472	-
Dr Fiona Lemmens Executive Clinical Director	2.5 - 5	2.5 - 5	15 - 20	15 - 20	248	58	328	-
Clare Watson Executive Director of Health and Integrated Care Commissioning	0 – 2.5	-	65 - 70	165 - 170	1,488	30	1,563	-
Ben Vinter Executive Director of Corporate Services and Governance	0 - 2.5	-	45 - 50	-	661	20	694	-
Jude Adams Interim Executive Director of Strategy and Transformation (Turnaround)	2.5 - 5	0 – 2.5	60 - 65	145 - 150	1,387	70	1,502	-

a) The pension entitlement above is the total pension entitlement for Board member and is not reduced for the effect contributions made in employment for other entities or for periods when the individual was employed in other roles.
b) A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.
A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.
The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.
c) Real Increase in Cash Equivalent Transfer Value is the increase in CETV that is funded by the Employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).
d) Christine Douglas and Liz Bishop were retired from the NHS Pension Scheme and therefore did not participate.
e) The 1995 and 2008 sections of the NHS Pension Scheme closed on 31 March 2022 and all staff that were contributing to those schemes on that date were automatically moved to the 2015 scheme on 1 April 2022. Benefits in the 1995 and 2008 sections of the scheme were deferred and from 1 March 2022 contributions are made to the 2015 scheme.

Pension benefits as at 31st March 2025 were:

Table 27

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age 31 March 2025 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 31 March 2024	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2025	(h) Employers Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Graham Urwin – Chief Executive	2.5 - 5	-	5 - 10	-	1,993	46	161	0
Mark Bakewell - Interim Executive Director of Finance	0 – 2.5	0 – 2.5	40 - 45	105 - 110	757	16	878	0
Professor Rowan Pritchard-Jones – Medical Director	2.5 – 5	-	65 - 70	160 - 165	1,259	27	1,394	0
Claire Wilson – Director of Finance to 8 Dec 2024	2.5 - 5	-	60 - 65	145 - 150	1,112	30	1,248	0

a) The pension entitlement above is the total pension entitlement for Board member and is not reduced for the effect contributions made in employment for other entities.
b) A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.
A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.
The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.
c) Real Increase in Cash Equivalent Transfer Value is the increase in CETV that is funded by the Employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).
d) Christine Douglas is retired from the NHS Pension Scheme.
e) The 1995 and 2008 sections of the NHS Pension Scheme closed on 31 March 2022 and all staff that were contributing to those schemes on that date were automatically moved to the 2015 scheme on 1 April 2022. Benefits in the 1995 and 2008 sections of the scheme were deferred and from 1 March 2022 contributions are made to the 2015 scheme. Graham Urwin took partial retirement on 18 October 2024, drawing benefits from the 1995 and 2008 section of the scheme, and returned to work on 4 November 2024 continuing to pay contributions into the 2015 section of the scheme. Accordingly, the calculations for Graham Urwin are based on the values attributable to the 2015 section of the scheme only. The CETV for Graham Urwin reported at 31 March 2024 includes values relating to the 1995, 2008 and 2015 sections. The CETV reported at 31 March 2025 includes only those values relating to the 2015 section of the scheme.

2.3.1.7 Compensation on early retirement or for loss of office

There were no payments for compensation on early retirement or for loss of office in 2025-26 (2024-2025 – none).

2.3.1.8 Payments to past directors

No payments have been made to past senior managers in 2025-26 (2024-2025 – none).

2.3.1.9 Exit Packages

There were no exit packages for members of the Board. Exit packages for other staff are set out in the staff report.

2.3.2 Staff Report

As at 31 March 2026, NHS Cheshire and Merseyside employed 1,148 staff. The headcount has decreased by 21 compared to last year's headcount which was reported as 1,167 on 31st March 2025. Of the 172 exits agreed in the year under the voluntary redundancy scheme, 151 staff left in the year with 21 leaving after the year end. The majority of those taking voluntary redundancy were in post at 31 March 2026 and are therefore included in the tables below.

2.3.2.1 Number of senior managers and gender split

At 31 March 2026, the headcount, including the Board members, at NHS Cheshire and Merseyside consisted of the following breakdown:

Table 28

	Headcount by Gender		
Staff Grouping	**Female**	**Male**	**Totals**
Board (including office holders)	12	7	**19**
Other Senior Management (Band 8C+)	113	65	**178**
All Other Employees	778	173	**951**
Grand Total	**903**	**245**	**1,148**

The percentage split by gender was as follows:

Table 29

	% by Gender	
Staff Grouping	**Female**	**Male**
Board (including office holders)	63.2%	36.8%
Other Senior Management (Band 8C+)	63.5%	36.5%
All Other Employees	81.8%	18.2%
Grand Total	**78.66%**	**21.34%**

2.3.2.2 Staff numbers at 31 March 2026

A breakdown of staff headcount, excluding Non-Executive members, by band at 31st March 2026 is outlined in Table 30.

Table 30

Pay Band	Headcount
Band 2	3
Band 3	48
Band 4	88
Band 5	138
Band 6	178
Band 7	220
Band 8A	164
Band 8B	112
Band 8C	75
Band 8D	14
Band 9	44
Medical	27
VSM	19
Total	**1,130**

2.3.2.3 Staff numbers and costs during the year - Audited

Average staffing numbers, on a full-time equivalent basis, by occupation during the year are summarised in the Table 31:

Table 31

Staff Grouping	Permanent	Other	Total
Administrative and Estates	639	20	659
Medical and Dental	14	-	14
Nursing and Midwifery	188	16	204
Scientific/ Therapeutic / Technical	191	-	191
Total	**1,032**	**36**	**1,068**

Total staffing costs are set out in note 4 to the accounts and are summarised in Table 32.

Table 32

	Permanent Employees £000s	Other £000s	Total £000s
Salaries and wages	58,022	2,141	60,163
Social security costs	9,668	-	9,668
Employer contributions to the NHS Pension Scheme	13,217	-	13,217
Other pension costs	15	-	15
Apprenticeship Levy	287	-	287
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	17,610	-	17,610
Gross Employee Benefits Expenditure	**98,819**	**2,141**	**100,960**

2.3.2.4 Sickness absence data

The sickness absence data for NHS Cheshire and Merseyside in the calendar year 2025 was whole time equivalent (WTE) days available of 238,155 and WTE days lost to sickness absence of 10,907 and average working days lost per employee was 10.30 which was managed through the absence management policy (Table 33).

Table 33

Staff sickness absence 2025	Number
Total days lost	10,907
Total staff years	1,058
Average working days lost	10.30

2.3.2.5 Staff turnover percentages

NHS Cheshire and Merseyside's Staff Turnover Rate for 2025-26 has been calculated by dividing the total Full Time Equivalent (FTE) Leavers in-year by the average FTE Staff in Post during the year. The Total FTE Leavers in year was 183.56. The Average FTE Staff in Post during the year was 1057.21 (2024-25 – 1,070.91). The Staff Turnover Rate for the year was 17.36% (2023-2024 – 8.98%) (Table 34).

Table 34

Staff turnover	Number
Average FTE employed	1057
Total FTE leavers	184
Turnover rate	17.36%

Throughout the period NHS Cheshire and Merseyside's staff turnover rate was reported regularly to its Board and Executive Team. Workforce data provided to NHS Cheshire and Merseyside by Midlands and Lancashire Commissioning Support Unit outlined all recorded reasons for staff leaving NHS Cheshire and Merseyside with the top reasons being:

- Voluntary Resignation – Promotion
- Retirement.

2.3.2.6 Staff Survey

From April 2025 we focused on developing action plans from the 2024 national NHS Staff Survey and undertaking the 2025 staff survey from September – November 2025.

The national staff survey results for 2024 were published with the backdrop of the national announcements of workforce changes and cuts. In uncertain times and times of change we know it is even more important to listen to staff, we organised a series of staff engagement sessions based on the NHS People Promise themes to:

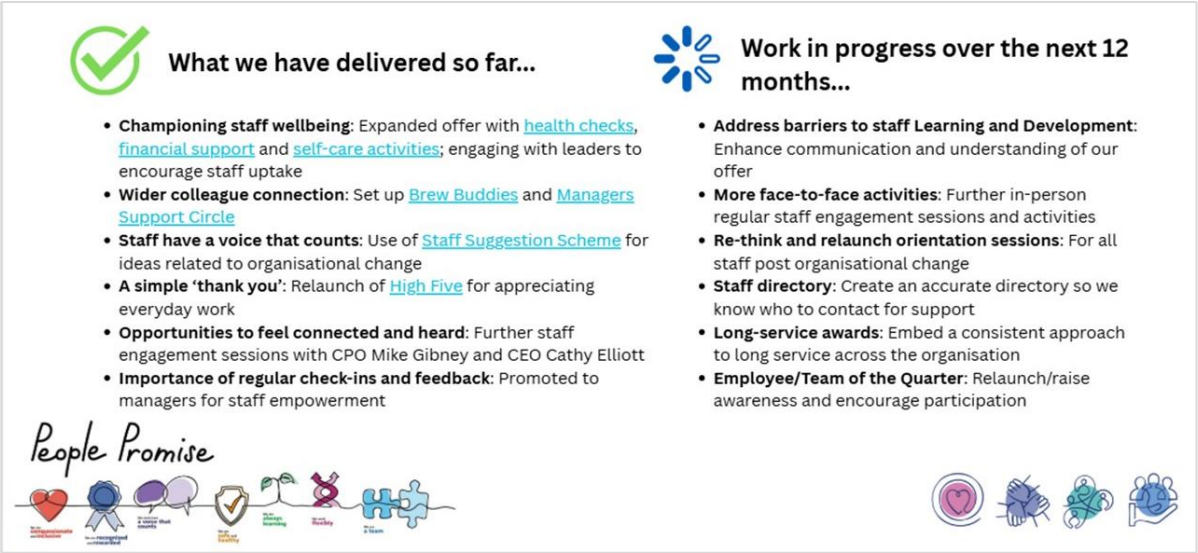
- Play back the staff survey results and outcomes from last year
- Check in with staff – how are people feeling?
- Hear what staff needed from us now to feel supported, valued, and motivated during this challenging period

By using the People Promise themes, which are aligned to the staff survey results and our values-based approach, we used the staff engagement sessions to prioritise

our support over the next six to 12 months. There was over 250 staff who attended the sessions, with local sessions also taking place, as well as the results shared with our staff networks, Staff Engagement Forum and People Operations Group, with oversight from the People Committee.

Feedback from the engagement sessions was collated and presented as 'you said/we did,' detailed in Figure 12.

Figure 12: People Promise – You Said, We Did



Through the months of September and November 2025, NHS Cheshire and Merseyside participated in the 2025 national NHS Staff Survey. Response rates decreased from the previous year from 73% to 58%.

The results from the 2025 survey, against the seven areas of the NHS People Promise, are detailed in Table 35, with comparisons from the previous year.

Table 35

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

In addition to the People Promise Themes, the survey also produces reports related to staff morale and engagement.

Staff morale is measured across three sub themes in relation to staff thinking about leaving, work pressures and stressors. The score in this area of the survey was 5.09 compared to 5.73 from the previous year.

Staff engagement is measured across three sub themes relating to staff motivation, their involvement in work and advocacy in relation to recommending the organisation as a place to work and the NHS as place to treated. The score in this area of the survey was 5.69 compared with 6.50 from the previous year.

Some of the key areas of focus for the coming year are:

- Understand work pressures and protect wellbeing – visible action on burnout drivers.
- Rebuild confidence that voice leads to change – strengthen listening and response.
- Fix the learning and performance experience – make development meaningful and fair.

A presentation of the survey results was delivered to the Executive Team in March 2026 and following the lifting of the NHS England embargo relating to sharing information in mid-March, presentations have taken place with Trade Unions, Staff Engagement Forum and People Operations Group.

Upon completion of the communication cascade, an Assurance Report detailing actions and plans for the coming year will be delivered to the NHS Cheshire and Merseyside People Committee.

Staff engagement sessions with individual teams will be planned throughout April and May 2026, both face to face and online, to provide staff with the opportunity to provide feedback and make recommendations for further improvement.

From August 2025 we recommitted to being involved in the NHS Pulse Survey to ensure more opportunities for feedback. We will invite staff to participant in the Pulse survey every quarter. In January 2026 there was a response rate on 8%, the feedback will be aligned to the national staff survey action plan. In summary the feedback showed us that the mood of staff was predominately negative, with 77% of staff choosing a negative word to describe their current mood, however 82.8% felt their immediate team supported each other. Areas of improvement included the need to streamline and simplify process and improved communications.

2.3.2.7 Staff policies

NHS Cheshire and Merseyside is committed to creating an environment in which people can feel valued, where they are treated fairly and with dignity and respect. Our people policies are reviewed regularly via the HR Policy Review Group in partnership with staff side colleagues taking into account feedback from staff networks. This process ensures all staff policies remain up to date.

NHS Cheshire and Merseyside conduct an Equality Impact Analysis for all strategies, policies and processes to ensure it treats people fairly and does not undermine their rights.

Policy reviews are reflective of legislative changes and any changes to NHS employment terms and conditions within the Agenda for Change framework. NHS Cheshire and Merseyside is aligned to the ongoing development of a suite of people policy frameworks being undertaken by NHS England. This will introduce a new format for policies ensuring they are simple and easy to read, staff-centric, inclusive, accessible and reflective of best practice.

The adoption of the national people policy frameworks into NHS Cheshire and Merseyside will mean staff are supported by managers and colleagues and will help build a culture of compassion across the service and:

- improve inclusion and diversity.
- ensure consistency across the system and NHS, improving staff experience and saving time.
- reduce absence, staff turnover, grievances and disputes, improving the working environment and our staff survey results.
- reduce duplication of effort across our organisation, enabling the scaling of people services and cross-system working.
- ensure our organisation continues to align to the NHS Long Term Workforce Plan and People Promise.

NHS Cheshire and Merseyside is committed to creating an environment that promotes equality and embraces diversity as an employer. It adheres to legal and performance requirements and mainstreams its equality and diversity principles through its policies, procedures and processes. Policies are equality impact assessed during the policy development and review processes to ensure that our policies do not have an adverse impact in response to the requirements of The Equality Act 2010. NHS Cheshire and Merseyside will act when necessary to address any unexpected or unwarranted disparities and monitor workforce and employment practices to ensure that employment policies are fairly implemented.

The Recruitment and Selection Policy aims to ensure compliance with current legislation for employing staff in accordance with the Equality Act, Immigration Rules and the Disclosure and Barring Service (as applicable). It operates a fair and objective system for recruiting, which places emphasis on individual skills, abilities and experience. Selection criteria contained within our Job Descriptions and Person Specifications are reviewed to ensure that they are justifiable and so do not unfairly discriminate directly or indirectly and are essential for the effective performance of the role.

NHS Cheshire and Merseyside is positive about employing people with disabilities and all applicants who declare that they have a disability and who meet the essential criteria for a post are shortlisted and invited to interview. We are committed to making reasonable adjustments in the workplace, including appropriate training, to support the continuation of employment. Recruitment and selection training is available for managers and regular support, advice and guidance is provided to recruiting managers by the Recruitment Team.

We strive to enable all staff to achieve their full potential in an environment of dignity and mutual respect. Support for staff who become disabled is provided under the Management of Attendance Policy and Performance Management Policy (if required). Where medical advice recommends temporary or permanent changes, managers will consider how we can support our employees to continue in their present role or where more appropriate in an alternative role. Redeployment may be on a temporary or permanent basis depending on the needs of the individual and the requirements of the role.

A new Disability and Neurodiversity Policy has been created and will be introduced with input from the Disability Network and includes a 'Health Passport' to support those with disabilities and long term health conditions to move between roles much easier and to ensure any reasonable adjustments and personal information related to their health is shared with their new line manager without the individual having to request specific support each time.

One of the key policies that has been embedded is the Sexual Misconduct Policy as NHS Cheshire and Merseyside is committed to a zero-tolerance approach to sexual misconduct in the workplace to creating a workplace where everyone feels safe. This includes protecting employees and people employed by other organisations, such as suppliers or visitors, from sexual misconduct in any form.

2.3.2.8 Expenditure on consultancy

Consultancy is the provision to management of objective advice and assistance relating to strategy, structure, management or operations of an organisation in pursuit of its purposes and objectives. Such assistance will be provided outside the 'business as-usual' environment when in-house skills are not available and will be of no essential consequence and time-limited. Consultancy may include the identification of options with recommendations, or assistance with (but not delivery of) the implementation of solutions.

During 2025-2026, £73k (2024-2025 - £260k) was spent on external consultancy including:

- £41k on pre-consultation engagement work on women's hospital services in Liverpool
- £31K advisory work on a VCSE sector collaboration strategy.

As expalined in section 1.3, £5.6m was incurred on support from a large accountancy firm to help drive financial recovery and sustainable improvement and this cost is included in professional fees in note 5 to the accounts.

2.3.2.9 Off-payroll engagements

Off payroll engagements are payments made by NHS Cheshire and Merseyside to employees outside of its payroll system that are for more than £245 per day and that last for longer than six months.

Table 36: Length of all highly paid off-payroll engagements
For all off-payroll engagements as at 31st March 2026 for more than £245* per day:

	Number
Number of existing engagements as of 31st March 2026	37
for less than 1 year at the time of reporting	-
for between 1 and 2 years at the time of reporting	-
for between 2 and 3 years at the time of reporting	37
for between 3 and 4 years at the time of reporting	-
for 4 or more years at the time of reporting	-

Existing off payroll engagements have been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and where necessary, that assurance has been sought.

Table 37: Off-payroll workers engaged at any point during the financial year
For all off-payroll engagements between 1st April 2025 and 31st March 2026, for more than £245* per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2025 and 31 March 2026	66
No. not subject to off-payroll legislation**	-
No. subject to off-payroll legislation and determined as in-scope of IR35**	52
No. subject to off-payroll legislation and determined as out of scope of IR35**	14
the number of engagements reassessed for compliance or assurance purposes during the year	-
Of which: no. of engagements that saw a change to IR35 status following review	-

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.
**A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 38: Off-payroll engagements / senior official engagements
For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1st April 2025 and 31st March 2026:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during reporting period	-
Total no. of individuals on-payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the reporting period. This figure should include both on-payroll and off-payroll engagements.	28

2.3.2.10 Exit packages, including special (non-contractual) payments – AUDITED

Table 39: Exit Packages

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of agreed exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£s
Less than £10,000	-	-	9	50,250	10	50,250	-	-
£10,000 - £25,000	-	-	22	388,977	22	388,977	-	-
£25,001 - £50,000	-	-	35	1,243,984	35	1,243,984	-	-
£50,001 - £100,000	-	-	45	3,083,353	45	3,083,353	-	-
£100,001 - £150,000	-	-	37	4,514,628	37	4,514,628	-	-
£150,001 – £200,000	-	-	24	3,826,835	24	3,826,835	-	-
>£200,000	-	-	-	-	-	-	-	-
TOTALS	-	-	172	£13,108,027	172	£13,108,027		

Of the 172 exits agreed in the year under the voluntary redundancy scheme, 151 staff left in the year with 21 departing after the year end. The full cost of these redundancies is accounted for in the year.

Redundancy and other departure cost have been paid in accordance with the Agenda for Change Terms and Conditions. Exit costs in this note are accounted for in full in the year when these have been agreed. Where NHS Cheshire and Merseyside has agreed early retirements, the additional costs are met by NHS Cheshire and Merseyside and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Table 40: Analysis of Other Departures

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	172	13,108
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice*	-	-
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval**	-	-
TOTAL	172	13,108

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match.

No exit packages related to individuals disclosed in the Remuneration Report.

2.4 Parliamentary Accountability and Audit Report

NHS Cheshire and Merseyside is not required to produce a Parliamentary Accountability and Audit Report.

Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report at pages 153 to 188.

An audit certificate and report is also included in this Annual Report at pages 147 to 151.

Liz Bishop

Liz Bishop
Chief Executive
19th June 2025

Independent auditor's report to the members of the Board of NHS Cheshire and Merseyside Integrated Care Board

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of NHS Cheshire and Merseyside Integrated Care Board (the 'ICB') for the year ended 31 March 2026, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of Schedule 1B of the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2026 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006, as amended by the Health and Care Act 2022.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2024) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the ICB in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accountable Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the ICB's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the ICB to cease to continue as a going concern.

In our evaluation of the Accountable Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2025-26 that the ICB's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services currently provided by the ICB. In doing so we had regard to the guidance provided in Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the ICB and the ICB's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report and accounts, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report and accounts. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in November 2024 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the requirements of the Department of Health and Social Care Group Accounting Manual 2025-26 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2025-26; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the period for which the financial statements are prepared is consistent with the financial statements.

Opinion on regularity of income and expenditure required by the Code of Audit Practice

In our opinion, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make a written recommendation to the ICB under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's responsibilities, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the ICB without the transfer of its services to another public sector entity.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the ICB and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as amended by the Health and Care Act 2022 and interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2025-26).
- We enquired of management and the audit committee, concerning the ICB's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the audit committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the ICB's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:
  - Management override of controls through inappropriate journal entry.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on large and unusual items and those falling within identified risk criteria including; journals posted by senior management, material journals, year-end journals, journals posted after 31 March 2026, journals reducing expenditure and journals posted on the weekend;
  - challenging assumptions and judgements made by management in its accounting estimates in respect of the prescribing accrual;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- We communicated relevant laws and regulations and potential fraud risks to all engagement team members, including the potential for fraud in management override of controls. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.

- The engagement partner's assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the ICB operates
  - understanding of the legal and regulatory requirements specific to the ICB including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The ICB's operations, including the nature of its other operating revenue and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The ICB's control environment, including the policies and procedures implemented by the ICB to ensure compliance with the requirements of the financial reporting framework.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026.

We have nothing to report in respect of the above matter except the following.

On 9 June 2026 we identified a significant weakness in respect of the ICB's arrangements to secure financial sustainability. This was in relation to the adverse outturn position compared to plan at both ICB and system level in 2025-26 and the enforcement undertakings issued by NHS England in November 2025.We recommended that the ICB must strengthen and embed its financial governance arrangements to provide assurance over delivery of the breakeven position in the medium-term.

On 9 June 2026 we identified a significant weakness in respect of the ICB's governance arrangements. This was in relation to arrangements to deliver financial plans and to provide effective system quality governance and quality risk management, as referenced in the enforcement undertakings issued by NHS England in November 2025. We recommended that the ICB must deliver and embed the Single Improvement Plan to address the enforcement undertakings and support delivery of the ICB Model Blueprint.

Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the ICB's resources.

Auditor's responsibilities for the review of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in March 2026. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the ICB plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the ICB ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the ICB uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the ICB has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for NHS Cheshire and Merseyside Integrated Care Board for the year ended 31 March 2026 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed the work necessary in relation to the ICB's consolidation schedules and we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2026. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2026.

Use of our report

This report is made solely to the members of the Board of the ICB, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Board of the ICB those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the ICB and the members of the Board of the ICB as a body, for our audit work, for this report, or for the opinions we have formed.

Michael Green

Michael Green, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Manchester
18 June 2026

ANNUAL ACCOUNTS

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Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2026

	Note	2025-26 £'000	2024-25 £'000
Income from sale of goods and services	2	(92,968)	(93,916)
Other operating income	2	(102)	(42)
Total operating income		**(93,070)**	**(93,958)**
Staff costs	4	100,960	77,757
Purchase of goods and services	5	8,373,815	7,936,698
Depreciation and impairment charges	5	670	879
Provision expense	5	-	-
Other operating expenditure	5	6,970	8,403
Total operating expenditure		**8,482,415**	**8,023,738**
Net Operating Expenditure		**8,389,345**	**7,929,780**
Finance expense	8	117	67
Other Gains and Losses	7	-	296
Total Net Expenditure for the Financial Year		**8,389,462**	**7,930,143**
Comprehensive Expenditure for the year		**8,389,462**	**7,930,143**

Notes 1 to 25 form part of this statement

Statement of Financial Position as at 31 March 2026

	Note	2025-26 £'000	2024-25 £'000
Non-current assets:			
Property, plant and equipment	9	-	26
Right-of-use assets	9a	2,939	3,896
Total non-current assets		**2,939**	3,922
Current assets:			
Trade and other receivables	11	90,999	83,159
Cash and cash equivalents	12	-	1
Total current assets		**90,999**	83,160
Total assets		**93,938**	87,082
Current liabilities			
Trade and other payables	13	(392,032)	(328,261)
Lease liabilities	9a	(549)	(632)
Borrowings	14	(3,642)	(8,321)
Total current liabilities		**(396,223)**	(337,214)
Net Current Liabilities		**(302,285)**	(250,132)
Non-current liabilities			
Lease liabilities	9a	(2,509)	(3,310)
Total non-current liabilities		**(2,509)**	**(3,310)**
Assets less Liabilities		**(304,794)**	(253,443)
Financed by Taxpayers' Equity			
General fund		(304,794)	(253,443)
Total taxpayers' equity:		**(304,794)**	(253,443)

Notes 1 to 25 form part of this statement

The financial statements on pages 151 to 186 were approved by the Board on 18 June 2026 and signed on its behalf by:

Liz Bishop

Liz Bishop
Chief Accountable Officer
18 June 2026

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2026

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2025-26		
Balance at 1 April 2025	**(253,443)**	**(253,443)**
Changes in ICB taxpayers' equity for 2025-26		
Net operating expenditure for the financial year	(8,389,462)	(8,389,462)
Net Recognised ICB Expenditure for the Financial year	**(8,389,462)**	**(8,389,462)**
Net funding	8,338,111	**8,338,111**
Balance at 31 March 2026	**(304,794)**	**(304,794)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for 2024-25		
Balance at 1 April 2024	**(312,747)**	**(312,747)**
Changes in ICB taxpayers' equity for 2024-25		
Net operating expenditure for the financial year	(7,930,143)	(7,930,143)
Net Recognised ICB Expenditure for the Financial Year	**(7,930,143)**	**(7,930,143)**
Net funding	7,989,447	7,989,447
Balance at 31 March 2025	**(253,443)**	**(253,443)**

Notes 1 to 25 form part of this statement

Statement of Cash Flows for the year ended 31 March 2026

	Note	**2025-26 £'000**	2024-25 £'000
Cash Flows from Operating Activities			
Total Net expenditure for the financial year		(8,389,463)	(7,930,143)
Depreciation and amortisation	5	670	879
Interest paid / received	8	116	66
Other Gains & Losses	7	0	296
(Increase)/decrease in trade & other receivables	11	(7,840)	12,806
Increase/(decrease) in trade & other payables	13	63,771	(72,581)
Provisions utilised	15	-	(240)
Net Cash Outflow from Operating Activities		**(8,332,745)**	(7,988,916)
Net Cash Outflow before Financing		**(8,332,745)**	(7,988,916)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		8,338,111	7,989,447
Repayment of lease liabilities		(687)	(723)
Net Cash Inflow from Financing Activities		**8,337,424**	7,988,724
Net increase/(decrease) in Cash & Cash Equivalents	12	**4,679**	(193)
Cash & Cash Equivalents at the Beginning of the Financial Year		**(8,320)**	(8,128)
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**(3,642)**	(8,321)

Notes 1 to 25 form part of this statement

Notes to the financial statements

1. **Accounting Policies**

NHS England has directed that the financial statements of Integrated Care Boards (ICB) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2025-26 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on a going concern basis.

Public sector bodies are assumed to be a going concern where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents. The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

1.2 **Accounting Convention**

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, inventories and certain financial assets and financial liabilities.

1.3 **Joint arrangements**

Joint operations are arrangements in which the ICB has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The ICB includes within its financial statements its share of the assets, liabilities, income and expenses.

1.4 **Pooled Budgets**

The ICB has entered into a pooled budget arrangement with local authorities in Cheshire and Merseyside in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for Better Care Funds with local authorities in which a programme is funded to deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers. Note 20 provides details of the scheme and the associated expenditure.

The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement

1.5 **Operating Segments**

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the ICB.

1.6 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

• As per paragraph 121 of the Standard, the ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

• The FReM (HM Treasury's Financial Reporting Manual) has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.

Notes to the financial statements

The main source of funding for the ICBs is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles. Significant terms include all amounts being due within thirty days of the invoice.

The value of the benefit received when the ICB accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.7 **Employee Benefits**

1.7.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

1.7.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

Some employees are members of National Employment Savings Trust, which is a defined contribution pension scheme. The cost to the ICB of participating in the scheme is the contributions payable to the scheme for the accounting period.

1.8 **Other Expenses**

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.9 **Grants Payable**

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the ICB recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

Notes to the financial statements

1.10 **Property, Plant & Equipment**

Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the ICB;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.10.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.10.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Notes to the financial statements

1.11 **Intangible Assets**

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the ICB's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the ICB;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.11.2 **Measurement**

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

From 1 April 2025, intangible assets are carried at cost. Where intangible assets have been carried historically under a revaluation approach following initial recognition, the carrying net amount as 31 March 2026 will be considered to be the deemed historic cost. In accordance with the GAM this change in valuation is being applied prospectively.

1.11.3 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the ICB expects to obtain economic benefits or service potential from the asset. This is specific to the ICB and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the ICB checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.12 **Donated Assets**

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.13 **Government grant funded assets**

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.14 **Leases**

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.

The ICB assesses whether a contract is or contains a lease, at inception of the contract.

1.14.1 **The ICB as Lessee**

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the ‘Depreciation, amortisation and impairments’ policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

Notes to the financial statements

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.15 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management.

1.16 **Provisions**

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

• A nominal short-term rate of 3.64% (2024-25: 4.03%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 4.22% (2024-25: 4.07%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

• A nominal long-term rate of 5.32% (2024-25: 4.81%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

• A nominal very long-term rate of 5.07% (2024-25: 4.55%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the ICB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.17 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with ICB. As at 31 March 2026, the amount maintained in the provisions of NHS Resolution in respect of clinical negligence liabilities of the ICB was £11.285m (2024-25: £4.659m).

1.18 **Non-clinical Risk Pooling**

The ICB participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the ICB pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

Notes to the financial statements

1.19 **Contingent liabilities and contingent assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.20 **Financial Assets**

Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.
Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income; and
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.20.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.20.2 **Financial assets at fair value through other comprehensive income**

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the ICB elected to measure an equity instrument in this category on initial recognition.

1.20.3 **Financial assets at fair value through profit and loss**

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

1.20.4 **Impairment of financial assets**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets or assets measured at fair value through other comprehensive income, the ICB recognises a loss allowance representing the expected credit losses on the financial asset.

Notes to the financial statements

The ICB adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The ICB therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies and the ICB does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

Lifetime credit losses for Non Government trade receivables are determined by applying a percentage representing lifetime expected losses depending on the age of the debt. For example, debts greater than 90 days old have an expected credit loss of 10.6%.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.21 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.21.1 **Financial Liabilities at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the ICB's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.21.2 **Other Financial Liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.22 **Value Added Tax**

Most of the activities of the ICB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.23 **Foreign Currencies**

The ICB's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the spot exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the ICB's surplus/deficit in the period in which they arise.

Notes to the financial statements

1.24 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.25 **Critical accounting judgements and key sources of estimation uncertainty**

In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.25.1 **Critical accounting judgements in applying accounting policies**

There are no critical accounting judgements that management has made in the process of applying the ICB's accounting policies that have significant effect on the amounts recognised in the financial statements.

1.25.2 **Sources of estimation uncertainty**

There are no assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

1.26 **New and revised IFRS Standards in issue but not yet effective**

● IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. Any impact cannot be assessed until this standard is adopted by the FReM.

● IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. Implementation of this standard will have no impact on the finacial statements of the ICB.

2. Other Operating Revenue

	2025-26 Total £'000	2024-25 Total £'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	**3,958**	5,556
Prescription fees and charges	**39,798**	39,962
Dental fees and charges	**48,976**	46,662
Other Contract income	**236**	1,737
Total Income from sale of goods and services	**92,968**	**93,916**
Other operating income		
Non cash apprenticeship training grants revenue	**102**	41
Other non contract revenue	**-**	1
Total Other operating income	**102**	**42**
Total Operating Income	**93,070**	**93,958**

2.1 Disaggregation of Income - Income from sale of good and services (contracts)

2025-26	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000
Source of Revenue				
NHS	1,368	-	-	227
Non NHS	2,590	39,798	48,976	9
Total	**3,958**	**39,798**	**48,976**	**236**
Timing of Revenue				
Point in time	3,958	39,798	48,976	236
Over time	-	-	-	-
Total	**3,958**	**39,798**	**48,976**	**236**

2024-25	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000
Source of Revenue				
NHS	2,671	-	-	210
Non NHS	2,885	39,962	46,662	1,527
Total	**5,556**	**39,962**	**46,662**	**1,737**
Timing of Revenue				
Point in time	5,556	39,962	46,662	1,737
Over time	-	-	-	-
Total	**5,556**	**39,962**	**46,662**	**1,737**

3. Cost Allocation and Setting of Charges

NHS England, which sets charges on behalf of the ICB, certifies that it has complied with the HM Treasury guidance on cost allocation and the setting of charges. The following table provides details of income generation activities whose full cost exceeded £1 million or was otherwise material:

		Year ended 31 March 2026			Year ended 31 March 2025		
	Notes	**Income**	**Full Cost**	**Deficit**	Income	Full Cost	Deficit
		£'000	**£'000**	**£'000**	£'000	£'000	£'000
Prescription	2 & 5	39,798	560,285	(520,487)	39,962	553,936	(513,974)
Dental	2 & 5	48,976	200,767	(151,790)	46,662	194,927	(148,266)
		88,774	**761,051**	**(672,277)**	**86,624**	**748,864**	**(662,240)**

The fees and charges information in this note is provided in accordance with section 6.7.1f of the Government Financial Reporting Manual for 2025/26. It is provided for fees and charges purposes and not for International Financial Reporting Standards (IFRS) 8 purposes.

The financial objective of prescription and dental charges is to collect charges only from those patients that are eligible to pay.

Prescription charges are a contribution to the cost of pharmaceutical services including the supply of drugs. In 2025-26, the NHS prescription charge for each medicine or appliance dispensed was £9.90 (2024-25: £9.90). However, around 90% of prescription items are dispensed free each year where patients are exempt from charges. In addition, patients who were eligible to pay charges could purchase pre-payment certificates at £32.05 for 3 months (2024-25: £32.05) or £114.50 for a year (2024-25: £114.50) for a year. A HRT prepayment certificate was charged at £19.80 (2024-25: £19.80) for a year. A number of other charges were payable for wigs and fabric supports.

Those who are not eligible for exemption are required to pay NHS dental charges which fall into 3 bands depending on the level and complexity of care provided. The charge for Band 1 treatments was £27.40 (2024-25: £26.80), for Band 2 was £75.30 (2024-25: £73.50) and for Band 3 was £326.70 (2024-25: £319.10).

4. Employee benefits and staff numbers

4.1 Employee benefits

	Total Permanent Employees £'000	Other £'000	2025-26 Total £'000
Employee Benefits			
Salaries and wages	58,022	2,141	**60,163**
Social security costs	9,668	-	**9,668**
Employer contributions to NHS Pension scheme	13,217	-	**13,217**
Other pension costs	15	-	**15**
Apprenticeship Levy	287	-	**287**
Termination benefits	17,610	-	**17,610**
Gross employee benefits expenditure	**98,819**	**2,141**	**100,960**

The cost of termination benefits above comprises £13,108K for exits packages agreed in year (see note 4.3) and £4,502k for terminations planned but not finally agreed in 2025/26 that will be payable in 2026/27.

	Total Permanent Employees £'000	Other £'000	2024-25 Total £'000
Employee Benefits			
Salaries and wages	56,740	1,362	**58,102**
Social security costs	6,455	-	**6,455**
Employer contributions to NHS Pension scheme	12,803	-	**12,803**
Other pension costs	18	-	**18**
Apprenticeship Levy	300	-	**300**
Termination benefits	80	-	**80**
Gross employee benefits expenditure	76,396	1,362	**77,757**

4.2 Average number of people employed

	2025-26			2024-25		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**1,032**	**36**	**1,068**	**1,053**	**60**	**1,113**

4.3 Exit packages agreed in the financial year

	2025-26 Compulsory redundancies		2025-26 Other agreed departures		2025-26 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	9	50,250	9	50,250
£10,001 to £25,000	-	-	22	388,977	22	388,977
£25,001 to £50,000	-	-	35	1,243,984	35	1,243,984
£50,001 to £100,000	-	-	45	3,083,353	45	3,083,353
£100,001 to £150,000	-	-	37	4,514,628	37	4,514,628
£150,001 to £200,000	-	-	24	3,826,835	24	3,826,835
Total	**-**	**-**	**172**	**13,108,027**	**172**	**13,108,027**

	2024-25 Compulsory redundancies		2024-25 Other agreed departures		2024-25 Total	
	Number	£	Number	£	Number	£
£50,001 to £100,000	-	-	1	80,000	1	80,000
Total	**-**	**-**	**1**	**80,000**	**1**	**80,000**

There were no departures where special payments were made.

Analysis of Other Agreed Departures

	2025-26		2024-25	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	172	13,108,027	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	1	80,000
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval*	-	-	-	-
Total	**172**	**13,108,027**	**1**	**80,000**

These tables report the number and value of exit packages agreed in the financial year.

4.4 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years".

An outline of these follows:

4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

Some employees are members of National Employment Savings Trust, which is a defined contribution pension scheme. The cost to the ICB of participating in the scheme is the contributions payable to the scheme for the accounting period.

5. Operating expenses (excluding staff costs)

	2025-26 Total £'000	2024-25 Total £'000
Purchase of goods and services		
Services from other ICBs and NHS England	11,066	10,325
Services from foundation trusts	4,432,544	4,220,463
Services from other NHS trusts	1,146,857	1,110,174
Services from other WGA bodies	345	8
Purchase of healthcare from non-NHS bodies	1,028,499	936,268
Purchase of social care	106,651	99,955
General Dental services and personal dental services	200,767	194,927
Prescribing costs	560,285	553,936
Pharmaceutical services	134,320	116,221
General Ophthalmic services	28,223	27,003
GPMS/APMS and PCTMS	648,760	604,660
Supplies and services – clinical	1,646	790
Supplies and services – general	14,670	14,661
Consultancy services	73	260
Establishment	13,471	13,274
Transport	83	80
Premises	30,430	22,358
Audit fees	299	299
Other non statutory audit expenditure		
· Other services	120	-
Other professional fees	13,047	9,447
Legal fees	1,008	923
Education, training and conferences	549	625
Non cash apprenticeship training grants	102	41
Total Purchase of goods and services	**8,373,815**	**7,936,698**
Depreciation and impairment charges		
Depreciation	670	879
Total Depreciation and impairment charges	**670**	**879**
Other Operating Expenditure		
Chair and Non Executive Members	218	207
Grants to Other bodies	3,091	3,091
Research and development (excluding staff costs)	3,436	4,876
Expected credit loss on receivables	196	(63)
Other expenditure	29	292
Total Other Operating Expenditure	**6,970**	**8,403**
Total operating expenditure (excluding staff costs)	**8,381,455**	**7,945,981**

Audit fees of £299k relate to the ICB only and include Value Added Tax. Other audit services of £120k relate to MHIS audit fee

In accordance with SI 2008 No. 489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, where an ICB's contract with its auditors provides for a limitation of the auditor's liability, the principal terms of this limitation must be disclosed. The contract for the provision of external audit services is held by Grant Thornton UK LLP. This limitation has been confirmed as £311,400. External audit fees include Value Added Tax

Internal audit services during the year were provided by Mersey Internal Audit Agency and hosted by Liverpool University Hospitals NHS Foundation Trust.

6 Payment Compliance Reporting

6.1 Better Payment Practice Code

Measure of compliance	2025-26 Number	2025-26 £'000	2024-25 Number	2024-25 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	165,307	1,940,776	164,300	1,824,577
Total Non-NHS Trade invoices paid within target	163,764	1,913,716	162,224	1,786,852
Percentage of Non-NHS Trade invoices paid within target	**99.07%**	**98.61%**	**98.74%**	**97.93%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	12,752	5,595,667	15,257	5,423,293
Total NHS Trade Invoices Paid within target	12,706	5,594,670	15,184	5,422,074
Percentage of NHS Trade Invoices paid within target	**99.64%**	**99.98%**	**99.52%**	**99.98%**

The Better Payment Practice Code requires the ICB to aim to pay all valid invoices by the due date or within 30 days of the receipt of a valid invoice, whichever is later. The Better Payment Practice Code sets out target compliance of 95%.

6.2 The late payment of commercial debts (interest) act 1998	2025-26 £'000	2024-25 £'000
Amounts included in finance costs from claims made under this legislation	1	-
Compensation paid to cover debt recovery costs under this legislation	-	-
Total	**1**	**-**

7. Other gains and losses

	2025-26 £'000	2024-25 £'000
Gain/(loss) on disposal of right-of-use assets other than by sale	-	296
Total	**-**	**296**

8. Finance costs

	2025-26 £'000	2024-25 £'000
Interest		
Interest on lease liabilities	116	67
Interest on late payment of commercial debt	1	-
Other interest expense	-	1
Total finance costs	**117**	**67**

9. Property, plant and equipment

2025-26	Buildings excluding dwellings £'000	Information technology £'000	Total £'000
Cost or valuation at 1 April 2025	685	829	1,514
Disposals other than by sale	(685)	(708)	(1,393)
Cost/Valuation at 31 March 2026	**-**	**121**	**121**
Depreciation 1 April 2025	674	814	1,488
Disposals other than by sale	(685)	(708)	(1,393)
Charged during the year	11	15	26
Depreciation at 31 March 2026	**-**	**121**	**121**
Net Book Value at 31 March 2026	**-**	**-**	**-**
Purchased	-	-	-
Donated	-	-	-
Government Granted	-	-	-
Total at 31 March 2026	**-**	**-**	**-**
Asset financing:			
Owned	-	-	-
Total at 31 March 2026	**-**	**-**	**-**

9.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Buildings excluding dwellings	5	5
Information technology	3	5

9. Property, plant and equipment

2024-25	Buildings excluding dwellings £'000	Plant & machinery £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 1 April 2024	685	152	829	(11)	1,655
Disposals other than by sale	-	(152)	-	11	(141)
Cost/Valuation at 31 March 2025	**685**	**-**	**829**	**-**	**1,514**
Depreciation 1 April 2024	537	152	761	(11)	1,440
Disposals other than by sale	-	(152)	-	11	(141)
Charged during the year	137	-	53	-	190
Depreciation at 31 March 2025	**674**	**-**	**814**	**-**	**1,488**
Net Book Value at 31 March 2025	**11**	**-**	**15**	**-**	**26**
Purchased	11	-	15	-	26
Total at 31 March 2025	**11**	**-**	**15**	**-**	**26**
Asset financing:					
Owned	11	-	15	-	26
Total at 31 March 2025	**11**	**-**	**15**	**-**	**26**

9a. Leases

9a.1 Right-of-use assets

2025-26	Buildings excluding dwellings £'000	Total £'000
Cost or valuation at 1 April 2025	5,654	5,654
Derecognition for early terminations	(665)	(665)
Cost/Valuation at 31 March 2026	**4,989**	**4,989**
Depreciation 1 April 2025	1,758	1,758
Charged during the year	645	645
Derecognition for early terminations	(352)	(352)
Depreciation at 31 March 2026	**2,050**	**2,050**
Net Book Value at 31 March 2026	**2,939**	**2,939**

2024-25	Buildings excluding dwellings £'000	Total £'000
Cost or valuation at 1 April 2024	4,601	4,601
Additions	1,782	1,782
ROU Delapidations	240	240
Lease remeasurement	79	79
Derecognition for early terminations	(1,048)	(1,048)
Cost/Valuation at 31 March 2025	**5,654**	**5,654**
Depreciation 1 April 2024	1,534	1,534
Charged during the year	689	689
Derecognition for early terminations	(465)	(465)
Depreciation at 31 March 2025	**1,758**	**1,758**
Net Book Value at 31 March 2025	**3,896**	**3,896**

Net Book Value by counterparty	2025-26 £'000	2024-25 £'000
Leased from DHSC	922	1,570
Leased from NHS Providers	499	592
Leased from external bodies	1,518	1,734
Net Book Value at 31 March 2026	**2,939**	**3,896**

9a.2 Lease liabilities

2025-26	2025-26 £'000	2024-25 £'000
Lease liabilities at 1 April 2025	(3,942)	(3,024)
Additions purchased	-	(1,783)
Interest expense relating to lease liabilities	(116)	(67)
Repayment of lease liabilities (including interest)	687	723
Lease remeasurement	-	(79)
Derecognition for early terminations	313	287
Lease liabilities at 31 March 2026	**(3,058)**	**(3,942)**

9a.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2025-26		2024-25	
	Total £'000	**Of which: leased from DHSC group bodies £000**	Total £'000	Of which: leased from DHSC group bodies £000
Within one year	(648)	(385)	(751)	(513)
Between one and five years	(1,825)	(981)	(2,325)	(1,380)
After five years	(999)	(172)	(1,406)	(417)
Balance at 31 March 2026	**(3,472)**	**(1,538)**	**(4,482)**	**(2,309)**

The difference between the lease liability recognised and the undiscounted payments arises from discounting future lease payments.

Balance by counterparty		
Leased from DHSC	(961)	(1,622)
Leased from NHS Providers	(578)	(687)
Balance as at 31 March 2026	**(1,538)**	**(2,309)**

9a.4 Amounts recognised in Statement of Comprehensive Net Expenditure

2025-26	2025-26 £'000	2024-25 £'000
Depreciation expense on right-of-use assets	645	689
Interest expense on lease liabilities	116	67
Expense relating to leases of low value assets	83	-

9a.5 Amounts recognised in Statement of Cash Flows

	2025-26 £'000	2024-25 £'000
Total cash outflow on leases under IFRS 16	687	723

9.a Leases cont'd

Leases are recognised under the leasing standard IFRS 16, applied from 1 April 2022. Under IFRS 16 leases are recognised as a right of use asset with a corresponding lease liability on the Statement of Financial Position. Each lease payment is allocated between a reduction of the liability and the interest expense. The interest expense is charged to the Statement of Comprehensive Net Expenditure over the lease period. The right of use asset is depreciated over the shorter of the asset's useful life and the lease term on a straight line basis. The ICB has applied the exemption for short-term leases (less than 12 months) and low value assets. In these cases, the lease payments associated with them are recognised as an expense in the Statement of Comprehensive Net Expenditure.

As at 31st March 2026 the ICB holds the following leases which fall within the scope of IFRS 16:

Name	Lessor	Use
1829 Building, Chester	NHS Property Services	ICB administrative building
Magdalen House, Bootle	Sefton Council	ICB administrative building
No.1 Lakeside, Warrington	PJD Property Management Ltd	ICB administrative building
Nutgrove Villa, Huyton	NHS Property Services	ICB administrative building
Curzon Road, Southport	NHS Property Services	ICB administrative building
Infinity House, Crewe	Mid Cheshire Hospitals NHS Foundation Trust	ICB administrative building
Old Market House, Wirral	University of Chester	ICB administrative building

The ICB also pays for void space, bookable space and subsidies for properties owned and managed by Community Health Partnerships (CHP) and NHS Property Services (NHSPS), and for space occupied by NHS providers in buildings run by CHP and NHSPS. These do not fall within the definition of a lease and as such are not included in this note.

10. Intangible assets

2025-26

Intangible assets held by the ICB are fully amortised and written out of the accounts.

2024-25	Computer Software: Purchased £'000	Total £'000
Cost or valuation at 1 April 2024	**227**	**227**
Disposals other than by sale	(227)	**(227)**
Cost / Valuation At 31 March 2025	**-**	**-**
Amortisation 1 April 2024	**227**	**227**
Disposals other than by sale	(227)	**(227)**
Amortisation At 31 March 2025	**-**	**-**
Net Book Value at 31 March 2025	**-**	**-**

10.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Computer software: purchased	-	-

Intangible assets held by the ICB are fully amortised and therefore economic lives are deemed to be nil.

11.1 Trade and other receivables	Current 2025-26 £'000	Current 2024-25 £'000
NHS receivables: Revenue	10,259	4,572
NHS prepayments	-	1,844
NHS accrued income	16,644	16,443
NHS Contract Receivable not yet invoiced/non-invoice	6,937	98
Non-NHS and Other WGA receivables: Revenue	29,121	30,700
Non-NHS and Other WGA prepayments	4,047	6,686
Non-NHS and Other WGA accrued income	4,289	9,154
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	7,267	3,897
Expected credit loss allowance-receivables	(277)	(81)
VAT	1,122	1,109
Other receivables and accruals	11,590	8,738
Total Trade & other receivables	**90,999**	**83,159**
Total current and non current	**90,999**	**83,159**

There were no non-current receivables in 2025-26 (2024-25: Nil)

11.2 Receivables past their due date but not impaired

	2025-26 DHSC Group Bodies £'000	2025-26 Non DHSC Group Bodies £'000	2024-25 DHSC Group Bodies £'000	2024-25 Non DHSC Group Bodies £'000
By up to three months	(3)	7,103	45	7,173
By three to six months	-	201	519	2,944
By more than six months	1,066	4,575	1,641	4,840
Total	**1,063**	**11,879**	**2,206**	**14,957**

11.3 Loss allowance on asset classes	Trade and other receivables - Non DHSC Group Bodies £'000	Total £'000
Balance at 1 April 2025	**(81)**	**(81)**
Lifetime expected credit loss on credit impaired financial assets	**-**	**-**
Lifetime expected credit losses on trade and other receivables-Stage 2	**(195)**	**(195)**
Total at 31 March 2026	**(277)**	**(277)**

12. Cash and cash equivalents

	2025-26 £'000	2024-25 £'000
Balance at 1 April 2025	(8,320)	(8,128)
Net change in year	4,679	(193)
Balance at 31 March 2026	**(3,642)**	**(8,321)**
Made up of:		
Cash in hand	-	1
Cash and cash equivalents as in statement of financial position	**-**	**1**
Bank overdraft: Government Banking Service	(3,642)	(8,321)
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**(3,642)**	**(8,321)**
Balance at 31 March 2026	**(3,642)**	**(8,320)**

The ICB does not hold any Patients' money.

The bank overdraft shown above is all due within one year and includes BACS payment runs which have been approved in March 2026 but which will be paid from the bank account in April 2026. These outstanding payments therefore give rise to a technical overdraft which is classified as borrowing in accordance with International Financial Reporting Standards. If these payments had not been made the closing cash balance at 31 March 2026 would be £1,612,511 (2024-25: £1,405,970).

13. Trade and other payables

	Current 2025-26 £'000	Current 2024-25 £'000
NHS payables: Revenue	17,336	3,701
NHS accruals	43,592	31,579
Non-NHS and Other WGA payables: Revenue	52,886	48,897
Non-NHS and Other WGA accruals	246,997	233,324
Non-NHS and Other WGA deferred income	420	509
Social security costs	1,819	777
Tax	3,178	826
Other payables and accruals	25,804	8,649
Total Trade & Other Payables	**392,032**	**328,261**
Total current and non-current	**392,032**	**328,261**

There were no non-current payables in 2025-26 (2024-25: Nil)

Included above are liabilities of £1k due in future years under arrangements to buy out the liability for early retirement over 5 years (2024-25: £1k).

Other payables include £5.262m outstanding pension contributions at 31 March 2026 (2024-25: £4.937m)

14. Borrowings	Current 2025-26 £'000	Current 2024-25 £'000
Bank overdrafts:		
· Government banking service	3,642	8,321
Total Borrowings	**3,642**	**8,321**

The bank overdraft shown above is all due within one year and includes BACS payment runs which have been approved in March 2026 but which will be paid from the bank account in April 2026. These outstanding payments give rise to a technical overdraft which is classified as borrowings in accordance with International Financial Reporting Standards.

14.1 Repayment of principal falling due

	Government Banking Service 2025-26 £'000	Total 2025-26 £'000	Government Banking Service 2024-25 £'000	Total 2024-25 £'000
Within one year	3,642	3,642	8,321	8,321
Total	**3,642**	**3,642**	**8,321**	**8,321**

15. Provisions

The ICB does not have any provisions in 2025-26 (2024-25: Nil)

16. Contingencies

The ICB does not have any contingencies in 2025-26 (2024-25: Nil)

17. Capital commitments

The ICB does not have any capital commitments at 31 March 2026 (2024-25: Nil)

18. Financial instruments

18.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the ICB is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The ICB has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the ICB in undertaking its activities.

The ICB has no overseas operations and therefore has low exposure to currency rate fluctuations.

18.1.2 Interest rate risk

The ICB borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The ICB therefore has low exposure to interest rate fluctuations.

18.1.3 Credit risk

Because the majority of ICB revenue comes parliamentary funding, the ICB has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

18.1.4 Liquidity risk

The ICB is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The ICB draws down cash to cover expenditure, as the need arises. The ICB is not, therefore, exposed to significant liquidity risks.

18.1.5 Financial Instruments

As the cash requirements of the ICB are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with the ICB's expected purchase and usage requirements and is therefore exposed to little credit, liquidity or market risk.

18. Financial instruments cont'd

18.2 Financial assets

	Financial Assets measured at amortised cost 2025-26 £'000	**Total 2025-26 £'000**	Financial Assets measured at amortised cost 2024-25 £'000	Total 2024-25 £'000
Trade and other receivables with NHSE bodies	8,655	8,655	3,546	3,546
Trade and other receivables with other DHSC group bodies	25,185	25,185	18,878	18,878
Trade and other receivables with external bodies	52,267	52,267	51,178	51,178
Cash and cash equivalents	-	-	1	1
Total at 31 March 2026	**86,107**	**86,107**	73,603	73,603
Non-financial instruments				
NHS prepayments	-	-	1,844	1,844
Non-NHS and other WGA prepayments	4,047	4,047	6,686	6,686
Expected credit loss allowance	(277)	(277)	(81)	(81)
VAT	1,122	1,122	1,109	1,109
Total current assets as at 31 March 2026 (as per Statement of Financial Position)	**90,999**	**90,999**	**83,160**	**83,160**

18.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2025-26 £'000	**Total 2025-26 £'000**	Financial Liabilities measured at amortised cost 2024-25 £'000	Total 2024-25 £'000
Loans with external bodies	3,642	**3,642**	8,321	8,321
Trade and other payables with NHSE bodies	2,567	**2,567**	581	581
Trade and other payables with other DHSC group bodies	59,019	**59,019**	37,336	37,336
Trade and other payables with external bodies	328,087	**328,087**	292,174	292,174
Total at 31 March 2026	**393,315**	**393,315**	338,412	338,412
Non-financial instruments				
Non-NHS and other WGA deferred income	420	420	509	509
Social security costs	1,819	1,819	777	777
Tax	3,178	3,178	826	826
Total liabilities as at 31 March 2026 (as per Statement of Financial Position)	**398,733**	**398,733**	**340,524**	**340,524**

19. Operating segments

International Financial Reporting Standards (IFRS) require financial performance to be analysed across key decision making segments.

The ICB operates nine segments across nine places all of which commission Health Care Services. As permitted by IFRS 8 information for segments with similar economic characteristics may be presented in aggregate and therefore these segments are included in aggregate below as the commissioning of healthcare services.

	Gross expenditure	Income	Net expenditure	Total assets	Total liabilities	Net assets
	£'000	£'000	£'000	£'000	£'000	£'000
Commissioning of Healthcare	8,482,533	(93,070)	**8,389,463**	93,939	(398,733)	**(304,794)**
Total	**8,482,533**	**(93,070)**	**8,389,463**	**93,939**	**(398,733)**	**(304,794)**

20. Joint arrangements - interests in joint operations

20.1 Interests in joint operations - Amounts recognised in ICB's books

Name of arrangement	Parties to the arrangement	Description of principal activities	2025-26				2024-25			
			Assets	Liabilities	Income	Expenditure	Assets	Liabilities	Income	Expenditure
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Better Care Fund	Cheshire East Council	Pooled budget arrangement for Carers Breaks, Local Authority s256, BCF Home First, Community Equipment and discharge funding	-	-	-	35,938	-	-	-	36,127
Better Care Fund	Cheshire West & Chester Council	Pooled budget arrangement for Carers Breaks, Local Authority s256, BCF Home First, Community Equipment and discharge funding	-	-	-	36,539	-	-	-	36,745
Integrated pooled fund for adult continuing healthcare	St Helens Council	Pooled budget arrangement for the provision of care packages for adults who qualify for CHC/FNC, are S117 or joint funded.	2,665	2,665	-	46,648	4,291	4,291	-	44,543
Better Care Fund	St Helens Council	Pooled budget arrangement for the provision of integrated spend on health and social care.	-	-	-	22,682	-	-	-	22,157
Better Care Fund	Sefton Council	Pooled budget arrangement for the provision of integrated spend on health and social care.	-	-	-	39,745	-	-	-	18,861
Better Care Fund	Wirral Council	Pooled budget arrangement for the commissioning service for the provision of health and social care.	-	-	-	40,646	-	-	-	39,272
Better Care Fund	Halton Council	Pooled budget arrangement for the provision of integrated spend on health and social care.	-	-	-	18,187	-	-	-	17,726
Integrated pooled fund for adult continuing healthcare	Halton Council	Pooled budget arrangement for the provision of care packages for adults who qualify for CHC/FNC, are S117 or joint funded.	5,175	5,175	-	2,910	3,308	3,308	-	4,239
Better Care Fund	Warrington Borough Council	Pooled budget arrangement for the integration of Health & Social Care	-	-	-	28,754	-	-	-	27,593
Better Care Fund	Knowsley Metropolitan Borough Council	Pooled budget arrangement for the provision of integrated spend on health and social care.	-	-	-	21,208	-	-	-	20,732
Integrated pooled fund for Mental Health, Community Support Services, Disability Services and Discharge Fund	Knowsley Metropolitan Borough Council	Pooled budget arrangement for the provision of Mental Health Services, Community Support Services, Disability Services and Discharge Fund	3,362	3,362	-	32,110	747	747	-	28,064
Better Care Fund	Liverpool City Council	Pooled budget arrangement for the provision of integrated spend on health and social care.	-	-	-	95,525	-	-	-	89,205
Integrated Community Equipment and Disability Advice Services (ICEDAS)	Liverpool City Council	Pooled budget arrangement for Community equipment	-	-	1,115	1,115	-	-	1,131	1,131
TOTAL			**11,202**	**11,202**	**1,115**	**422,008**	**8,346**	**8,346**	**1,131**	**386,394**

20. Joint arrangements - interests in joint operations cont'd

Cheshire
Cheshire has two pooled budget arrangements with Cheshire East Council and Cheshire West and Chester Council. Under the arrangements, funds are pooled for Cheshire East Better Care Fund and for Cheshire West and Chester Better Care Fund. The pools are hosted by Cheshire East Council and Cheshire West and Chester Council under section 75 agreements between the ICB and the other party. The agreements require that plans are jointly agreed and that services under the agreements are jointly commissioned. Regular meetings are held to monitor plans and commissioning arrangements. This is a joint arrangement and the ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Knowsley

Knowsley has a pooled budget arrangement with Knowsley Metropolitan Borough Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for Adult's Learning Disability, Mental Health, Community Support Services and the Better Care Fund. The Better Care Fund is a plan for the ICB and Local Authority to work closely together, driving integration and improved outcomes for the three core initiatives being Localities, Safe Supported Discharge and Access Knowsley. The pool is hosted by KMBC. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Liverpool

Liverpool has a pooled budget arrangement with Liverpool City Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for the provision of Integrated Community Equipment and Disability Advice Services (ICEDAS) and to operate a pooled budget for the required Better Care Fund arrangements. The Better Care Fund is hosted by Liverpool City Council. The ICEDAS is hosted by the ICB. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Halton
Halton has a pooled budget arrangement with Halton Borough Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for the provision of Adult's Learning Disability, Mental Health, Community Support Services and the Better Care Fund. The pool is hosted by Halton Borough Council. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

St Helens

St Helens has a pooled budget arrangement with St Helens Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for the majority of Continuing Health Care and the Better Care Fund. The pool is hosted by St Helens Council. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement

Sefton

Sefton has a pooled budget arrangement with Sefton Metropolitan Borough Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for Self Care, Wellbeing and Prevention, Integrated Care at locality level building on Virtual Ward and Care Closer to Home Initiatives and Intermediate Care and Reablement. The pool is hosted by Sefton Metropolitan Borough Council. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Warrington
Warrington has a pooled budget arrangement with Halton Borough Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for the provision of Adult's Learning Disability, Mental Health, Community Support Services and the Better Care Fund. The pool is hosted by Halton Borough Council The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

Wirral
Wirral has a pooled budget arrangement with Wirral Borough Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for health and social care activities. The pool is hosted by Wirral Borough Council. The ICB accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

21. Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
iGPC Primary Care Network (Naomi Rankin is also a Clinical Director and Shareholder of iGPC Primary Care Network)	2,820	-	243	-
Allen & Partners (Naomi Rankin is also a GP Partner at Belle Vale Medical Centre)	1,616	-	122	-
The Health Foundation (Ruth Hussey is also Deputy Chair of the The Health Foundation)	-	(84)	-	-
Voluntary Sector North West (Warren Escadale is also Chief Executive of Voluntary Sector North West)	227	-	28	-
Accurx LTD is considered a related party by virtue of relationships with the Department of Health and Social Care and therefore with the Group	1,495	-	148	-
Keys Group is considered a related party by virtue of relationships with the Department of Health and Social Care and therefore with the Group	52	-	-	8
Lancaster University is considered a related party by virtue of relationships with the Department of Health and Social Care and therefore with the Group	226	-	-	-

Transactions with the parties above were on the same trading terms as other supplier and providers.

The Department of Health and Social Care is a related party and the parent body. During the year the ICB has had a significant number of material transactions with entities which the Department is regarded as the parent.

The main parties in the public sector with which the ICB had dealings were:

NHS England
NHS Business Services Authority
Alder Hey Children's Hospital NHS Foundation Trust
Bridgewater Community Healthcare NHS Foundation Trust
Cheshire and Wirral Partnership NHS Foundation Trust
East Cheshire NHS Trust
Liverpool Heart and Chest Hospital NHS Foundation Trust
Liverpool University Hospital NHS Foundation Trust
Liverpool Women's NHS Foundation Trust
Manchester University NHS Foundation Trust
Mersey Care NHS Foundation Trust
Mersey and West Lancashire Teaching Hospitals NHS Trust
Mid Cheshire Hospitals NHS Foundation Trust
North West Ambulance Service NHS Trust
The Clatterbridge Cancer Centre NHS Foundation Trust
The Countess of Chester Hospital NHS Foundation Trust
The Walton Centre NHS Foundation Trust
Warrington and Halton Hospitals NHS Trust
Wirral Community NHS Foundation Trust
Wirral University Teaching Hospital NHS Foundation Trust
Cheshire East Council
Cheshire West and Chester Council
Halton Borough Council
Knowsley Council
Liverpool City Council
Metropolitan Borough Council of Sefton
St Helens Borough Council
Warrington Borough Council
Wirral Council

22. Events after the end of the reporting period

On 13 March 2025, the UK government signified their intention to reduce ICB management costs expenditure to a new cost per head of population of £19.40 for 2026-27. An organisational restructure commenced in the year to meet this target and implementation continues in 2026-27.

23. Losses and Special Payments

	2025-26 Total Number of Cases	**2025-26 Total Value of Cases £'000**	2024-25 Total Number of Cases	2024-25 Total Value of Cases £'000
Administrative write-offs	-	-	7	23
Cash losses	-	-	1	5
	-	**-**	**8**	**28**

24. Mental Health expenditure

	2025-26 £'000	**2024-25 £'000**
Minimum expenditure in mental health services to meet the Mental Health Investment Standard as notified by NHS England	667,310	581,602
Eligible mental health expenditure	673,970	591,031
Mental health expenditure above minimum investment required	6,660	9,429
Mental health expenditure as a proportion of total expenditure	8.03%	7.45%

Mental health expenditure as a proportion of total ICB expenditure increased from 7.45% in 2024/25 to 8.03% in 2025/26. This increase reflects real-terms growth in mental health spend and continued delivery of Long Term Plan priorities.

25. Financial performance targets

ICBs have a number of financial duties under the NHS Act 2006 (as amended).

The ICB's performance against those duties was as follows:

	2025-26 Target £'000	**2025-26 Performance £'000**	**Target Met Y/N**	2024-25 Target £'000	2024-25 Performance £'000	Target Met Y/N
Expenditure not to exceed income	8,482,563	8,482,532	Y	8,049,506	8,024,101	Y
Capital resource use does not exceed the amount specified in Directions	-	-		1,519	1,519	Y
Revenue resource use does not exceed the amount specified in Directions	8,389,493	8,389,463	Y	7,955,548	7,930,143	Y
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-		-	-	
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-		-	-	
Revenue administration resource use does not exceed the amount specified in Directions	61,035	60,979	Y	48,572	48,103	Y

Appendix One – Board and Committee Membership and Attendance

NHS Cheshire and Merseyside Board

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Raj Jain (Chair) (Until Sept 2025)	Chair of NHS Cheshire and Merseyside ICB	3 (3)
Sir David Henshaw (Chair) (From Nov 2025)	Chair of NHS Cheshire and Merseyside ICB	3 (3)
Graham Urwin (Until June 2025)	Chief Executive of NHS Cheshire and Merseyside ICB	1 (1)
Liz Bishop (From Nov 2025)	Chief Executive of NHS Cheshire and Merseyside ICB	3 (3)
Cathy Elliot (June 2025 - Sept 2025)	Chief Executive of NHS Cheshire and Merseyside ICB	2 (2)
Tony Foy	Non-Executive Member of NHS Cheshire and Merseyside ICB	5 (6)
Erica Morriss	Non-Executive Member of NHS Cheshire and Merseyside ICB	4 (6)
Mike Burrows	Non-Executive Member of NHS Cheshire and Merseyside ICB	4 (6)
Prof. Hilary Garratt CBE	Non-Executive Member of NHS Cheshire and Merseyside ICB	5 (6)
Dr Ruth Hussey CB, OBE, DL	Non-Executive Member of NHS Cheshire and Merseyside ICB	6 (6)
Sue Lorimer (From Jan 2026)	Non-Executive Member of NHS Cheshire and Merseyside ICB	2 (2)
Prof. Steven Broomhead MBE (Until July 2025)	Local Authority Partner Member of NHS Cheshire and Merseyside ICB	1 (1)
Andrew Lewis	Local Authority Partner Member of NHS Cheshire and Merseyside ICB	4 (6)
Ann Marr OBE (Until sept 2025)	Provider NHS Trust Partner Member, of NHS Cheshire and Merseyside ICB	3 (3)
Janelle Holmes (From Sept 2025)	Provider NHS Trust Partner Member, of NHS Cheshire and Merseyside ICB	4 (4)
Trish Bennett MBE	Provider NHS Trust Partner Member, of NHS Cheshire and Merseyside ICB	5 (6)

Name	Position & Organisation	Attendance (eligible to attend)
Adam Irvine	Primary Care Partner Member of NHS Cheshire and Merseyside ICB	6 (6)
Dr Naomi Rankin	Primary Care Partner Member of NHS Cheshire and Merseyside ICB	6 (6)
Prof. Rowan Pritchard-Jones (Until Nov 2025)	Medical Director of NHS Cheshire and Merseyside ICB	4 (4)
Mark Bakewell (Until Aug 2025)	Interim Director of Finance of NHS Cheshire and Merseyside ICB	2 (2)
Andrea McGee (From Sept 2025)	Executive Director of Finance (interim)	3 (4)
Christine Douglas MBE (Until Nov 2025)	Director of Nursing and Care of NHS Cheshire and Merseyside ICB	4 (4)
Delyth Curtis (From July 2025)	Local Authority Partner Member of NHS Cheshire and Merseyside ICB	4 (5)
Warren Escadale	VCFSE Partner Member of NHS Cheshire and Merseyside ICB	2 (6)
Clare Watson (From Jan 2026)	Executive Director of Health and Integrated Care Commissioning of NHS Cheshire and Merseyside ICB	2 (2)
Dr Fiona Lemmens (From Jan 2026)	Executive Clinical Director of NHS Cheshire and Merseyside ICB	2 (2)
Ben Vinter (From March 2026)	Executive Director of Corporate Services and Governance of NHS Cheshire and Merseyside ICB	1 (1)

The quorum for meetings of the Board will be a majority of members (8) including: The Chair and Chief Executive (or designated deputies), at least one Executive Director, at least one Non-Executive Director, at least one Partner Member and at least one member who has a clinical background or qualification.

Cheshire and Merseyside Health Care Partnership

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Councillor Louise Gittins (Chair)	Political Representative, Cheshire West and Chester Council	0 (1)
Rev Ellen Loudon (Vice Chair)	Director of Social Justice & Canon Chancellor, Diocese of Liverpool	1 (1)
Raj Jain (Vice Chair)	Chair of NHS Cheshire and Merseyside ICB	0 (1)
Graham Urwin	Chief Executive of NHS Cheshire and Merseyside ICB	1 (1)
Clare Watson	Assistant Chief Executive NHS Cheshire and Merseyside ICB	1 (1)
Mark Bakewell	Interim Director of Finance of NHS Cheshire and Merseyside / Liverpool Place Director	0 (1)
Councillor Christine Bannon	Political representative, Knowsley Metropolitan Borough Council	1 (1)
Councillor Ian Moncur	Political representative, Sefton Council	1 (1)
Councillor Marie Wright	Political representative, Halton Borough Council	0 (1)
Cllr Maureen McLoughlin	Chair of Health and Wellbeing Board-Warrington Borough Council	1 (1)
Professor Ian Ashworth	Director of Population Health	1 (1)
Gareth Lee	Detective Chief Superintendent, Cheshire Police	0 (1)
Lee Shears	Cheshire Fire and Rescue	0 (1)
Dave Mottram	Merseyside Fire and Rescue	0 (1)
Helen Bennett	Merseyside Police	1 (1)
Alison Cullen	Chief Executive Officer, Warrington Voluntary Action, Voluntary, Community and Faith Sector Representative (Cheshire)	1 (1)
Racheal Jones	Chief Executive Officer, One Knowsley, Voluntary, Community and Faith Sector Representative (Merseyside)	1 (1)
Adam Irvine	Primary Care Representative	1 (1)
Dame Jo Williams	Chair of Alder Hey Children's Hospital Trust - Provider Collaborative (CMAST)	1 (1)
Isla Wilson	Chair of Cheshire & Wirral Partnership NHS FT - Provider Collaborative Representative (MHLDSC)	1 (1)

Name	Position & Organisation	Attendance (eligible to attend)
Kate Shone	Managing Director, Torus Foundation	1 (1)
Gideon Ben Tovim	Health Innovation Chair of LCR Climate Partnership	1 (1)
Nicola Freaney	Partnership Manager, Department of Work and Pensions	1 (1)
Steve Park	Director of Growth, Warrington Borough Council	0 (1)
Nikki O'Connor	C&M (and Greater Manchester) DWP Strategic Partnership Manager	0 (1)
Ian Moses	North West Ambulance Service	0 (1)
Jenny Turnross	Children's Services, Liverpool City Council	0 (1)

For the Health and Care Partnership to be quorate, there must be 50% of the membership present

Children and Young People's Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Raj Jain (Chair)	Chair of NHS Cheshire and Merseyside ICB	3 (3)
Denise Roberts	Associate Director of Quality and Safety Improvement, Halton Place, NHS Cheshire and Merseyside ICB	1 (3)
Christine Douglas MBE	Executive Director of Nursing & Care, NHS Cheshire and Merseyside ICB	3 (3)
Simon Banks	Wirral Place Director, NHS Cheshire and Merseyside ICB	2 (3)
Clare Watson	Assistant Chief Executive, NHS Cheshire and Merseyside ICB	1 (3)
Dani Jones	Chief Strategy & Partnerships Office, Alder Hey Childrens Hospital NHS FT	3 (3)
Dave Packwood	C&M VCSE Children and Young People Network Manager	1 (3)
Dr Elizabeth Crabtree	Programme Director, Alder Hey Childrens Hospital NHS FT	2 (3)
Kelly Taylor	Head of Children & Young People Transformation Programme, NHS England – North West	1 (3)
Prof. Ian Ashworth	Associate Director of Population Health, NHS Cheshire and Merseyside ICB	1 (3)
Amanda Perraton	Director, Children's Social Care (DCS), Warrington Borough Council then Cheshire West and Chester Council	2 (3)
Bev Morgan	CEO, Koala North West	3 (3)
Sinead Clarke	Associate Medical Director for System Quality & Improvement, NHS Cheshire and Merseyside ICB	1 (3)

Name	Position & Organisation	Attendance (eligible to attend)
Gill Bainbridge*	Chief Executive, Merseyside Youth Association	1 (3)
Dave McNicholl	Chief Executive, Onside Warrington Youth Zone	1 (3)
Stuart Dunne	Chief Executive Officer, Youth Focus NW	2 (3)
Nassima Patel	Programme Director Change & Integration (DCS) Programme, hosted @ Wirral MBC	2 (3)
Elizabeth Collins	Systems Programme Manager for the Lead Provider Collaborative	1 (3)
John Grinnell	CEO, Alder Hey Children's NHS FT	1 (3)
Steve Tatham	Programme Lead Starting Well, MH & Planned Care, Cheshire & Merseyside ICB	2 (3)

For a meeting or part of a meeting to be quorate a minimum of 50% of the membership must be present, including the Chair or Deputy Chair.

Audit Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Mike Burrows (Chair) (Chair from Dec 2025)	Non-Executive Member of NHS Cheshire and Merseyside ICB	3 (3)
Tony Foy (Chair) (Chair from April 2025 – Nov 2025)	Non-Executive Member of NHS Cheshire and Merseyside ICB	5 (5)
Erica Morriss	Non-Executive Member of NHS Cheshire and Merseyside ICB	1 (5)
Prof. Hilary Garratt CBE	Non-Executive Member of NHS Cheshire and Merseyside ICB	3 (5)
Dr Ruth Hussey CB, OBE, DL	Non-Executive Member of NHS Cheshire and Merseyside ICB	5 (5)

For a meeting to be quorate, a minimum of two Non-Executive members of the Board are required, including the Chair or Vice Chair of the Committee.

Executive Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Liz Bishop	Chief Executive of NHS Cheshire and Merseyside ICB	6 (6)
Clare Watson	Executive Director of Health and Integrated Care Commissioning of NHS Cheshire and Merseyside ICB	6 (6)
Prof. Rowan Pritchard-Jones (until Feb 2026)	Medical Director of NHS Cheshire and Merseyside ICB	3 (3)
Dr Fiona Lemmens	Executive Clinical Director of NHS Cheshire and Merseyside ICB	6 (6)
Andrea McGee	Executive Director of Finance and Contracting of NHS Cheshire and Merseyside ICB	6 (6)
John Llewellyn	Chief Information Officer of NHS Cheshire and Merseyside ICB	2 (6)
Anthony Middleton	Director of Planning and Performance of NHS Cheshire and Merseyside ICB	5 (6)
Mike Gibney	Chief People Officer of NHS Cheshire and Merseyside ICB	6 (6)
Jude Adams	Director of Transformation & Strategy (Turnaround) of NHS Cheshire and Merseyside ICB	4 (6)
Alison Lee	Interim Director of Transformation of NHS Cheshire and Merseyside ICB	4 (6)
Carl Marsh	Interim Director of Transformation of NHS Cheshire and Merseyside ICB	5 (6)
Simon Banks	Place Director (Wirral) of NHS Cheshire and Merseyside ICB	4 (6)
Anthony Leo	Place Director (Halton and interim in Liverpool) of NHS Cheshire and Merseyside ICB	3 (6)

Name	Position & Organisation	Attendance (eligible to attend)
Jenny Wood	Interim Place Director (Knowsley) of NHS Cheshire and Merseyside ICB	6 (6)
Richard Burgess	Interim Place Director (Cheshire East) of NHS Cheshire and Merseyside ICB	3 (3)
Amanda Ridge	Interim Place Director (Warrington) of NHS Cheshire and Merseyside ICB	6 (6)
Tracy Jeffes	Interim Place Director (Sefton) of NHS Cheshire and Merseyside ICB	6 (6)
Laura Marsh	Interim Place Director (Cheshire West) of NHS Cheshire and Merseyside ICB	4 (6)
Jamaila Hussain	Interim Place Director (St Helens) of NHS Cheshire and Merseyside ICB	4 (6)
Linda Buckley	Managing of Cheshire and Merseyside Provider Collaborative	5 (6)
Ben Vinter (From 05/03)	Executive Director of Corporate Services and Governance of NHS Cheshire and Merseyside ICB	2 (2)

For a meeting to be quorate, there must be three members, which must include the Chief Executive or nominated deputy.

Finance, Investment and Our Resources Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Mike Burrows (Chair from April 2025 - Nov 2025)	Non-Executive Member of NHS Cheshire and Merseyside ICB	11 (12)
Sue Lorimer (Chair) (From November 2025)	Non-Executive Member of NHS Cheshire and Merseyside ICB	5 (5)
Erica Morriss (Until Oct 2025)	Non-Executive Member of NHS Cheshire and Merseyside ICB	3 (6)
Tony Foy	Non-Executive Member of NHS Cheshire and Merseyside ICB	(3) 11
Clare Watson	Assistant Chief Executive of NHS Cheshire and Merseyside ICB	12 (12)
Christine Douglas MBE (Until Dec 2025)	Director of Nursing and Care of NHS Cheshire and Merseyside ICB	6 (9)
Anthony Middleton	Director of Performance and Planning of NHS Cheshire and Merseyside ICB	6 (11)
Mark Bakewell (Until Sept 25)	Interim Executive Director of Finance	5 (5)
Andrea McGee (From Sept 2025)	Executive Director of Finance & Contracting	6 (7)
Adam Irvine	Primary Care Representative	9 (11)
Jane Tomkinson (Until Dec 2025)	Partner CEO C&M provider collaboratives	7 (9)
Nik Khashu (From Jan 2026)	Partner CEO C&M Provider Collaborative	3 (3)
Rob Collins	Integrated Care System Provider Finance Director	8 (11)
Susannah Lynch	Chief Pharmacist of NHS Cheshire and Merseyside ICB	10 (12)
Mike Gibney	Chief People Officer of NHS Cheshire and Merseyside ICB	0 (11)
Emma Hood	Workforce Training & Education Transformation Lead, C&M ICB	1 (1)
Mandy Nagra (From May 2025 – Dec 2025)	Chief System Improvement and Delivery Officer – Leading system Recovery, of NHS Cheshire and Merseyside ICB	5 (6)
Jude Adams (From Dec 2025)	Interim Executive Director of Strategy and Transformation of NHS Cheshire and Merseyside ICB	4 (4)
David Cooper (From Nov 2025)	Deputy Director of Finance of NHS Cheshire and Merseyside ICB	5 (5)

Name	Position & Organisation	Attendance (eligible to attend)
Dr Fiona Lemmens (From Feb 2025)	Executive Clinical Director of NHS Cheshire and Merseyside ICB	2 (2)
Ben Vinter (From March 2025)	Executive Director of Corporate Services and Governance of NHS Cheshire and Merseyside ICB	1 (1)
John Llewellyn (From March 2025)	Chief Digital & Information Officer of NHS Cheshire and Merseyside ICB	0 (1)

For a meeting to be quorate, at least 50% of the membership must be present (six). This should include two NHS Cheshire and Merseyside Executives, one Non-Executive member of the Board and one Partner Member.

North West Specialised Services Joint Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Dr Ruth Hussey CB, OBE, DL (Chair until March 2026)	Non-Executive Member of NHS Cheshire and Merseyside ICB	6 (6)
Clare Watson	Assistant Chief Executive, NHS Cheshire and Merseyside ICB	5 (6)
Craig Harris	Chief Commissioning Officer, NHS Lancashire and South Cumbria ICB	5 (6)
Jim Birrell (Deputy Chair) (Until end of Dec 2025)	Non-Executive Member, NHS Lancashire and South Cumbria ICB	2 (4)
Richard Paver	Non-Executive Member, NHS Greater Manchester ICB	4 (6)
Steve Spill (Chair from March 2026)	Non-Executive Member, NHS Lancashire and South Cumbria ICB	1 (1)
Katherine Sheerin	Chief Healthcare Commissioning Officer, NHS Greater Manchester ICB	4 (6)

A Joint Committee meeting is quorate if the following members are in attendance: the Chair, or Deputy Chair, at least one Executive Officer (or deputy) and at least one Non-Executive Member (or deputy)

Quality and Performance Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Tony Foy (Chair)	Non-Executive Member of NHS Cheshire & Merseyside ICB	11(11)
Prof. Hilary Garratt CBE	Non-Executive Member of NHS Cheshire & Merseyside ICB	6(11)
Dr Naomi Rankin	Primary Care Member of NHS Cheshire & Merseyside ICB	6(11)
Christine Douglas MBE (Until Jan 2026)	Executive Director of Nursing & Care of NHS Cheshire & Merseyside ICB	9(11)
Prof. Rowan Pritchard-Jones (Until Jan 2026)	Medical Director of NHS Cheshire & Merseyside ICB	4(11)
Anthony Middleton	Director of Planning & Performance of NHS Cheshire & Merseyside ICB	11 (11)
Dr Fiona Lemmens (From Feb 2026)	Executive Clinical Director of NHS Cheshire & Merseyside ICB	1 (2)

For a meeting to be quorate, there must be one Non-Executive member of the Board present, including one other Non-Executive member of the Board or Partner Member and either the Medical Director or Director of Nursing and Care.

Remuneration Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Tony Foy (Chair)	Non-Executive Member of NHS Cheshire and Merseyside ICB	10 (10)
Erica Morriss	Non-Executive Member of NHS Cheshire and Merseyside ICB	6 (10)
Mike Burrows	Non-Executive Member of NHS Cheshire and Merseyside ICB	7 (10)
Prof. Hilary Garratt CBE	Non-Executive Member of NHS Cheshire and Merseyside ICB	5 (10)
Dr Ruth Hussey CB, OBE, DL	Non-Executive Member of NHS Cheshire and Merseyside ICB	10 (10)
Sue Lorimer (From Nov 2025)	Non-Executive Member of NHS Cheshire and Merseyside ICB	3 (5)

For a meeting to be quorate, a minimum of two of the Non-Executive Members of the Board is required, including the Chair or the Deputy Chair.

Shaping Care Together Joint Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Prof. Hilary Garratt (Chair)	Non-Executive Member, NHS Cheshire & Merseyside ICB	2 (2)
Jim Birrell (Deputy Chair) (Until Feb 2026)	Non-Executive Member, NHS Lancashire and South Cumbria ICB	1 (1)
Clare Watson	Assistant Chief Executive, NHS Cheshire and Merseyside ICB	2 (2)
Debbi Eyitayo	Chief People Officer, NHS Lancashire and South Cumbria ICB	1 (1)
Mark Bakewell (Until Aug 2025)	Director of Finance (Interim), NHS Cheshire & Merseyside ICB	1 (1)
Dr Andy Knox	Interim Medical Director, NHS Lancashire and South Cumbria ICB	2 (2)
Andrea McGee (From Sept 2025)	Director of Finance (Interim), NHS Cheshire & Merseyside ICB	0 (1)
Debbie Corcoran (Deputy Chair) (From March 2026)	Non-Executive Member, NHS Lancashire and South Cumbria ICB	1 (1)
Craig Harris (From March 2026)	Chief Commissioning Officer, NHS Lancashire and South Cumbria ICB	1 (1)

A Joint Committee meeting is quorate if at least the following members are in attendance: the Chair, or Deputy Chair an Executive Officer (or deputy) from both ICB

System Primary Care Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Erica Morriss (Chair)	Non-Executive Member of NHS Cheshire and Merseyside ICB	9 (11)
Tony Foy	Non-Executive Member of NHS Cheshire and Merseyside ICB	8 (11)
Adam Irvine	Primary Care Professional Group representative – Pharmacy / Primary Care Member of NHS Cheshire and Merseyside ICB	5 (11)
Dr Daniel Harle	Primary Care Professional Group representative – Primary medical care	7 (11)
Clare Watson	Executive Director of Health and Integrated Care Commissioning of NHS Cheshire and Merseyside ICB	11 (11)
Chris Leese	Associate Director of Primary Care of NHS Cheshire and Merseyside ICB	9 (11)
Christine Douglas MBE (Until Feb 2026)	Executive Director of Nursing and Care of NHS Cheshire and Merseyside ICB	6 (9)

Name	Position & Organisation	Attendance (eligible to attend)
Prof. Rowan Pritchard-Jones (Until Feb 2026)	Medical Director of of NHS Cheshire and Merseyside ICB	7 (9)
Dr Fiona Lemmens	Executive Medical Director, Cheshire and Merseyside ICB	1 (2)
Kerry Lloyd	Interim Director of Nursing & Care, of NHS Cheshire and Merseyside ICB	1 (2)
Anthony Leo	Halton Place Director of NHS Cheshire and Merseyside ICB	7 (11)
Tom Knight	Head of Primary Care of NHS Cheshire and Merseyside ICB	8 (11)
Dr Jonathan Griffiths	Associate Medical Director of NHS Cheshire and Merseyside ICB	7 (11)
Dr Naomi Rankin	Primary Care Partner Member of NHS Cheshire and Merseyside ICB	8 (11)
Louise Barry	Chief Executive, Healthwatch Cheshire	9 (11)
Fionnuala Stott	LOC Representative	8 (11)
Mark Woodger	LDC Representative	9 (11)
Matt Harvey	LPC Representative	(11)
Susanne Lynch *Chris Haigh (rep for SL)	Chief Pharmacy Officer of NHS Cheshire and Merseyside ICB	5 (11) 4* (6)
Mark Bakewell (Until September 2025) * Lorraine Weekes-Bailey (Rep for MB)	Interim Chief Finance Officer Cheshire and Merseyside ICB	1 & 5* (6)
Andrea McGee (Joined Sept 25) * Lorraine Weekes-Bailey (Rep for AMc)	Executive Director of Finance and Contracting Cheshire and Merseyside ICB	5* (5)

For a meeting to be quorate, there must be at least five committee members present including, at least one Non-Executive member of the Board or Partner Member, at least one clinical member and at least two NHS Cheshire and Merseyside Directors

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Women's Hospital Services in Liverpool Committee

Member names and attendance

Name	Position & Organisation	Attendance (eligible to attend)
Prof. Hilary Garratt CBE (Chair)	Non-Executive Member of NHS Cheshire and Merseyside ICB	4(4)
Dr Naomi Rankin (Deputy Chair)	Primary Care Partner Member, NHS Cheshire and Merseyside ICB	2(4)
Christine Douglas MBE	Executive Director of Nursing & Care, NHS Cheshire and Merseyside ICB	3(4)
Dr Fiona Lemmens	Deputy Medical Director, NHS Cheshire and Merseyside ICB	3(4)
Anthony Leo	Interim Liverpool Place Director, NHS Cheshire and Merseyside ICB	2(4)
Alison lee	Knowsley Place Director, NHS Cheshire and Merseyside ICB (Interim Director of Transformation)	0(4)
Tracey Jeffes	Interim Sefton Place Director, NHS Cheshire and Merseyside ICB	0(4)
James Sumner	Chief Executive, LUFHT & LWH	3(4)
Mandish Dhanjal	Independent Clinical Senior Responsible Officer	4(4)
Chris Dewhurst	Chief Medical Officer, Liverpool Women's NHS FT (LWH)	4(4)
Sheena Khanduri	Medical Director, Clatterbridge Cancer Centre	0(4)
Catherine McClennan	Director, Cheshire & Merseyside Local Maternity and Neonatal System	2(4)
Nigel Scawn	Medical Director, Countess of Chester.	1(4)
Andrew Bibby	Regional Director of Health & Justice and Specialised Commissioning, NHS England representative	3(4)
Rob Nolan	Associate Director of Finance - Liverpool Place, NHS Cheshire and Merseyside ICB	3(4)
John Grinnell	Chief Executive, Alder Hey Children's Hospital	3 (4)

For a meeting or part of a meeting to be quorate a minimum of five Committee members need to be present, including, the Committee Chair or Deputy Chair, at least one NHS Trust representative, at least one clinically qualified member, at least one ICB Executive member.