

NHS Cheshire and Merseyside ICB

Annual Report 2025/26 Appendix

Health Inequalities Statement Annual
Report

1. Introduction

- 1.1. Health inequalities are the unjust, systematic and avoidable differences in health status, life expectancy and care access between different population groups often driven by social, economic and environmental disadvantage.
- 1.2. There are different types of health inequalities these include:
 - Inequalities in health status for example life expectancy or healthy life expectancy
 - Inequalities in access to care
 - Inequalities in quality and experience of care
 - Inequalities in behavioural risks to health such as smoking, alcohol use, diet and physical activity
 - Inequalities in the wider determinants of health these include factors such as housing, employment, income and education

Inequalities can occur between a range of different groups including:

- Socio-economic factors
 - Geography
 - Specific characteristics protected by law such as age, gender and sexuality
 - Socially excluded groups such as homeless people and people in the criminal justice system
- 1.3. The NHS Constitution states that the NHS has a duty to “...*pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population*”. This is reflected in the NHS Act 2006 (as amended by the Health and Care Act 2022), which includes legal duties on NHS England and Integrated Care Boards (ICBs) to have regard to health inequalities in the exercise of their function have a legal duty.
 - 1.4. NHS England has a statutory duty to conduct an annual assessment of ICBs including the extent to which they have fulfilled their statutory obligations regarding health inequalities.

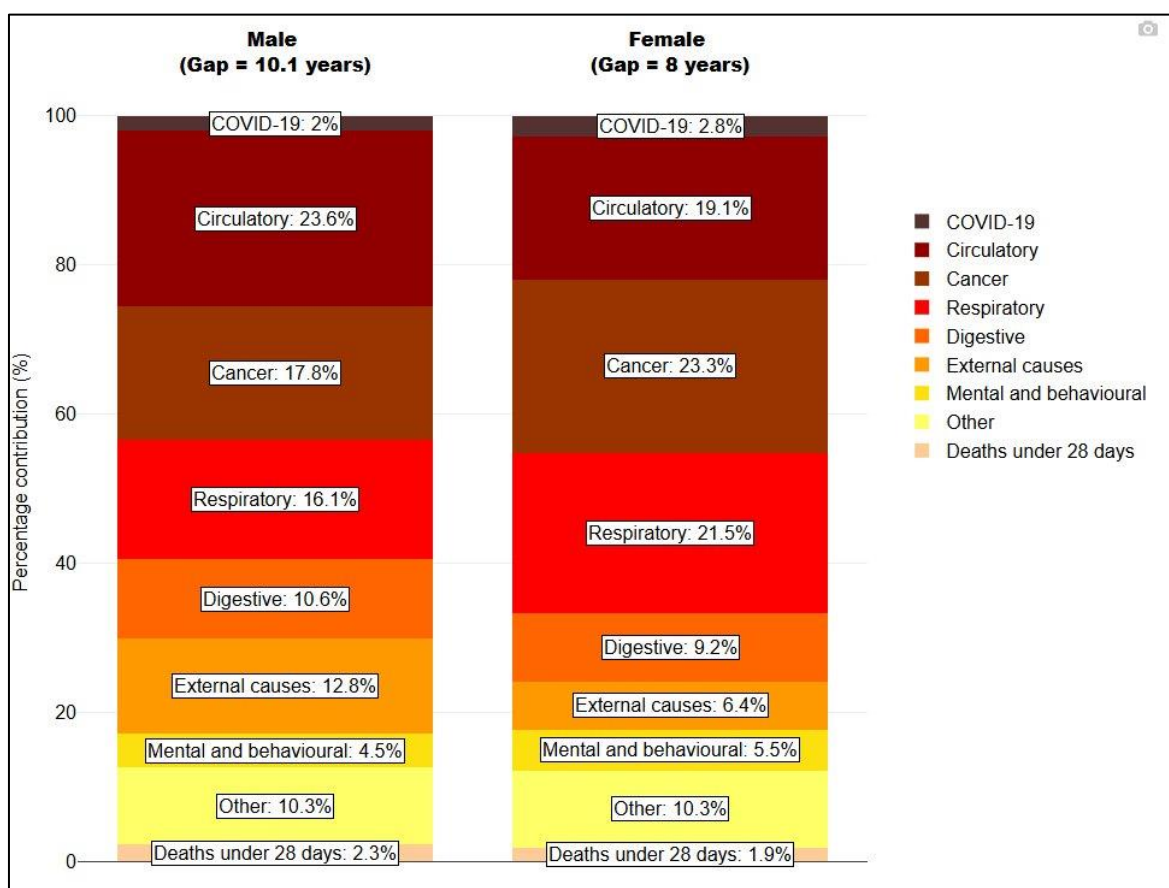
2. Health Inequalities in Cheshire and Merseyside

2.1. Data shows that there are inequalities across a range of outcomes for the population of Cheshire and Merseyside.

2.2. Inequalities in Life Expectancy

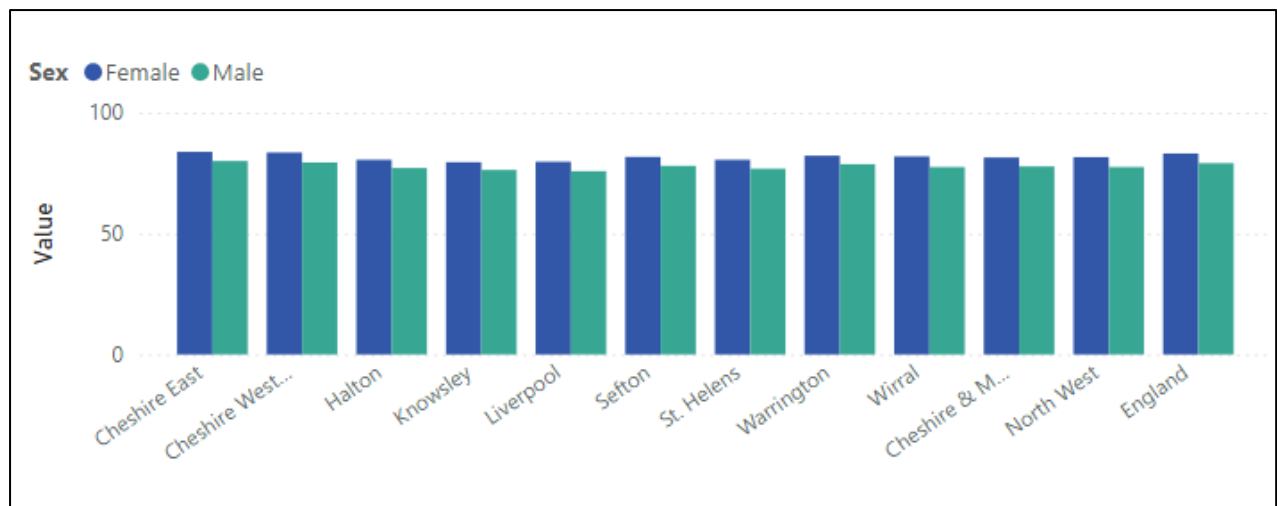
2.2.1. The latest published data shows there is a 10.1 year gap in life expectancy between males living in the most and least deprived areas of Cheshire and Merseyside and an eight-year gap in life expectancy for females living in the most and least deprived areas of Cheshire and Merseyside. Circulatory disease is the leading cause of the gap in male life expectancy and cancer is the leading cause of the gap in female life expectancy.

Figure 1. Gap in life expectancy between the most and least deprived in Cheshire and Merseyside by cause of death 2022-2023.



2.2.2. Geographically across Cheshire and Merseyside there is also variation in life expectancy with life expectancy for males highest in Cheshire East and lowest in St Helens and life expectancy for females highest in Cheshire East and lowest in Knowsley.

Figure 2. Male and female life expectancy by Local Authority in Cheshire and Merseyside.



2.3. Inequalities in healthy life expectancy

2.3.1. Healthy life expectancy is declining across all areas of Cheshire and Merseyside except for Warrington where rates began to increase again in 2021-2023. Factors contributing to this decline include an increase the number of people living with a chronic condition, an increase in people living with multiple chronic conditions and people living with poor mental health.

Figure 3. Healthy life expectancy for males by Local Authority in Cheshire and Merseyside.

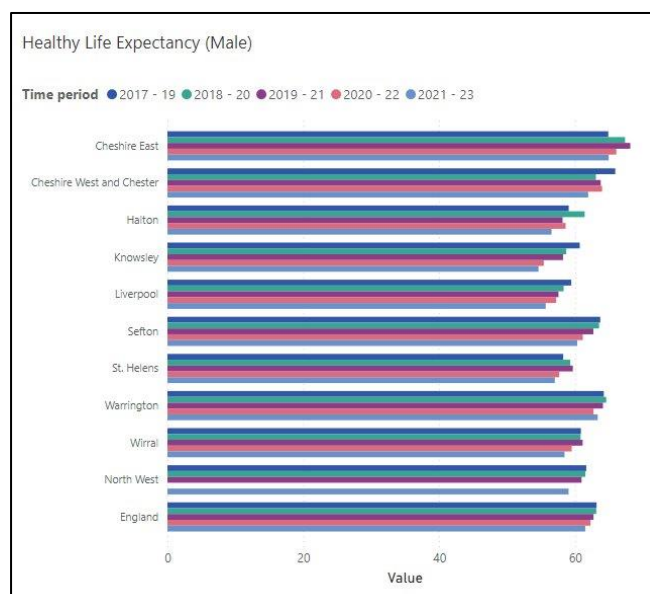
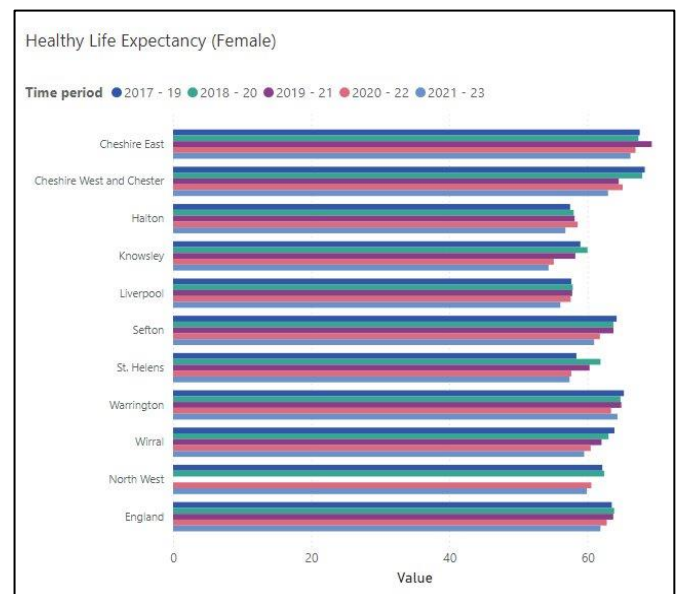


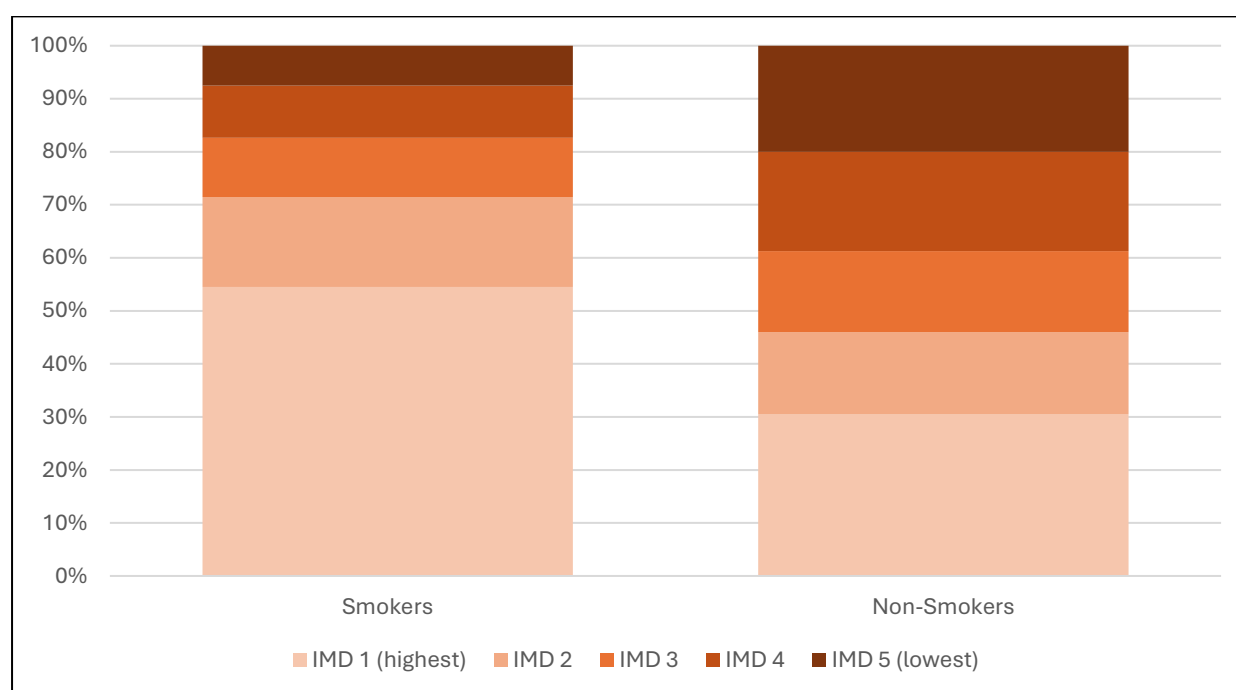
Figure 4. Healthy life expectancy for females by Local Authority in Cheshire and Merseyside.



2.4. Inequalities in behavioural risks to health: Smoking

- 2.4.1. Smoking remains the leading cause of preventable illness, death and health inequalities in Cheshire and Merseyside. The prevalence of smoking using smoking status of all patients aged 15+ registered with a GP in the Combined Intelligence for Population Health Action (CIPHA) system indicates the prevalence rate is 16.3%. There are inequalities in smoking by age, gender, geography and deprivation decile.
- 2.4.2. Smoking prevalence is highest in Merseyside (particularly Halton and Knowsley), where the proportion of smokers is around 5% greater than in Cheshire. Cheshire East, Cheshire West and Warrington have the lowest smoking prevalence rates of the nine sub-ICB locations.
- 2.4.3. A current smoker in Cheshire and Merseyside is 78% more likely to be in the most-deprived quintile of the population than a lifelong non-smoker and is 35% more likely to be in one of the highest four Patient Need Groups as a measure of clinical complexity.

Figure 5. Deprivation levels in current or past smokers and non-smokers.



- 2.4.4. Looking more closely at clinical complexity, a smoker in Cheshire and Merseyside is more than twice as likely to be diagnosed with depression or a mental health condition as a lifelong non-smoker, more than ten times as likely to have COPD, and more likely to have Diabetes or Stroke/TIA. In terms of multi-morbidity, a current smoker is 30% more likely to have multiple (3 or more) long-term conditions.

Figure 6. Prevalence of long-term conditions, split by current or past smokers and non-smokers.

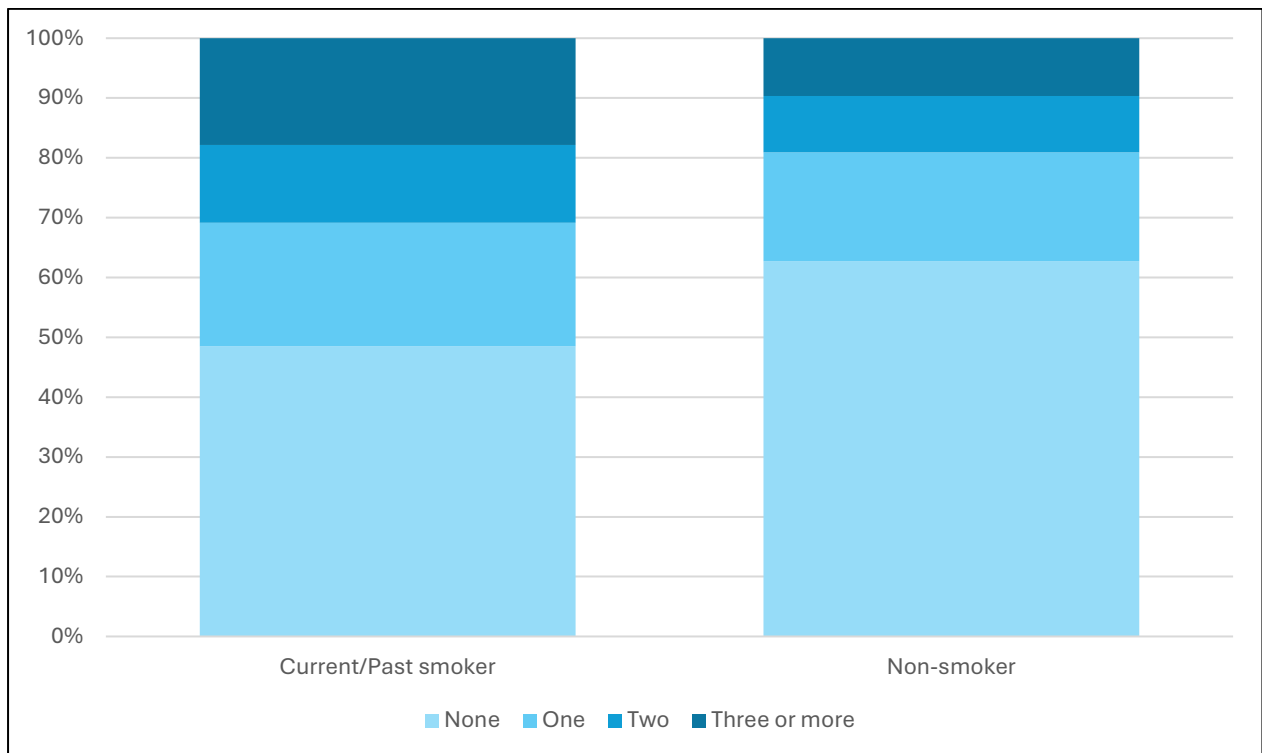
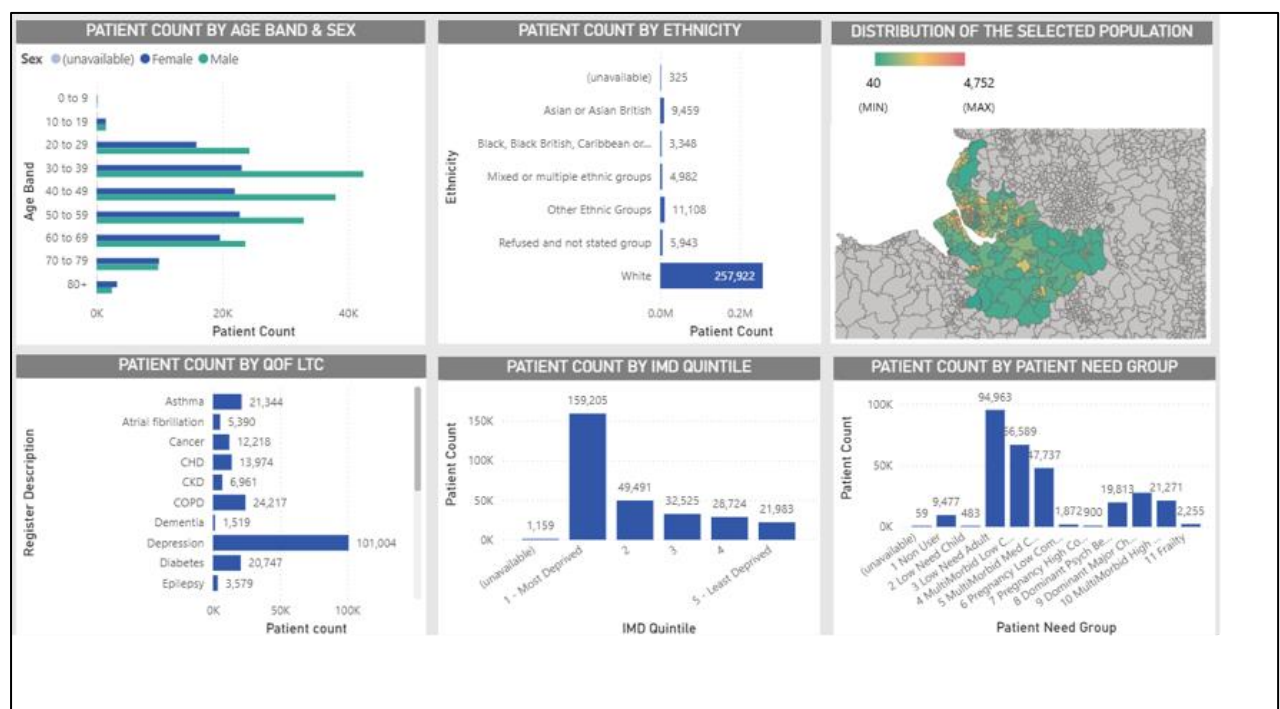


Figure 7. Numbers of smokers aged 15+ registered with a GP in Cheshire and Merseyside split by sex, age, ethnicity, geography, QoF Long Term Condition register, deprivation quintile and patient need group.



2.5. Inequalities in behavioural risks to health: Unhealthy weight in adults

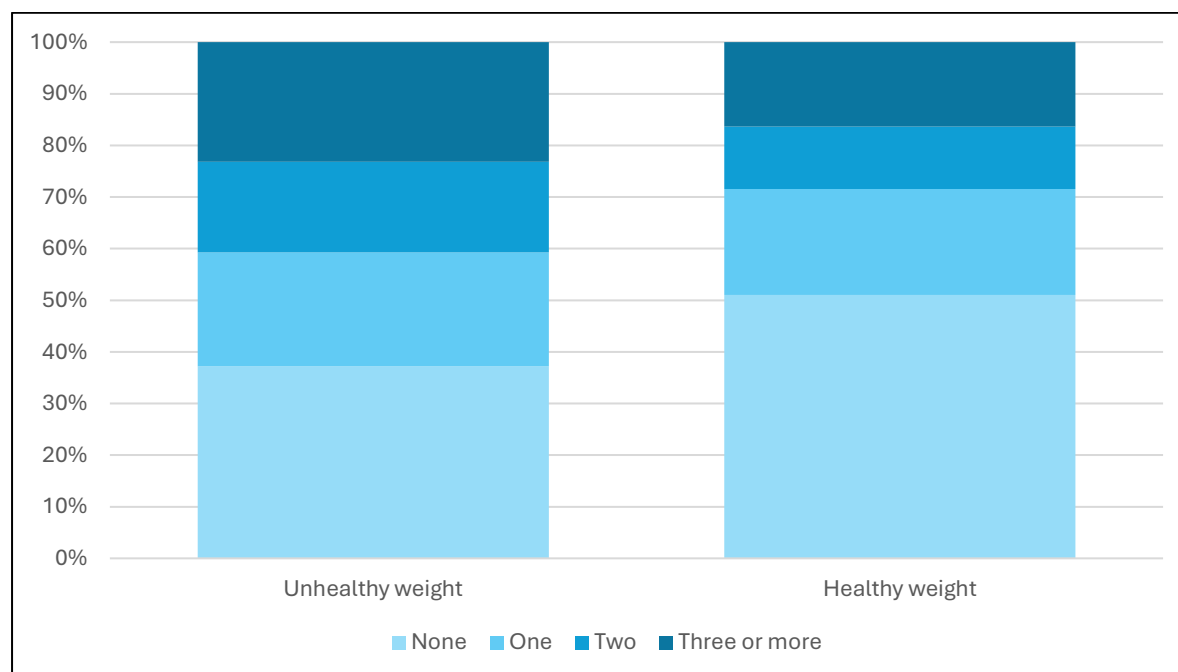
2.5.1. Overweight and obesity is the second leading cause of preventable illness and death in Cheshire and Merseyside and is predicted to take over smoking in the next few years as the leading cause. The prevalence of obesity is 66.4% based on data from the Sport England Active Lives survey.

2.5.2. Data on the prevalence of overweight and obesity in GP records is limited as almost half of our records don't have a recent Body Mass Index (BMI) recorded. For those that do have a BMI recorded the largest number of overweight and obese people are female, white and living in the most deprived decile. Geographically, Halton, Knowsley, St Helens and Cheshire West have the highest prevalence of obesity. Liverpool and Cheshire East have the lowest.

2.5.3. Compared to the population with a healthy weight, a person living with overweight or obesity in Cheshire and Merseyside is:

- a) 41% more likely to have three or more long term conditions.
- b) 14% more likely to be grouped to one of the four highest Patient Need Groups as a measure of overall complexity.
- c) 24% more likely to suffer from depression and 17% more likely to have a mental health condition.
- d) 88% more likely to have Diabetes, 66% more likely to have Hypertension and 34% more likely to have Asthma.

Figure 8. Prevalence of long-term conditions in adults with healthy and unhealthy weight



2.5.4. Given the volumes of people in Cheshire & Merseyside with no recent BMI recorded, the likelihood is that the differences between the overweight/obese and healthy weight populations are, in fact, even greater in actuality.

2.5.5. Comparing unhealthy weight with other known drivers of health inequalities, 44% of people in Cheshire & Merseyside with a BMI in excess of 25 are current or former smokers, compared with 40% in the population reporting a healthy weight. Thirty-six percent of overweight or obese people are in the most-deprived quintile of the population, compared to 27% of people with a healthy weight.

Figure 9. Deprivation levels in adults with healthy and unhealthy weight.

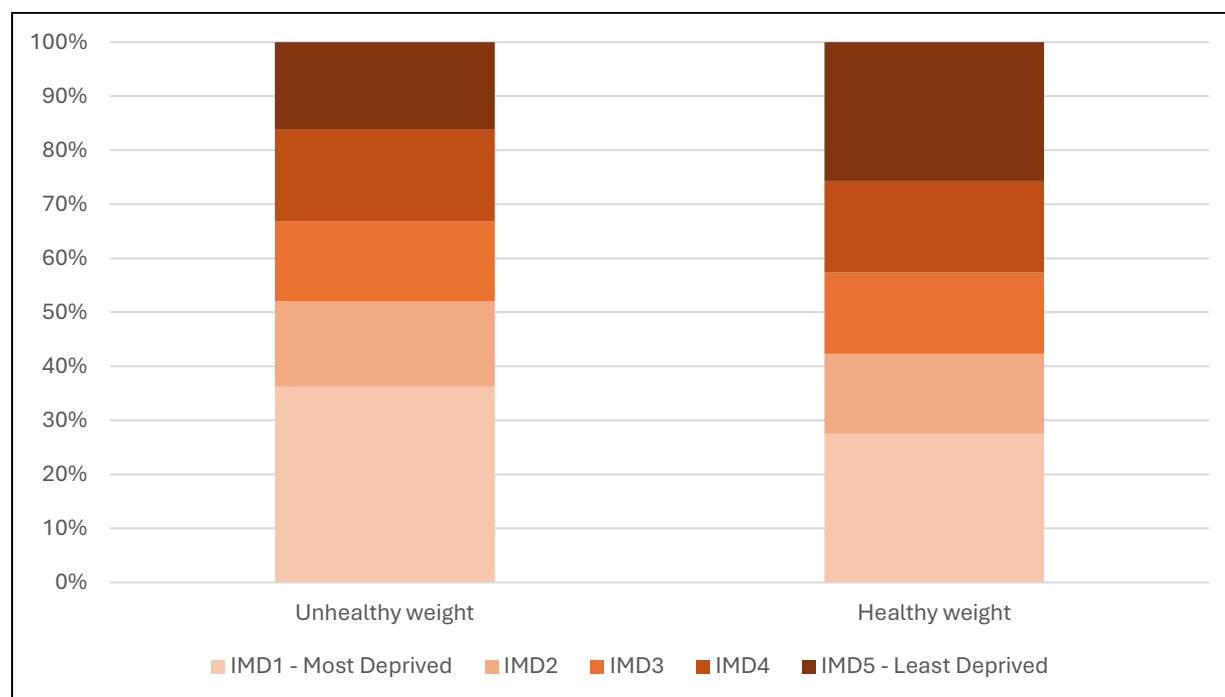
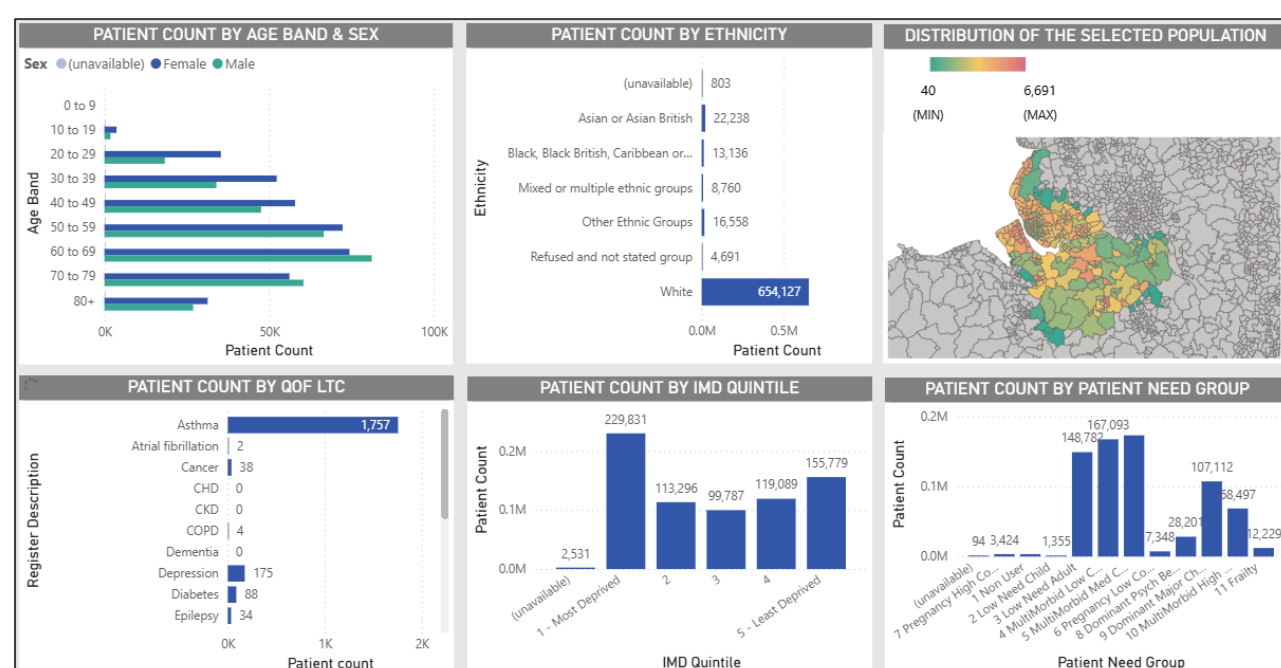


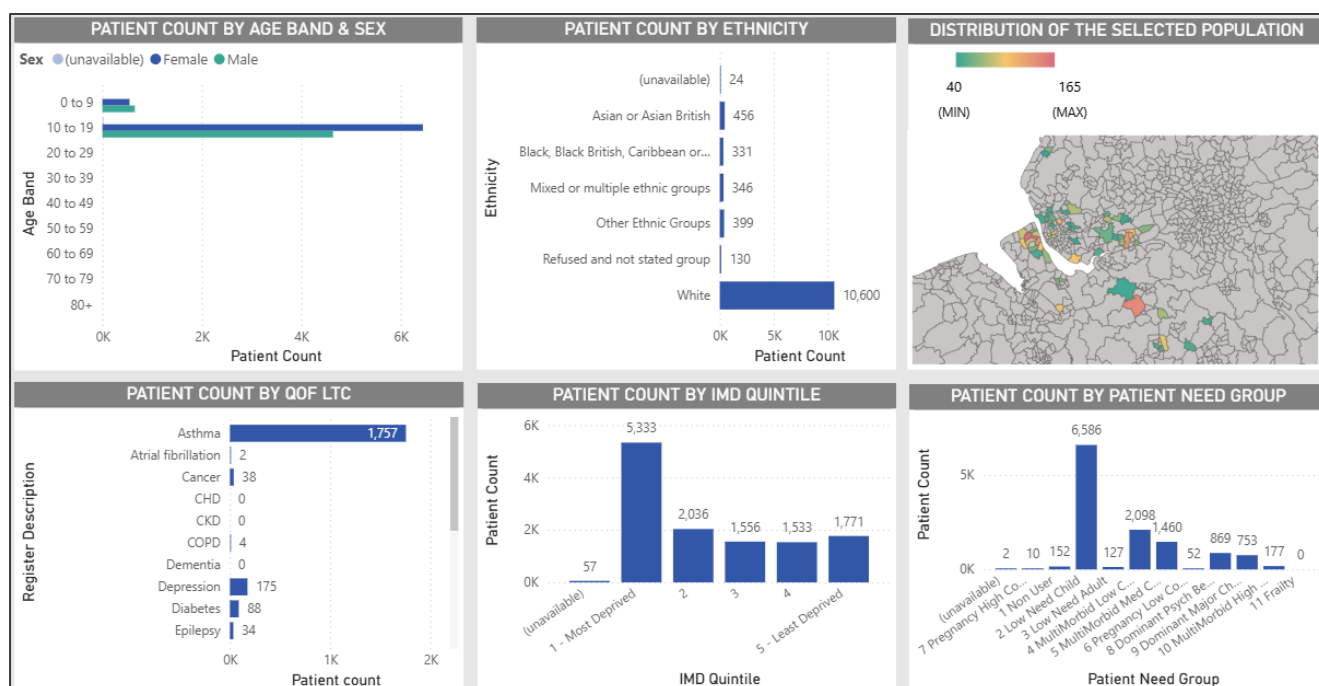
Figure 10. Numbers of overweight and obese patients registered with a GP in Cheshire and Merseyside split by sex, age, ethnicity, geography, QoF Long Term Condition register, deprivation quintile and patient need group.



2.6. Inequalities in behavioural risks to health: Unhealthy weight in children

- 2.6.1. Children's weight in England is assessed annually through the national child measurement programme. This programme weighs and measures all reception age and year six children who attend school and whose parent's consent to them being weighed and measured. In 2024/25, 72.9% of Reception age pupils (aged 4-5 years) in Cheshire and Merseyside were assessed to be a healthy weight (lower than the England average of 75.4%), 0.6% are considered underweight (below the England average of 1%), 26.4% were classed as living with overweight or obesity.
- 2.6.2. For children surveyed in year 6 (10–11-year-olds), 60% were assessed as a healthy weight (lower than the England average of 62.2%), 1.1% were underweight (lower than the England average of 1.4%) and 38.9% were living with overweight or obesity (significantly higher than the average for England).
- 2.6.3. Compared to the under-18 population with a healthy weight, an overweight or obese child in Cheshire and Merseyside is:
- a) Three times as likely to have three or more long term conditions.
 - b) 27% more likely to be grouped to one of the four highest Patient Need Groups as a measure of overall complexity.
 - c) Three times as likely to suffer from depression, twice as likely to have a mental health condition and four times as likely to have Diabetes.
 - d) Prevalence of Asthma is also significantly higher in overweight or obese children.
- 2.6.4. As with overweight and obese adults, children with unhealthy weight are 31% more likely to live in the bottom quintile for deprivation. Halton and Knowsley have the highest prevalence of childhood obesity, with Sefton and Cheshire East having the lowest.

Figure 11. Numbers of overweight and obese patients aged 0-19 registered with a GP in Cheshire and Merseyside split by sex, age, ethnicity, geography, QoF Long Term Condition register, deprivation quintile and patient need group.



2.6.5. Unhealthy weight in children by Local Authority area

2.6.5.1. Across Cheshire and Merseyside there is variation in the prevalence of Obesity (including severe obesity) by Local Authority area. In 2024/25 rates in Reception aged children were highest in Halton (15.38%) and lowest in Warrington (10.13%). In Year 6 pupil's rates were highest in Knowsley (30.06%) and lowest in Cheshire east (20.28%).

Figure 12. Reception prevalence of obesity (including severe obesity) by Local Authority area in Cheshire and Merseyside.

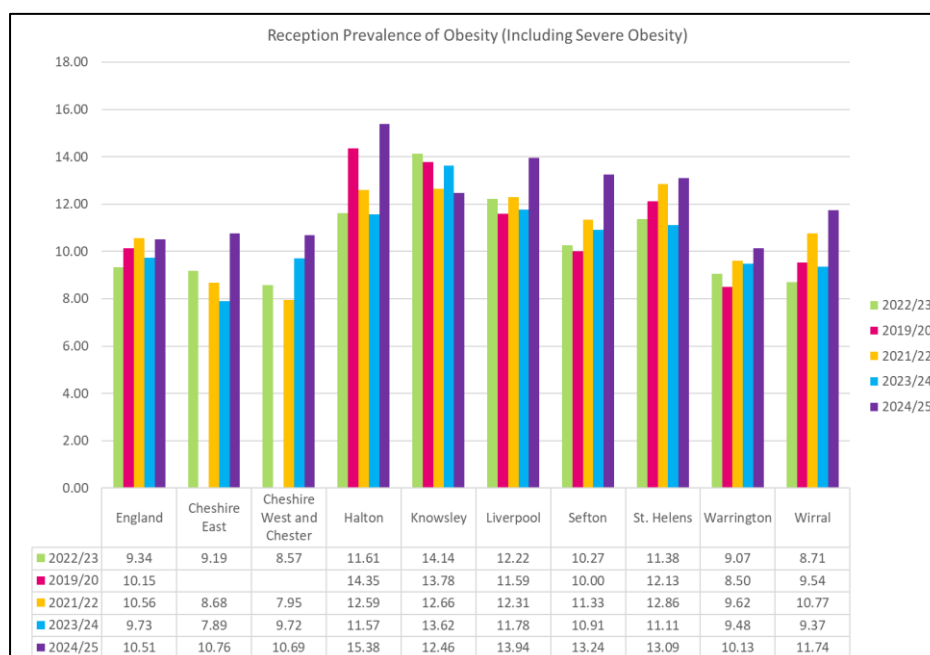
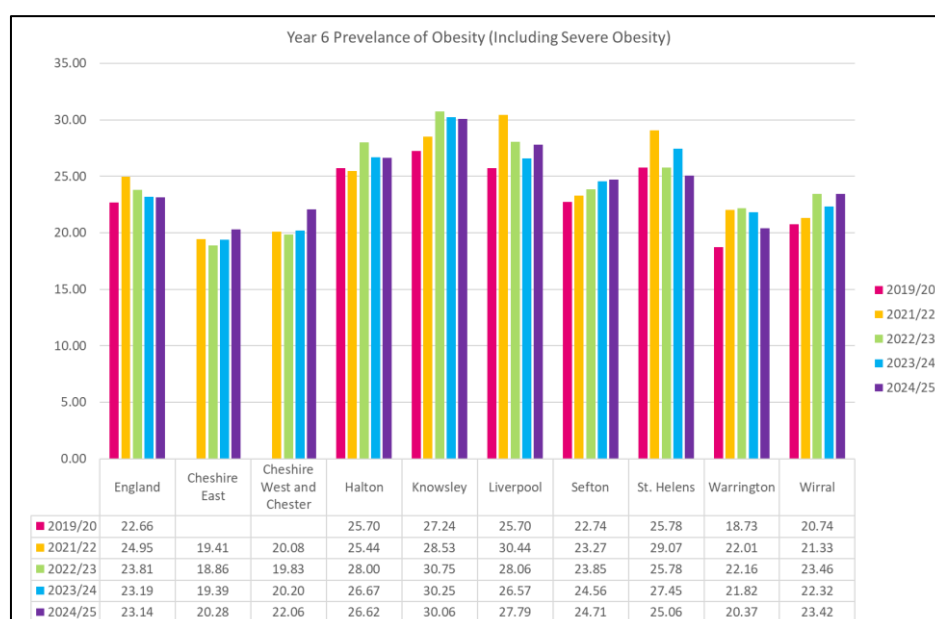


Figure 13. Year 6 prevalence of obesity (including severe obesity) by Local Authority area in Cheshire and Merseyside.



2.6.6. Unhealthy weight in children by Ethnic Group

2.6.6.1. Across Cheshire and Merseyside there is variation in the prevalence of unhealthy weight by ethnic group in children. The highest proportion of children aged 4-5 years living with overweight can be seen in the groups Black African and Any other black background ethnic group at 28.9%. In

year 6 children the highest proportion of children living with overweight can be seen in Any other Black background at 47.2%.

Figure 14. Prevalence of Reception aged children living with obesity by ethnic group in Cheshire and Merseyside.

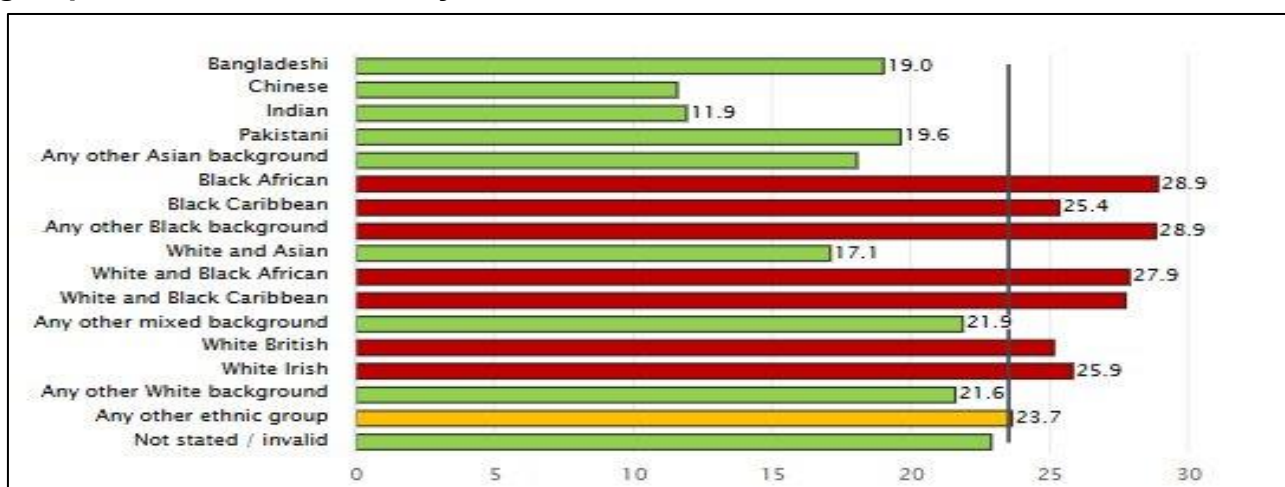
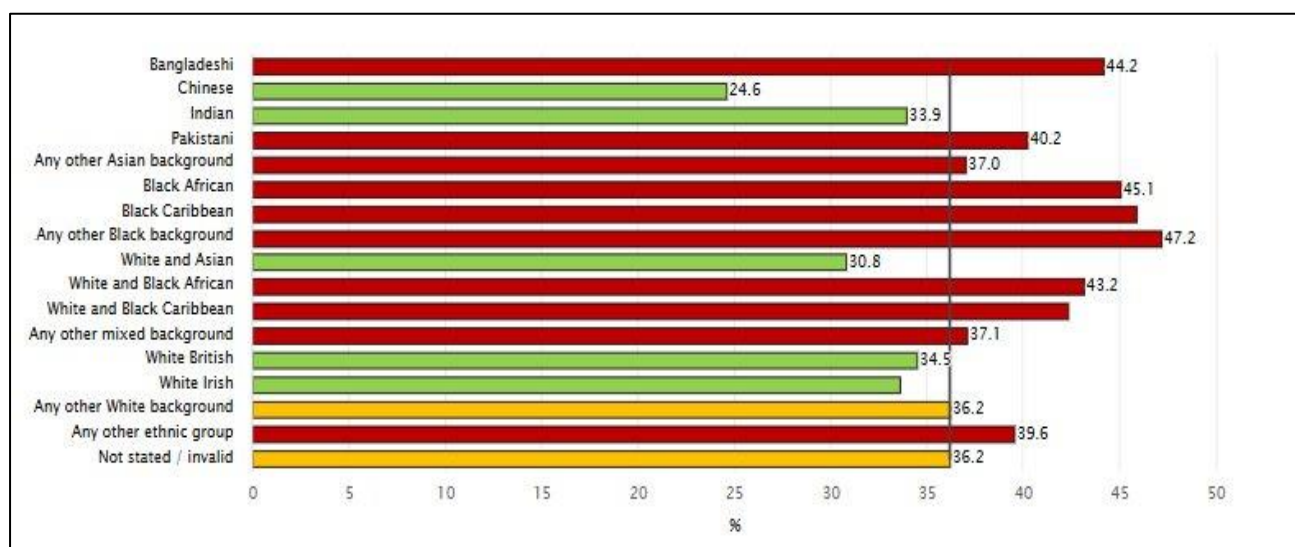


Figure 15. Prevalence of Year 6 Children living with obesity by ethnic group in Cheshire and Merseyside



2.7. Inequalities in behavioural risks to health Substance misuse

2.7.1. Substance misuse **widens health inequalities** by driving poorer physical and mental health outcomes in already disadvantaged groups, reinforcing cycles of deprivation and limiting opportunities for recovery, employment, and stable housing.

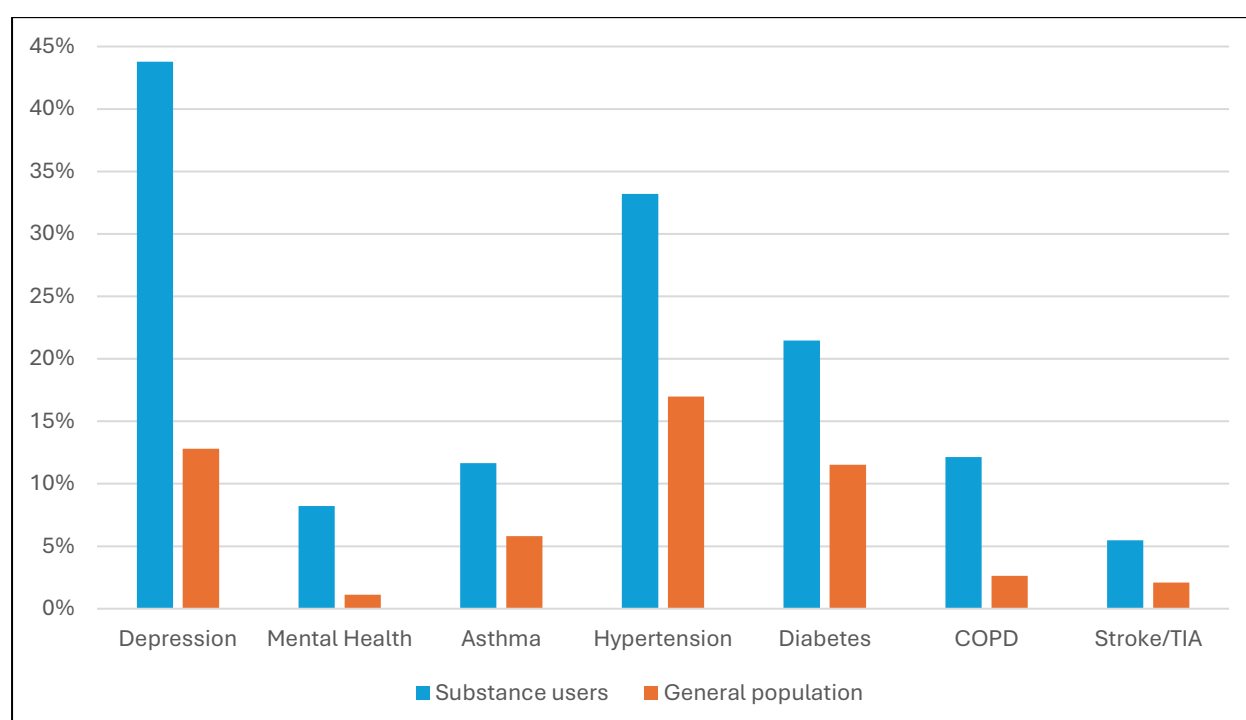
2.7.2. The average person *with a recording of substance misuse* is white, male and aged in their 50s. Men are 28% more likely to have a recording of substance misuse than women. However, recording of substance use in the primary care

record is almost certainly under-reported, with a prevalence in Cheshire and Merseyside of 2.8%.

2.7.3. Compared to the rest of the population, a substance user in Cheshire and Merseyside is:

- a) More than three times as likely to have three or more long term conditions.
- b) More than three times as likely to be grouped to one of the four highest Patient Need Groups as a measure of overall complexity.
- c) Nearly four times as likely to suffer from depression and more than six times as likely to have a mental health condition.
- d) Almost twice as likely to have Hypertension, Diabetes or Asthma.

Figure 16. Prevalence of common long-term conditions in people with a recording of substance misuse.



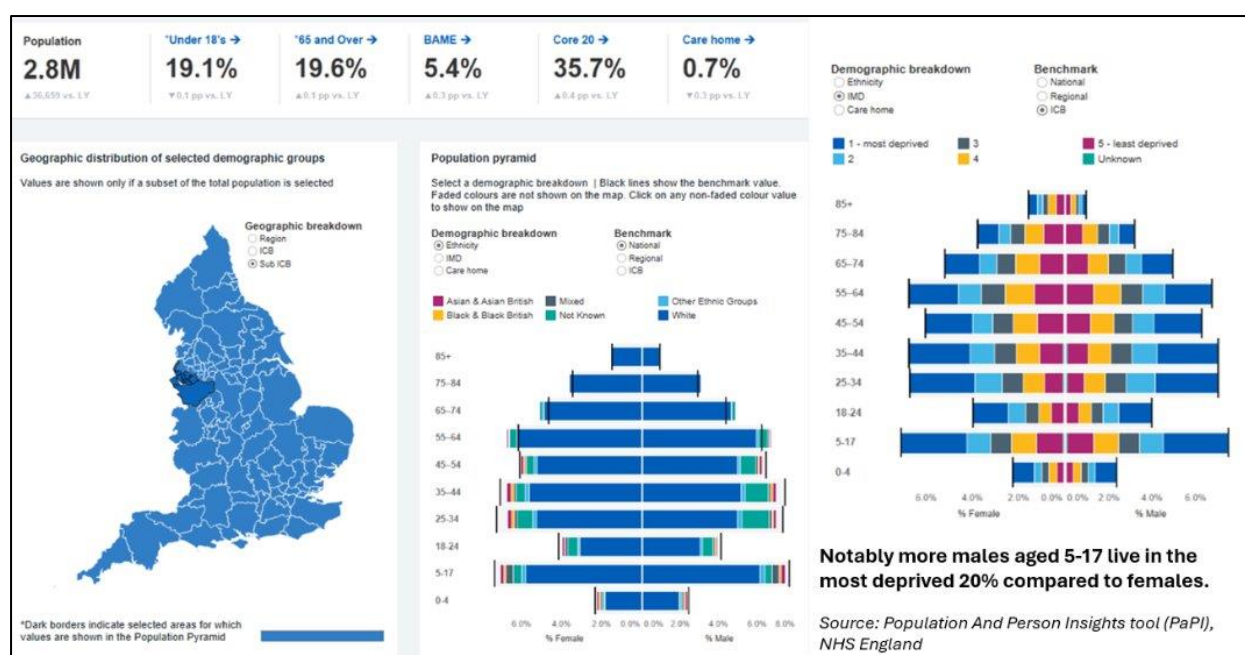
2.7.4. Local data shows that people with a substance misuse flag are disproportionately concentrated in the most-deprived communities, with 46% in the most deprived quintile compared to 32% of the general population. This reinforces the pattern that socioeconomic disadvantage, poor housing, unemployment and social exclusion increase vulnerability to harmful alcohol and drug use.

2.7.5. There are also commonalities between substance misuse and other drivers of poor health, 41% of people with a substance misuse problem are current smokers compared to 11% of the total population.

3. Demographic Profile of Cheshire and Merseyside

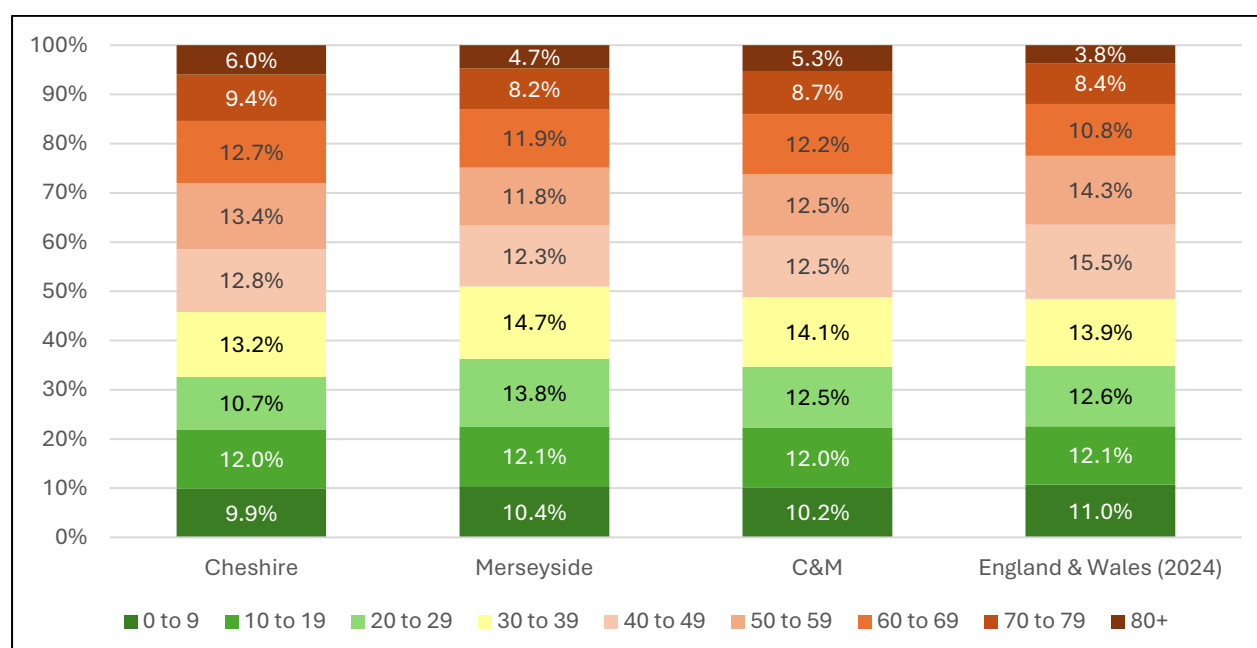
- 3.1. The Cheshire and Merseyside Integrated Care System (ICS) in the North-West of England is one of the largest and most diverse systems in the country. The area is home to over 2.8 million people, spans over 1200 square miles and includes a mix of metropolitan urban areas as well as rural and coastal areas.
- 3.2. The area borders other care systems such as Lancashire & South Cumbria, Greater Manchester, Derby & Derbyshire, Shropshire and Staffordshire & Stoke on Trent in England, as well parts of Wales including Flintshire and Wrexham.
- 3.3. There are nine local authorities within the ICS, plus 17 NHS Trusts, 337 GP practices, 559 pharmacies, and around 900 care homes.
- 3.4. Of the 2.8 million population, 19.1% are under 18, 19.6% are over 65, 5.4% are from the global majority and 35.7% live in the 20% most deprived areas of Cheshire and Merseyside.

Figure 17. Population profile of Cheshire and Merseyside.



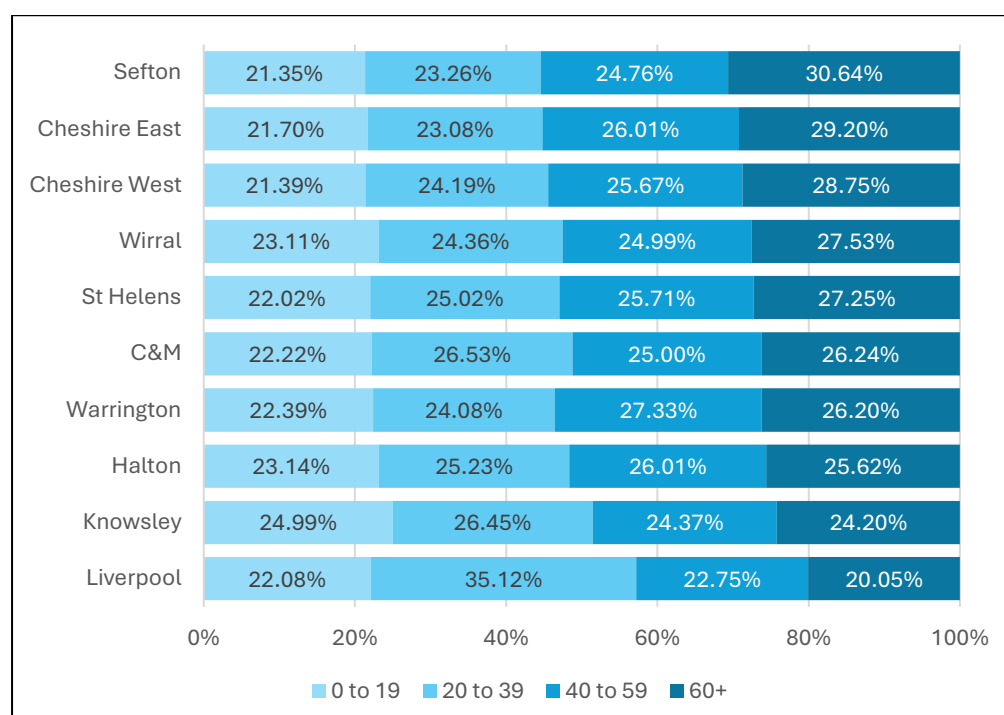
- 3.5. The population of Cheshire and Merseyside is due to grow by 10.8% by 2040, with variation in growth by place with Warrington expected to increase by a modest 3% compared to 16% in Knowsley and 17.4% in Cheshire East.
- 3.6. The population of Cheshire and Merseyside is slightly older than the average for the rest of England and Wales. The proportion of people aged under 10 is 7.5% lower than the England and Wales average, and the proportion of people aged 40 to 60 is 16% lower. In contrast, the proportion of people aged over 60 is 14% higher in Cheshire & Merseyside (39% higher for those aged over 80).

Figure 18. Age distribution of Merseyside and Cheshire compared to England & Wales.



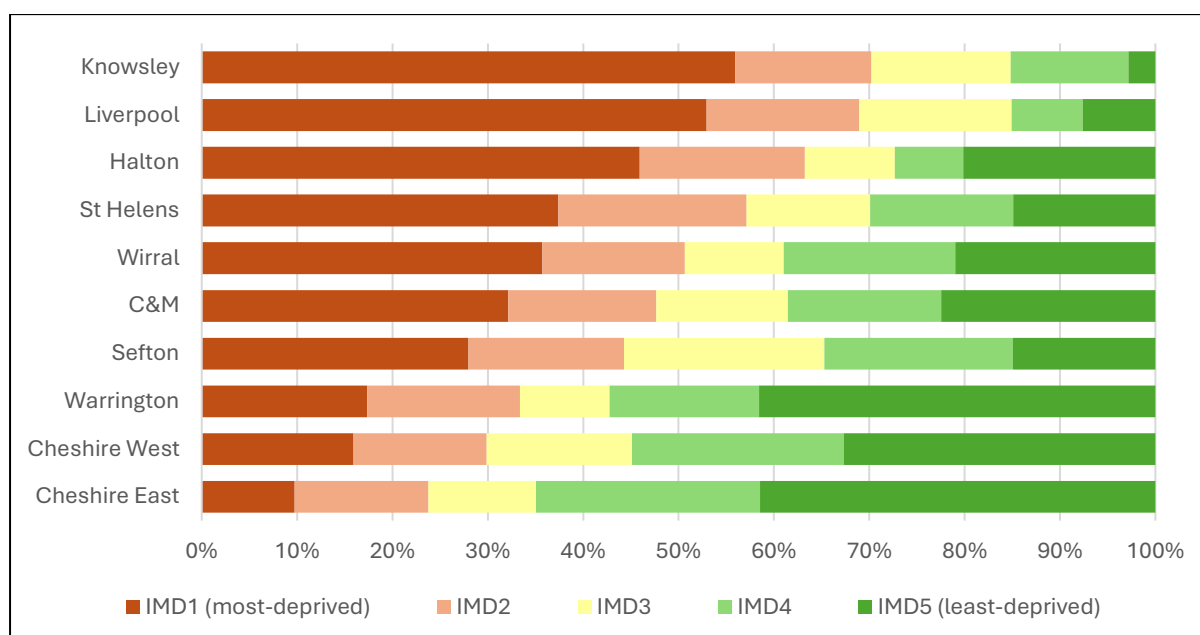
3.7. Within Cheshire & Merseyside, the average age of the population is higher in Cheshire than in Merseyside, the difference is greatest in older age groups.

Figure 20. Age distribution of Sub-ICBs within Cheshire & Merseyside.



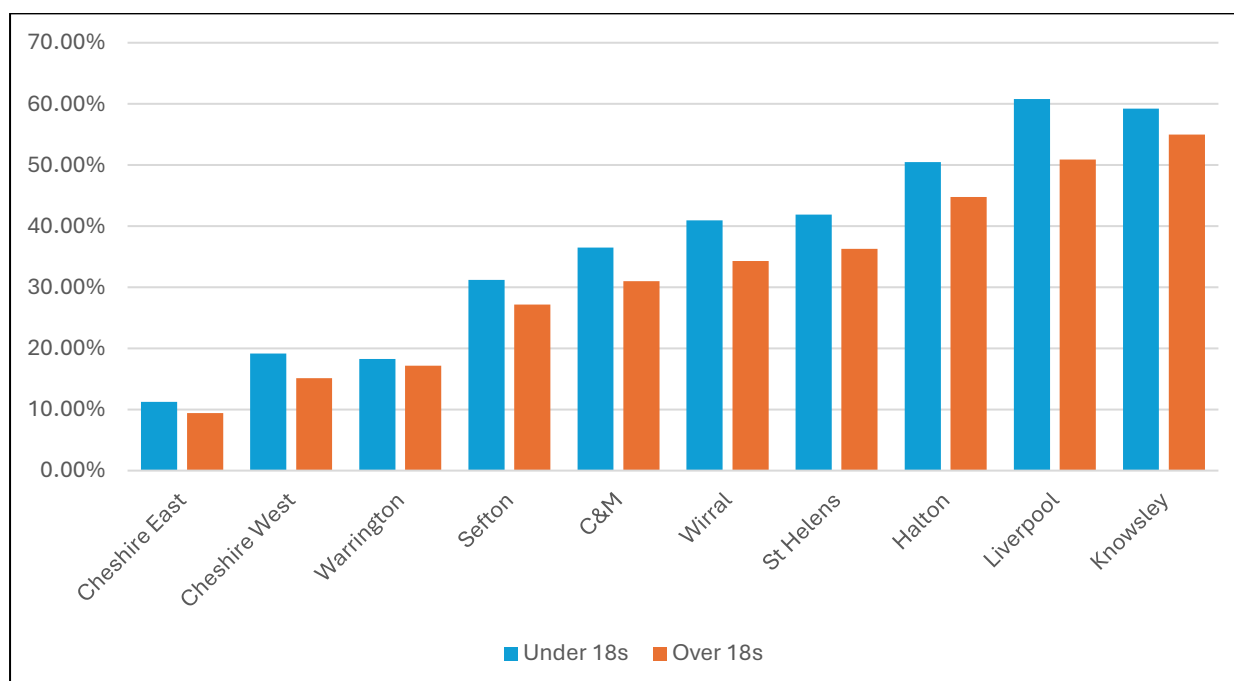
3.8. Looking at levels of deprivation, there are wide disparities across Cheshire & Merseyside. More than half of the populations of Knowsley and Liverpool are in the most-deprived quintile for deprivation, compared to less than a quarter in Warrington and Cheshire West, and less than a tenth in Cheshire East.

Figure 21. Deprivation levels in Sub-ICBs within Cheshire & Merseyside.



3.9. Looking specifically at childhood deprivation, levels are even higher. In every Place across Cheshire & Merseyside, there is a higher proportion of children than adults in high levels of deprivation compared to the overall population. In Liverpool, 61% of children are in the most-deprived quintile, compared to 51% of adults.

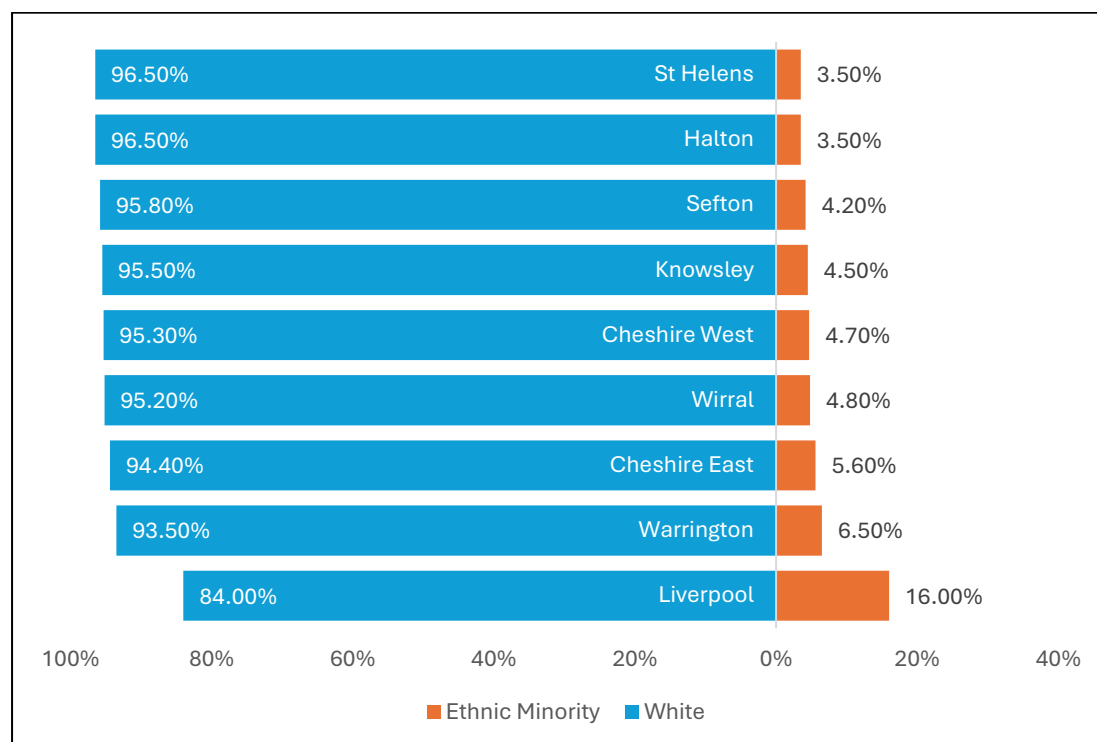
Figure 22. Children experiencing high levels of deprivation, split by Sub-ICBs within Cheshire & Merseyside.



3.10. Looking at ethnicity, roughly 7% of the population of Cheshire & Merseyside is from Black, Asian, or Minority Ethnic (BAME) groups. However, in almost all areas, this proportion is much lower, with the overall proportion inflated by the

BAME population of Liverpool being around 16%. It is worth noting though, that as with many other potential indicators of health inequalities, ethnicity recording is poor within healthcare reporting, which precludes more extensive analysis.

Figure 23. Ethnicity breakdown of Sub-ICBs within Cheshire & Merseyside.



Overall population growth to 2040 in Cheshire and Merseyside is forecast to be **10.8%** but growth expectations vary greatly by place from a modest 3% rise in Warrington, to 16% in Knowsley, and 17.4% in Cheshire East.

Figure 25. All-age population projection 2022-2040 by Local Authority in Cheshire and Merseyside.

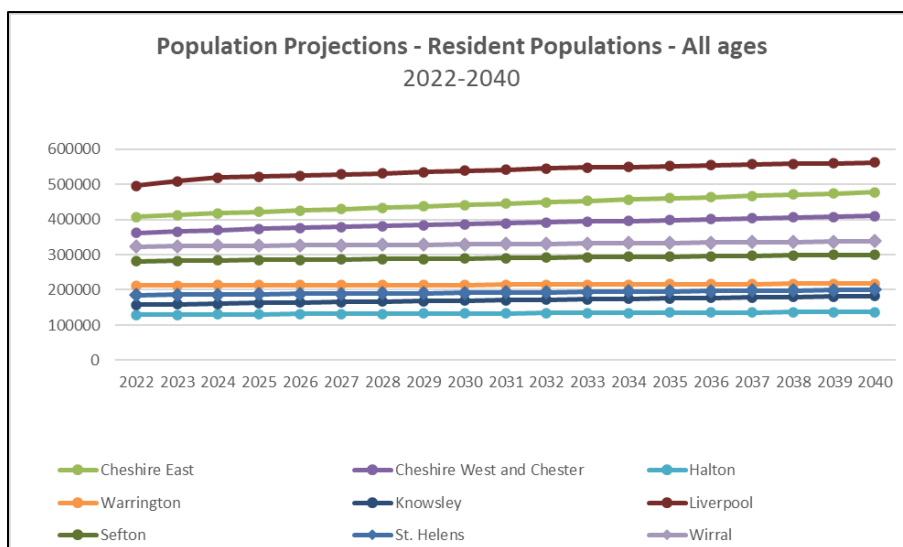
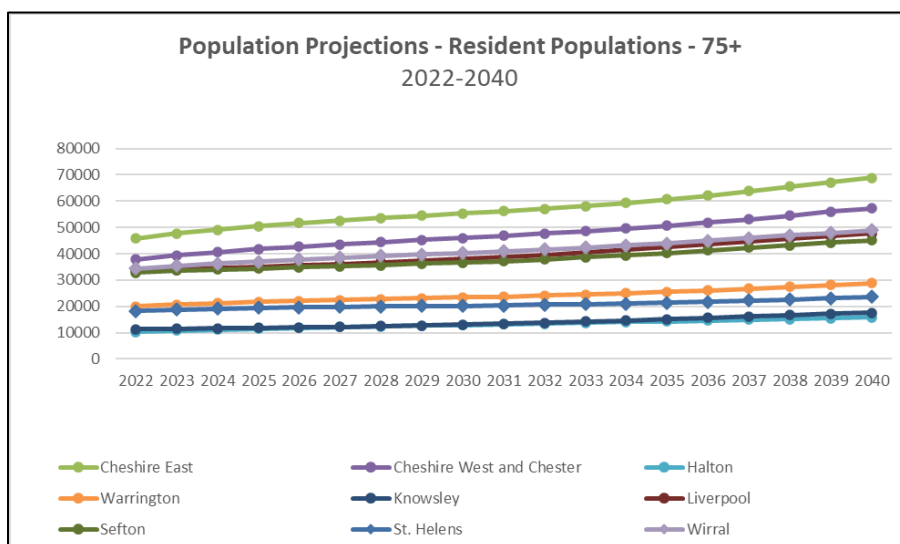


Figure 26. Population projection for over 75s 2022-2040 by Local Authority in Cheshire and Merseyside.

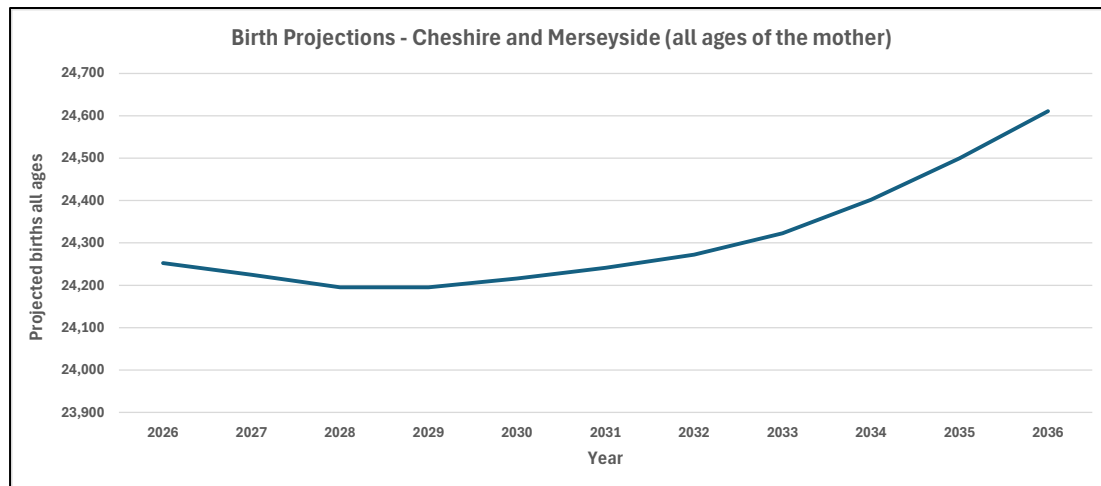


The over 75 population is due to grow by 45% by 2040 with the number of additional over 75s due to be equivalent to the population of St Helens. There will be variation in this growth by Place.

Birth and mortality rates

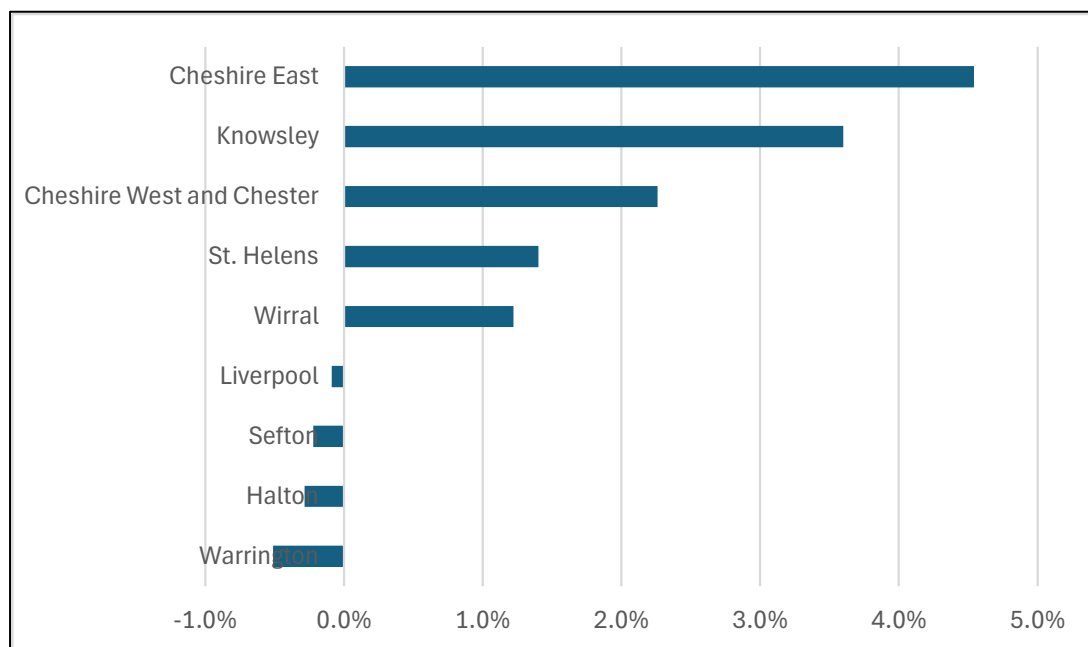
Overall, Cheshire and Merseyside is expected to see a 1.48% increase by 2036 in births by all ages of the mother.

Figure 27. Birth Projections Cheshire and Merseyside 2026-2036 (all ages)



Cheshire East is expected to see the highest increase with 4.76% births from 2026 to 2036 (3,676 vs 3,851) and Warrington is expected to see a decrease in births with -0.5% (1,800 vs 1,791).

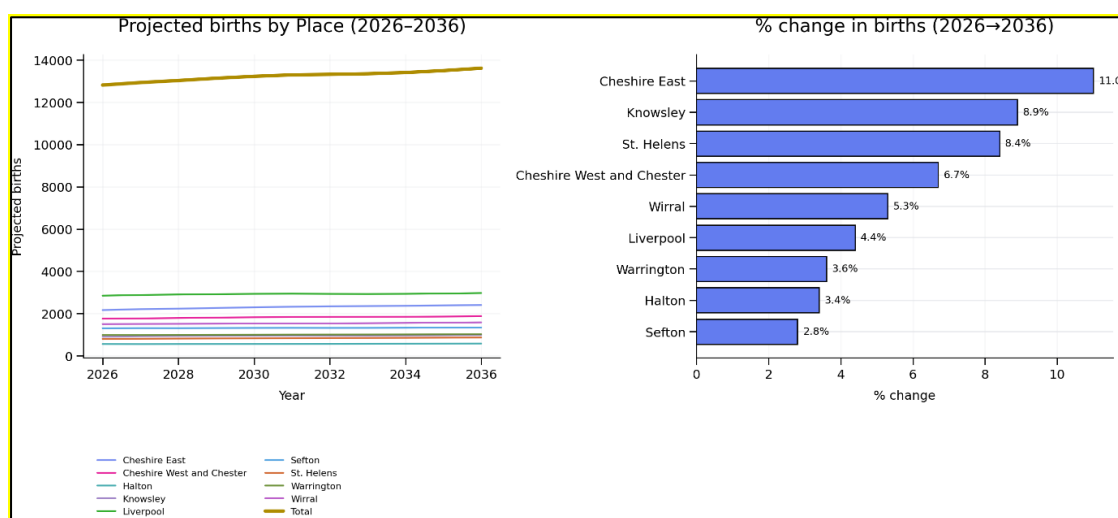
Figure 28. Percentage change in birth projections by Place 2026-2036 (all ages).



Projected births aged 31-44 years

According to the Office for National Statistics, nationally the average age of a mother giving birth is approximately 31.0 years. In Cheshire and Merseyside, the average age is around 30-31 years which is slightly below average. When exploring projected births by Place for the ages of 31-44 years Cheshire East is expected to see a 10% increase in births with 2,164 observed in 2026 compared to 2,403 in 2036. Sefton has the lowest projected increase in births in 31-44 year olds with 1,306 observed in 2026 vs 1,342 in 2036.

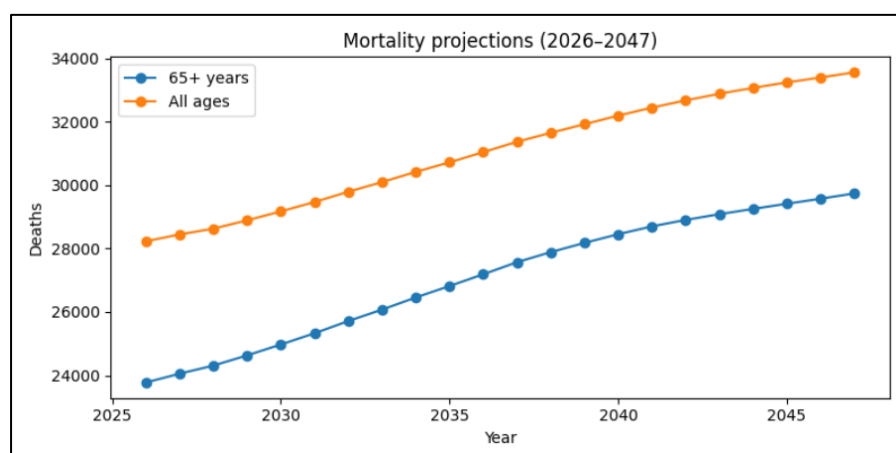
Figure 29. Birth projections by age of the mother 31- 44 years by place and percentage change, 2026-2036.



Mortality Projections

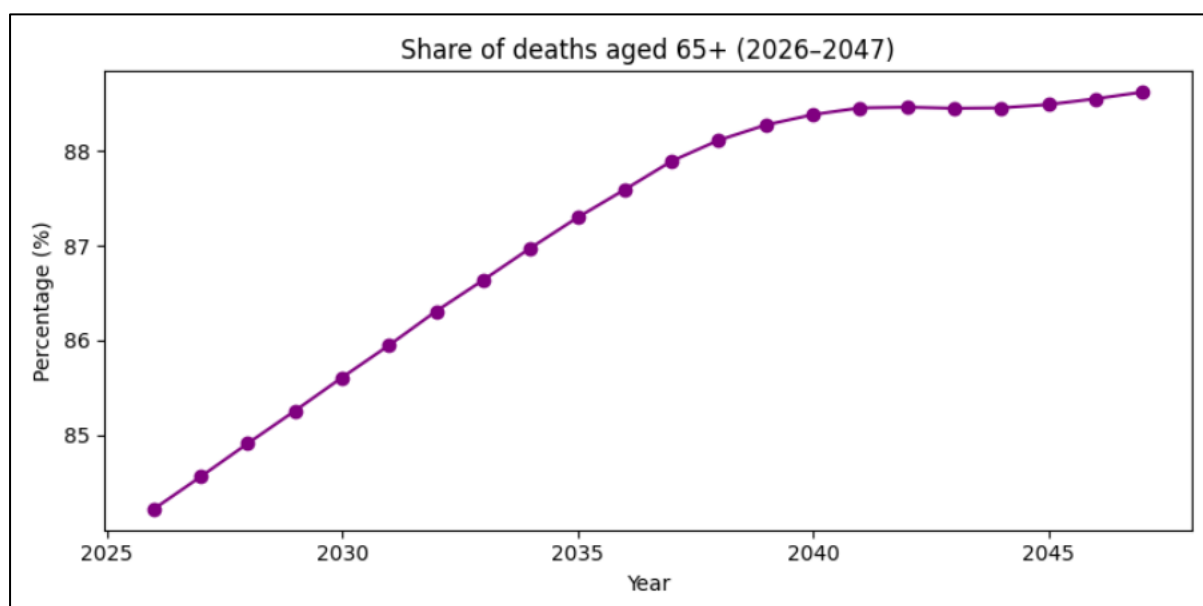
The latest statistics show projected annual deaths for Cheshire & Merseyside from 2026 to 2047, split by 65+ years and all ages. The projections show a smooth linear upward trend and deaths in those aged 65+ is projected to increase by 25% from 2026 to 2047. Death projections for all ages is expected to rise to 19% by 2047.

Figure 30. Mortality projections in Cheshire and Merseyside all ages and 65 years and over 2026 -2047.



The increase in deaths is driven more by those aged over 65 years suggesting population ageing is a strong driver of rising mortality with 84.2% expected in 2026 compared to 88.6% in 2047

Figure 31. Projected deaths in Cheshire and Merseyside aged 65 years and over 2026-2027.



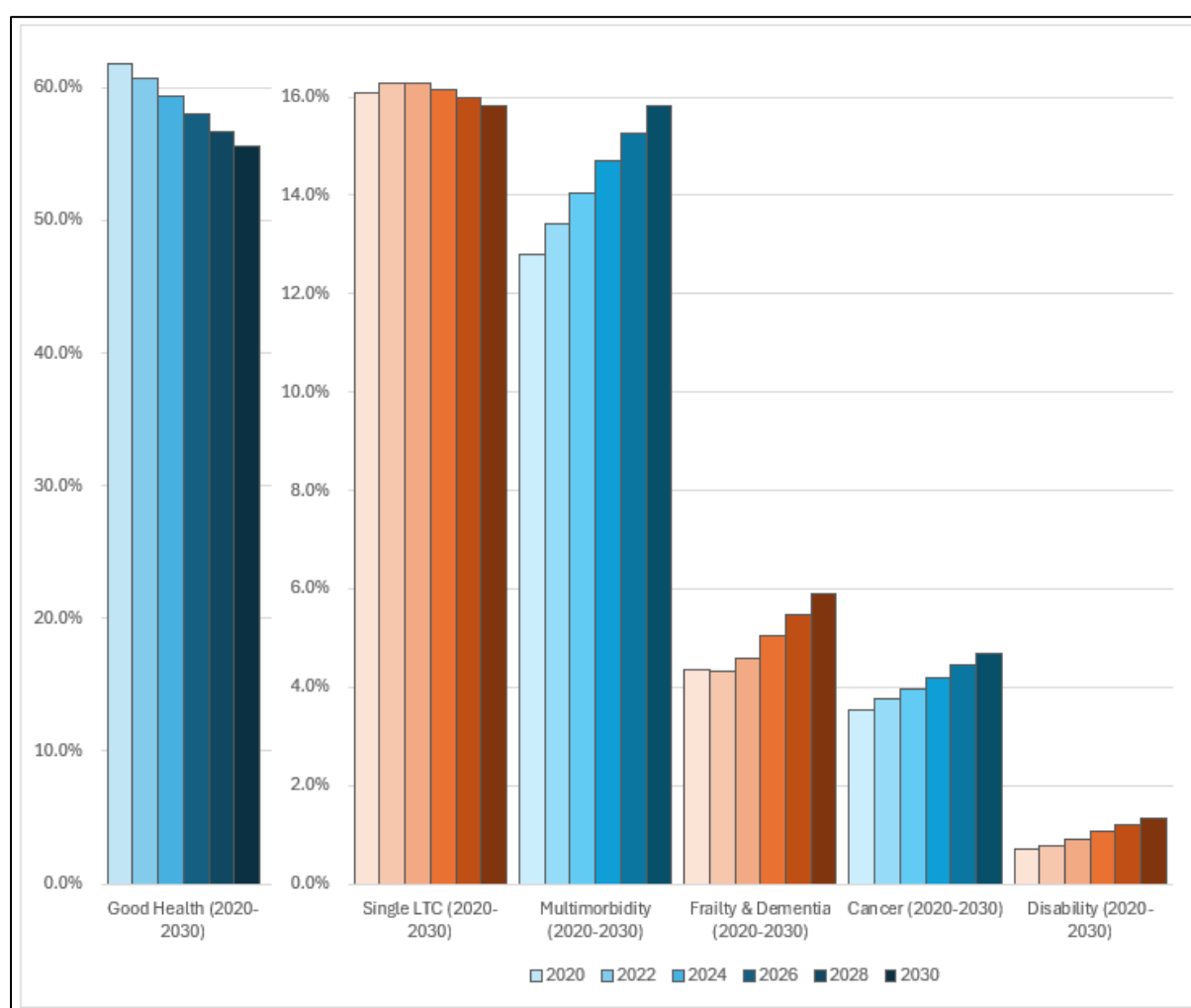
Disease frequency and multimorbidity

Looking over a ten-year period between 2020 and 2030, information from the Federated Data Platform is already showing a steady decline in the proportion of the Cheshire & Merseyside population in the 'Good Health' segment and an emerging decline in the 'Single Long Term Condition (LTC)' segment.

By 2030, the healthy population of Cheshire & Merseyside is projected to decrease from 61.8% to 55.6%. The population with a single long-term condition *increased* from 16.1% to 16.3% between 2020 and 2024 but is expected to *decrease* to 15.8% by 2030.

These declines are in contrast to increasing proportions of the population in more clinically-complex segments.

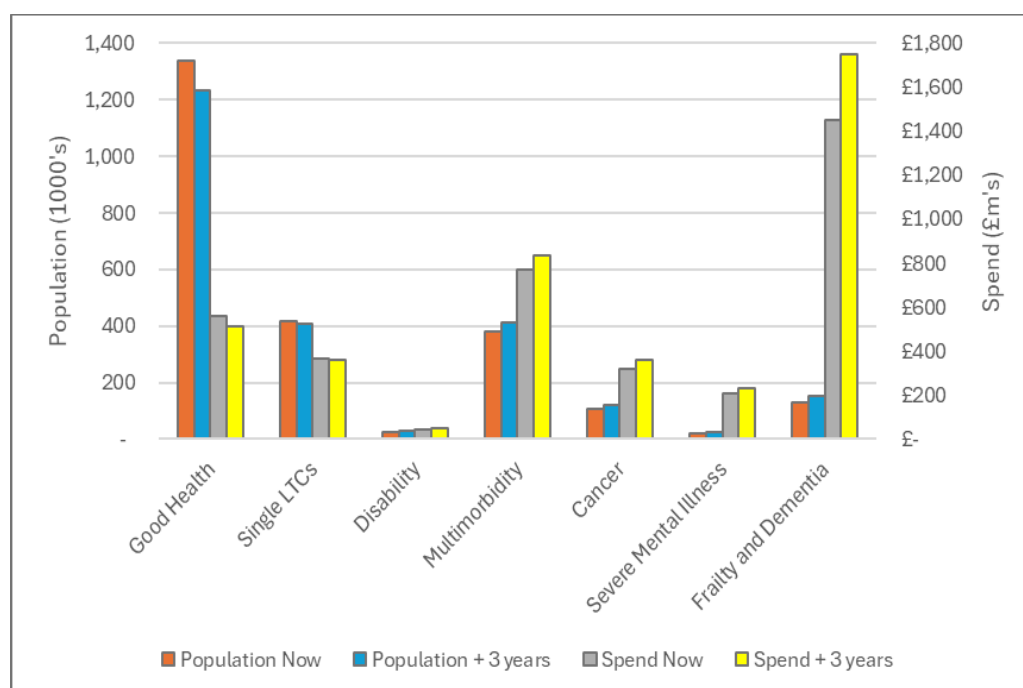
Figure 32. Population segmentation of Cheshire & Merseyside 2020-2030.



Looking specifically at these more complex segments, in the next three years the Federated Data Platform is predicting:

- **Disabilities** - Projected population increase of 5,831 and cost increase of £67 million
- **Multimorbidity** - Projected population increase of 34,007 and cost increase of £67 million
- **Cancer** - Projected population increase of 14,028 and cost increase of £41 million
- **Severe Mental Illness** - Projected population increase of 2,151 and cost increase of £19 million
- **Frailty and Dementia** - Projected population increase of 26,346 and cost increase of £297 million

Figure 33. Federated Data Platform projected population and spend now vs 3 years' time.



4. Wider social, environmental and economic factors that affect health and wellbeing

It is estimated that only about 10-20% of our health is determined by healthcare. The majority of our health outcomes are driven by what we call the social or wider determinants of health such as environment, income, education, employment and housing alongside genetics and individual behaviours. Inequalities in the social determinants of health can cause inequalities in health outcomes. Across Cheshire and Merseyside we know there are significant inequalities across income, education, housing and employment.

Inequalities in income

There is a strong direct link between income and health. People on lower income have less access to healthy food, warm homes and are more likely to experience stress, this leads to multiple long-term physical and mental health conditions. Twenty-three percent of the population in Cheshire and Merseyside live in relative poverty with rates highest in Liverpool at 33%.

The median household income for Cheshire and Merseyside is between £32,000 and £34,000, there is marked variation by local authority with Warrington displaying the largest household income (£41,000) compared to Knowsley having the lowest (£29,000).

Figure 34. Median Household Income by Local Authority.

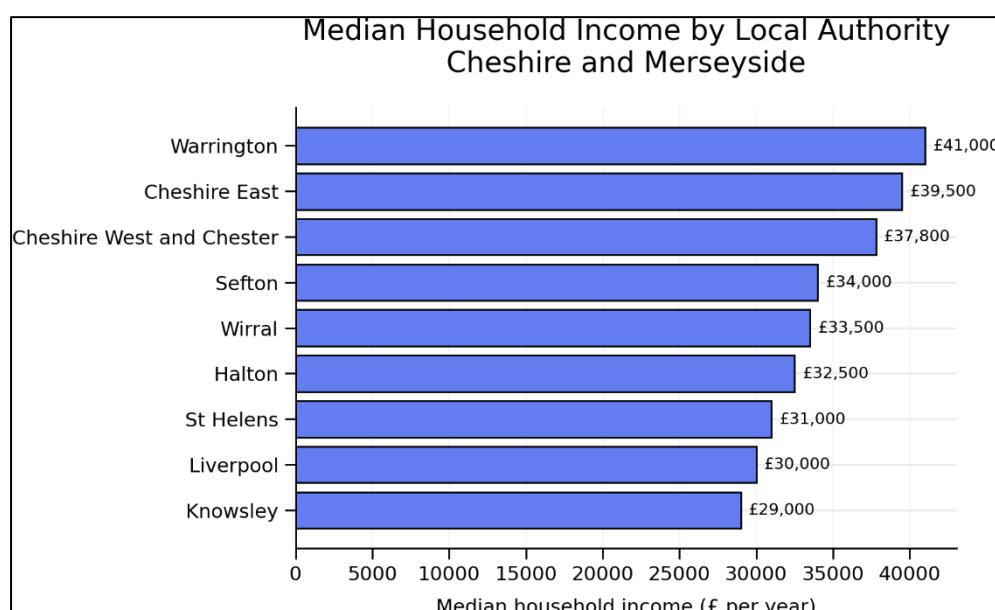
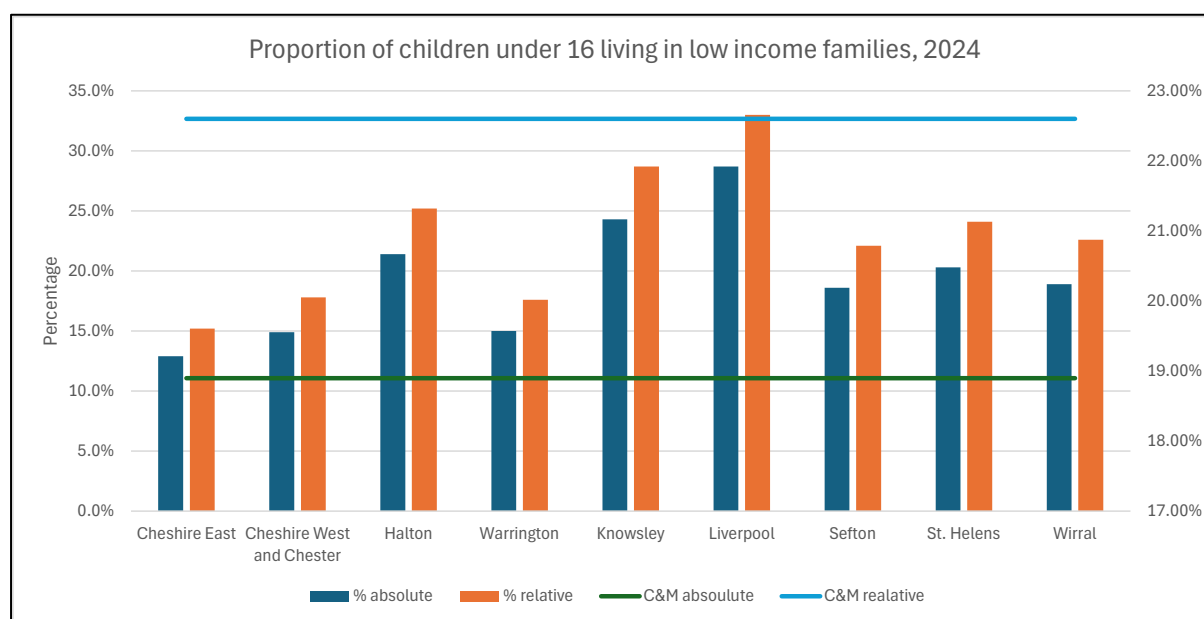


Figure 35. Absolute and relative low income families by Local Authority 2024.

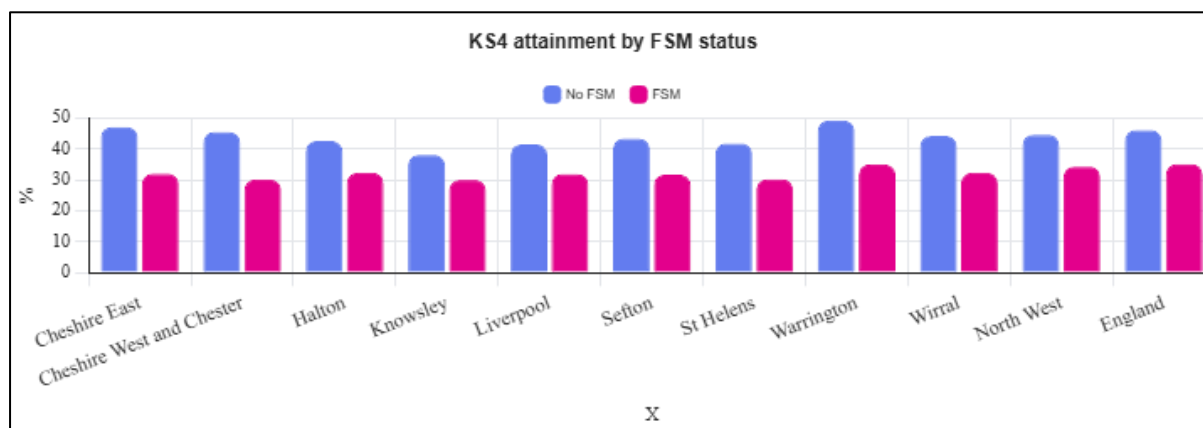


Inequalities in Education

Higher educational attainment is strongly associated with better health outcomes. Every additional year of education reduces adult mortality risk. Educated individuals are also less likely to smoke, and more likely to exercise and have better mental health. Free school meal provision is a proxy measure of deprivation and data suggests inequalities in educational attainment between those who are entitled to free school meals and those that aren't, 83.4% of pupils in Cheshire and Merseyside go on to achieve a level 2 qualification at 19 compared to 64.4% of pupils receiving free school meals.

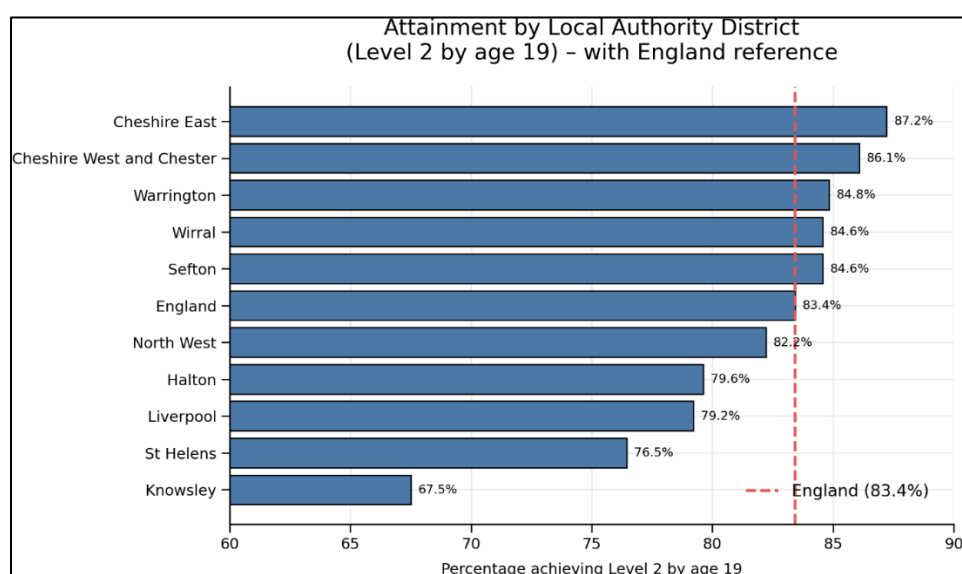
The chart below illustrates attainment average score 8 for Key stage 4 pupils split by local authority and free school meal status. There is a clear linkage to attainment and whether a child is eligible for a free school meal. Knowsley has the lowest attainment with 30% compared to the highest, Warrington (35%) and is significantly lower than the North West and England average 34.3% and 35.1% respectively. Patterns are also similar for those not eligible for free school meals illustrating that deprivation overall is a key factor to attainment.

Figure 36. Attainment average 8 score by Local Authority split by free school meal and non-free school meal pupils.



The chart below shows attainment for level 2 qualification by the age of 19 years. Knowsley (67.5%), is substantially below the North West (82.2%) and England (83.4%) average. St Helens (76.5%), Liverpool (79.2%), Halton (79.6%) are below the regional average of 82.2%. Local authorities that are above the national and regional average include, Cheshire East (87.2%), Cheshire West and Chester (86.1%), Warrington (84.8%) and Sefton and Wirral (both 84.6%) respectively.

Figure 37. Level 2 qualifications at aged 19 by Local Authority.



Inequalities in Environment

The table below show the proportion of households that have access to green or blue space within a 15-minute commitment. Overall 78% of Cheshire and Merseyside residents have access to of either green or blue space with a 15 minute commitment. Cheshire East has the largest proportion of households with 86.3% compared to Knowsley with 60%

Table 1. Percentage of households with access to green & blue space within 15-minute commitment 2025.

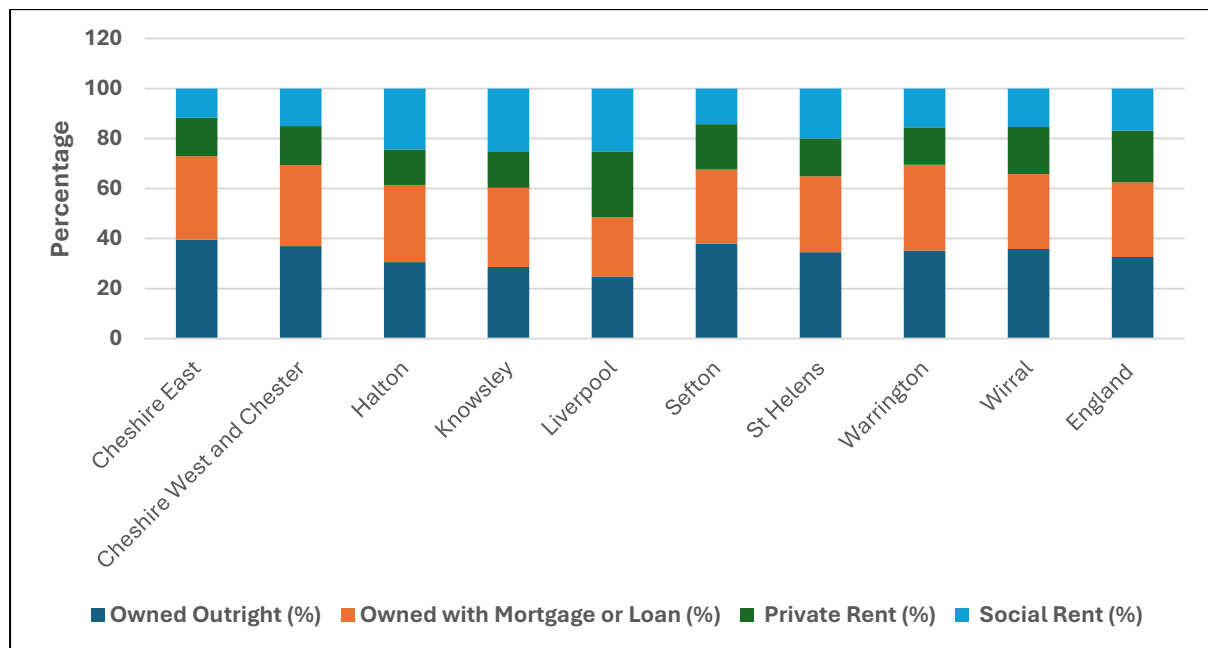
Local Authority	% households
Cheshire East	86.30%
Cheshire West and Chester	80.40%
Halton	83.90%
Knowsley	60.60%
Liverpool	65.40%
Sefton	77.30%
St Helens	86.20%
Warrington	88.00%
Wirral	76.10%
Cheshire and Merseyside	78.24%

- Cheshire authorities perform strongly on the 15-minute commitment, reflecting wider availability of green space
- Urban Merseyside authorities show lower doorstep and local access, despite often having nearby blue space
- Knowsley and Liverpool stand out as having the lowest overall access, which aligns with deprivation and urban density patterns
- Halton and St Helens perform relatively well on *very local* access compared with other Merseyside authorities

Inequalities in Housing

Cheshire and Merseyside has mixed housing tenure ranging from Owner Occupied, privately and socially rented. Liverpool and Knowsley sit above the England average for social rent, and Liverpool is also notably higher for private rent with having a high student population. Cheshire East and Cheshire West & Chester sit well above the England average for owner occupation.

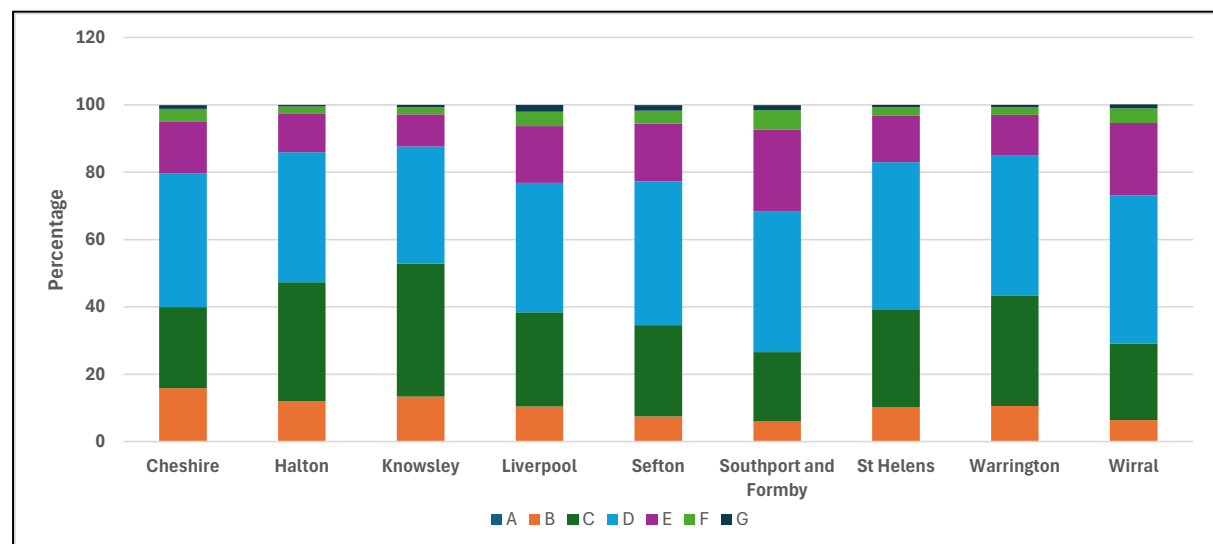
Figure 38. Housing Tenure by local authority 2024.



In Cheshire and Merseyside more than two-fifths (40.3%) of households are categorised as energy rating D.

When exploring energy household rating by Place Wirral has the largest proportion of category D with 44% and Knowsley has the lowest with 34.8% less than 1% of all Places in Cheshire and Merseyside have an energy rating overall as category A. one in ten households (10.2%) have a energy rating B classification.

Figure 39. Risk of Household Energy Rating.



5. Elective Care and community services

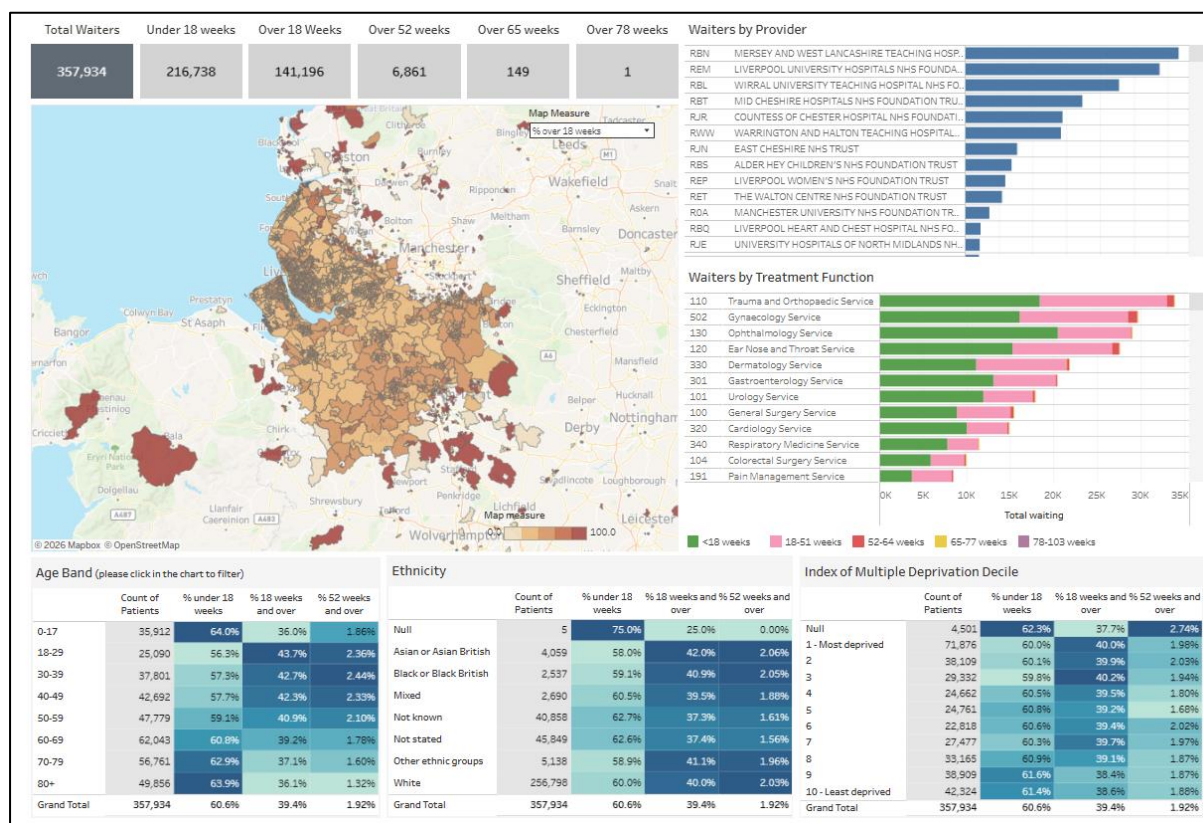
5.1 Inequalities in percentage of people waiting 18 weeks or less and waiting over 52 weeks for elective treatment

Data from our elective treatment recovery programme suggests there remains inequalities in the percentage of people waiting 18 weeks or less and over 52 weeks for elective treatment. Overall, a higher proportion of 0-17 year olds (64%) have waited less than 18 weeks for elective treatment and a higher proportion of working age adults aged 18-59 have waited 52 weeks and over.

Overall ethnicity data within the elective treatment waiting list data is poor with over 85,000 records where ethnicity is either not known or not stated. For those patients where ethnicity has been recorded mixed and white patients had the highest proportion waiting under 18 weeks (60.5% and 60% respectively) and a similar proportion of Asian or Asian British (2.06%), Black or Black British (2.05%) and White (2.03%) patients waited over 52 weeks.

The proportion of patients waiting under 18 weeks in each deprivation decile is similar with the least deprived having 61.4% of patients and the most deprived having 60% of patients who have waited less than 18 weeks. The proportion waiting over 52 weeks was also similar with 1.98% of those living in the most deprived decile and 1.88% of those living in the least deprived deciles.

Figure 40. Current Cheshire and Merseyside elective treatment waiting list profile by provider, treatment, age, ethnicity and deprivation.



5.2 inequalities in annual change in size of waiting list

Currently we are not able to demonstrate inequalities in the annual change in size of our waiting lists, but we will be working towards achieving this in preparation for the 2026/27 annual report.

5.3 inequalities in percentage of people waiting over 18 weeks, over 52 weeks, over 104 weeks for community services

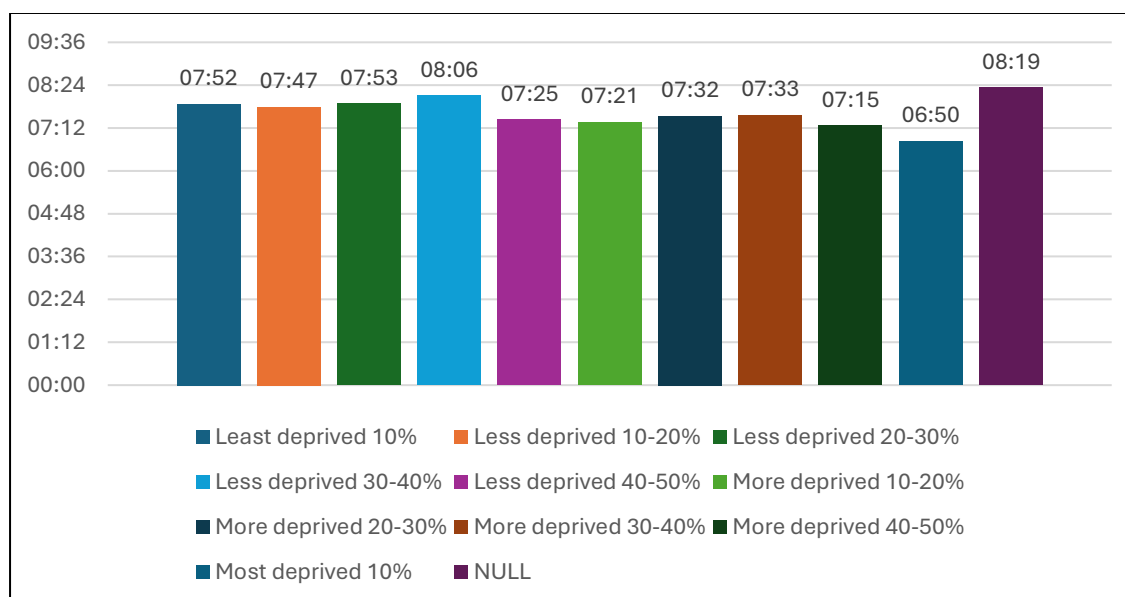
Currently we are not able to demonstrate inequalities in the percentage of people waiting over 18 weeks, over 52 weeks and over 104 weeks for community services, but we will be working towards achieving this in preparation for the 2026/27 annual report.

6. Urgent and emergency care

6.1 inequalities in mean time in emergency department

Waiting time data is available by deprivation decile, age and gender and ethnicity. Data broken down by deprivation decile shows that those living in the most deprived decile did spend less than the average time of 7 hours 23 minutes in the emergency department with their average time being 6 hours 50 minutes.

Figure 41. Average time in the emergency department by deprivation decile.

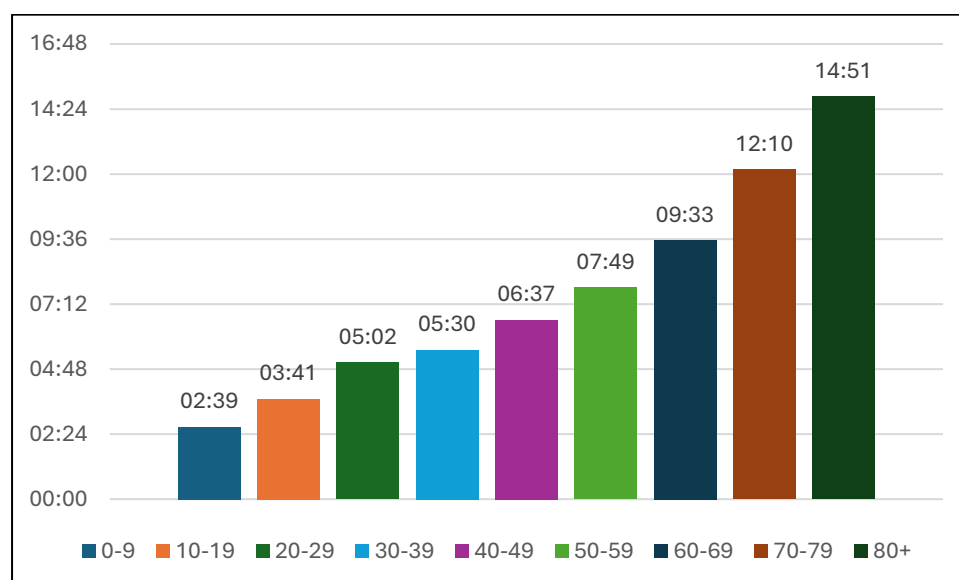


Time in the emergency department did vary by ethnicity but it is acknowledged that ethnicity recording is often poor so it is difficult to include whether these difference are a true reflection of differences in experience or due to poor recording.

Across the genders time spent in the emergency department was similar 7 hours 19 minutes for males and 7 hours 26 minutes for females.

There was a clear difference in time spent in the emergency department by age though with the time increasing as age increased with the longest time spent in the emergency department by those aged 80 plus.

Figure 42. Average time in the emergency department by age.



6.2 inequalities in the proportion of ambulance patients in cardiac arrest that receive a post-ROSC care bundle

Currently we are not able to demonstrate inequalities in the proportion of ambulance patients in cardiac arrest that receive a post-ROSC care bundle, but we will be working towards achieving this in preparation for the 2026/27 annual report.

6.3 inequalities in the proportion of ambulance patients with a ST-elevation myocardial infarction (STEMI) that receive the appropriate care bundle

Currently we are not able to demonstrate inequalities in the proportion of ambulance patients with a ST-elevation myocardial infarction (STEMI) that receive the appropriate care bundle, but we will be working towards achieving this in preparation for the 2026/27 annual report.

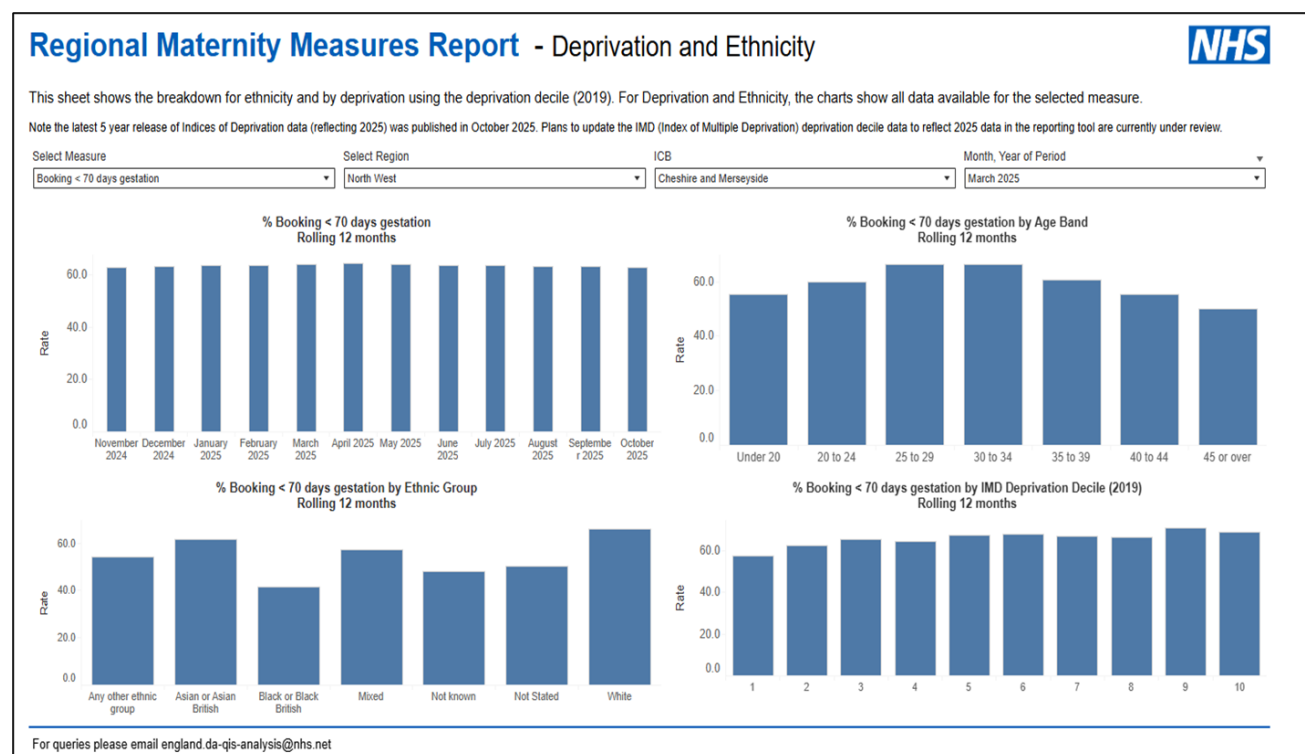
7. Maternity

7.1 inequalities in gestational age at booking

The Maternity Services Data Set (MSDS) highlights that between November 2024 and October 2025 persistent inequalities in the gestational age at which women access their first antenatal (booking) appointment occurred, with some population groups continuing to present significantly later than the nationally recommended 10-week standard. These disparities are most pronounced among women living in areas of higher deprivation and those from minority ethnic communities, as well as younger and older age groups reflecting ongoing challenges related to awareness of early pregnancy care, access to services, and levels of engagement with maternity teams. Delays in booking reduces opportunities for timely screening, early identification of

clinical or social risk factors, and personalised care planning, all of which are critical for improving maternal and neonatal outcomes.

Figure 43. Breakdown of the proportion of women booking before 70 days of gestation by age, ethnicity and deprivation decile.



To address these disparities, the Cheshire and Merseyside Women's Health and Maternity Programme has undertaken a range of engagement activities, including surveys and listening events, to better understand barriers to early booking and to improve awareness within communities about the importance of timely access to care. Targeted engagement and culturally informed outreach have also helped to address barriers to early booking.

Recognising digital exclusion as a barrier to early booking, the programme has also implemented a comprehensive digital inclusion approach to support women who face challenges accessing online maternity information or referral pathways. Key achievements include:

- Delivery of face-to-face digital inclusion workshops in partnership with the Women's Budget Group and Liverpool Combined Authority.
- Expansion of digital access resources, including updated online signposting, free digital-inclusion materials and improved access to co-produced maternity content.
- Involving a digital social prescriber in community events, enabling more women to use digital tools for early referral to midwifery services.

- A Google Ads campaign that increased visibility of early pregnancy information, generating more than 194,800 views and 1,300 hours of watch time.

The programme has also supported Trusts in the expansion of the Enhanced Continuity of Carer (ECoC) model, ensuring that women at highest risk, including those living in deprived areas and those with complex vulnerabilities receive personalised and consistent care from dedicated midwifery teams. Seventeen ECoC teams are now operational across Cheshire and Merseyside, with data showing that the system is supporting a higher proportion of women through these teams than the national average. In addition, the implementation of the English for Speakers of Other Languages (ESOL) Baby Steps Project is providing targeted English language support for non-English speaking mothers, helping to reduce communication barriers and enabling safer, more informed engagement with maternity services.

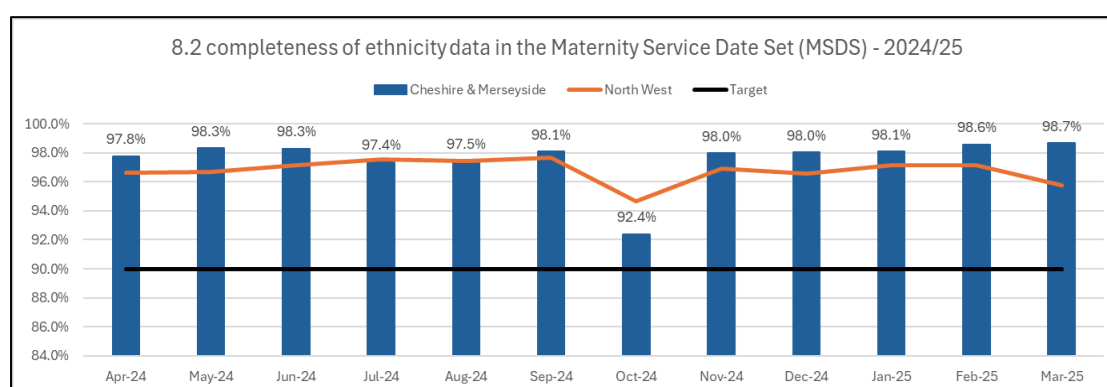
While progress is evident, the findings reinforce the need for continued and coordinated system-wide action. This includes the delivery of culturally informed, public-facing early-booking awareness initiatives, strengthened referral and access pathways, further roll-out of ECoC midwifery teams (including the development of the Maternity Support Worker role within these teams), health-literacy interventions, and further targeted support for population groups at greater risk of late engagement with maternity care (such as women living in areas of higher deprivation and those from minority ethnic communities).

7.2 completeness of ethnicity data in the Maternity Service Data Set (MSDS)*

The 2024/25 MSDS data demonstrates that Cheshire and Merseyside achieved an average ethnicity data completeness rate of 97%, which exceeds both the North West regional average and the national standard set out in Safety Action 2 of the Maternity Incentive Scheme (MIS)¹, requiring Trusts to record a valid ethnicity category for at least 90% of women booked each month. This performance reflects sustained local commitment to high-quality data capture to support equity-focused maternity care.

¹ The Maternity Incentive Scheme (MIS) is an NHS Resolution programme designed to improve the safety and quality of maternity services across NHS Trusts in England. It forms part of the Clinical Negligence Scheme for Trusts (CNST) and provides a financial incentive for Trusts that can demonstrate they have met a set of nationally agreed maternity safety actions

Figure 44. Completeness of Ethnicity Data in the Maternity Services Data Set.



As part of the region's approach to maternity safety, all Trusts were supported by the LMNS through a structured assurance process to meet the ten national MIS safety actions. Notably, Safety Action 2 is subject to external validation by NHS Resolution, following formal Trust Board sign-off, ensuring a robust and transparent assessment of data quality and compliance.

Accurate and complete ethnicity data is fundamental to identifying and monitoring inequalities in access, outcomes and experience within maternity services. High-quality data enables the system to understand variations between population groups, target interventions effectively and evaluate their impact over time.

While overall performance across Cheshire and Merseyside is strong, variation between providers highlights the need for ongoing LMNS oversight to ensure that emerging themes are identified and acted upon. Trusts must continue to embed strengthened data quality processes and maintain high levels of completeness to support equitable service delivery, effective health inequalities monitoring and targeted improvement work across the region.

There is also a need to ensure that each Trust has a maternity specific electronic patient record (EPR) system that reliably supports ethnicity data collection, reporting and analysis. This will be particularly important in enabling Trusts to use equity data to inform service planning and to target resources effectively - for example, aligning newly established ECoC teams to areas of greatest need based on ethnicity, deprivation or geography.

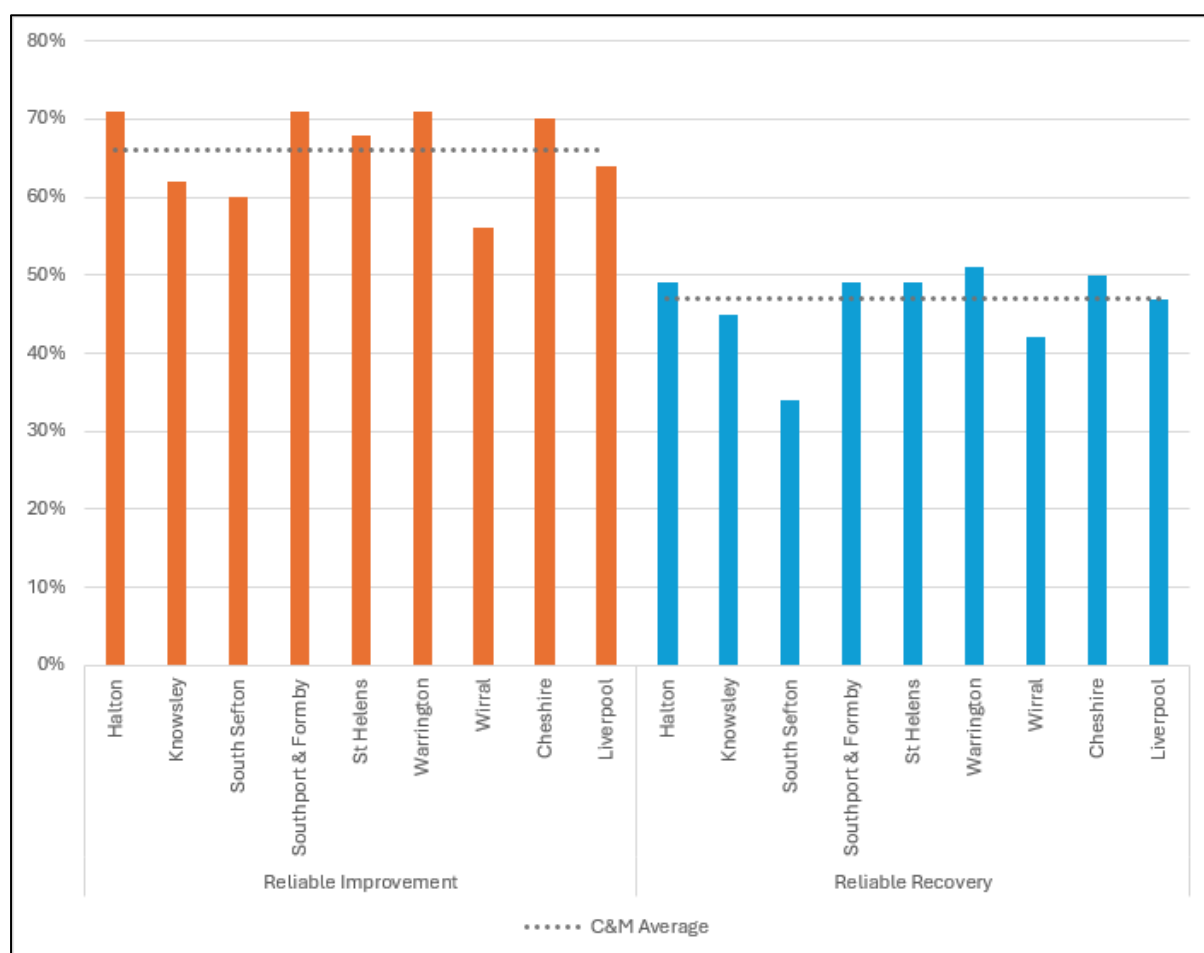
8. Mental Health

8.1 inequalities in people achieving access and outcomes for NHS Talking Therapies

Talking therapy services in NHS Cheshire and Merseyside provided access for 23,615 people in the 12 months to December 2025, meeting national access ambitions. Waits of over 90 days between first and second treatment reduced significantly, dropping from 36% to 13% at overall ICB level. However, variance is evident at place level, with only 3% of patients in Wirral and Liverpool experiencing long waits between treatment, compared with 41% in South Sefton. Recovery and improvement rates were marginally below target at ICB level; however, place level variance is reported, with five places achieving reliable recovery target rates of 48%

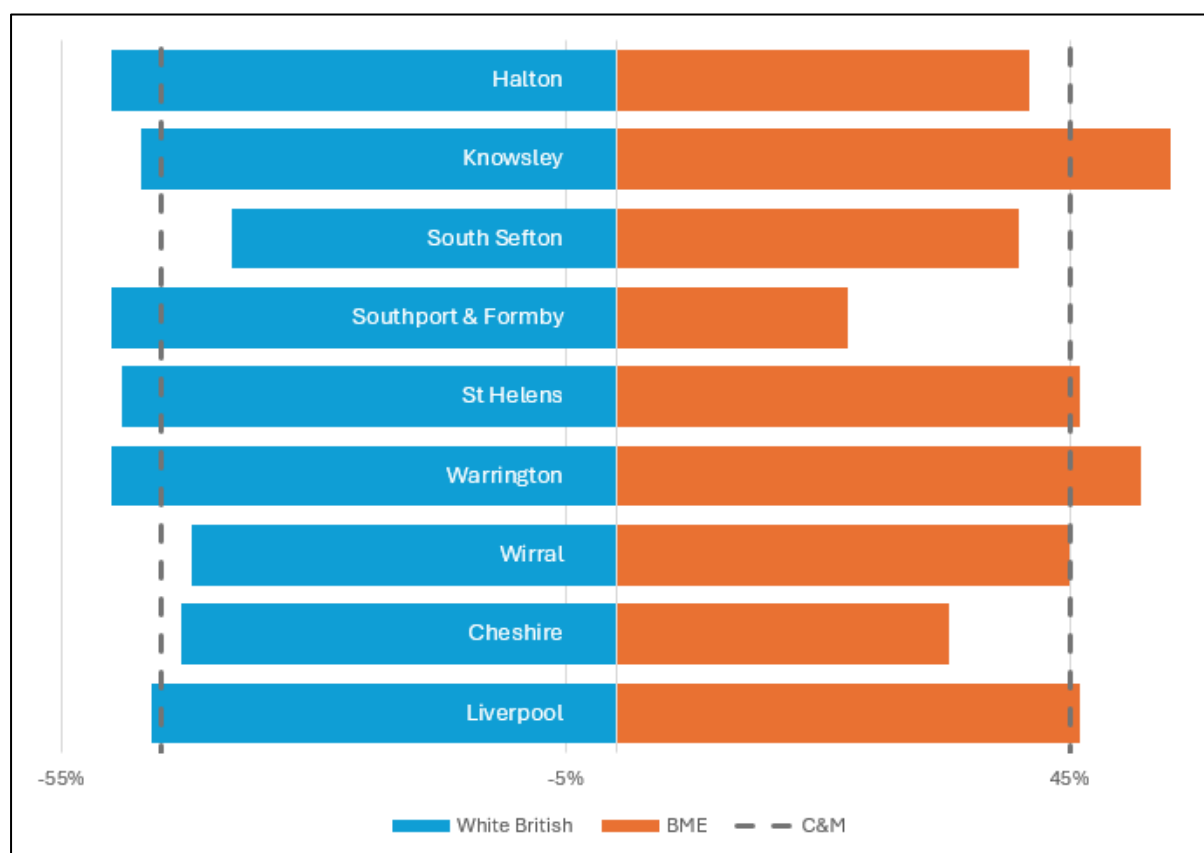
or more and reliable improvement rates of at least 67%. A six-week Readiness for Therapy campaign was developed to support better engagement and outcomes by place and provider. At ICB level, reliable recovery rates for ethnically minoritised and White British patients are comparable at 45%.

Figure 45. Talking therapies outcomes by place across Cheshire and Merseyside



When split by ethnicity, BAME people in Knowsley and Wirral (as well as South Sefton and Warrington) appear to have better recovery rates compared to White British people engaging with the same services. However, it is worth noting that BAME people in Southport & Formby and Cheshire have significantly lower recovery rates.

Figure 46. Talking therapies outcomes by place and ethnicity in Cheshire and Merseyside.



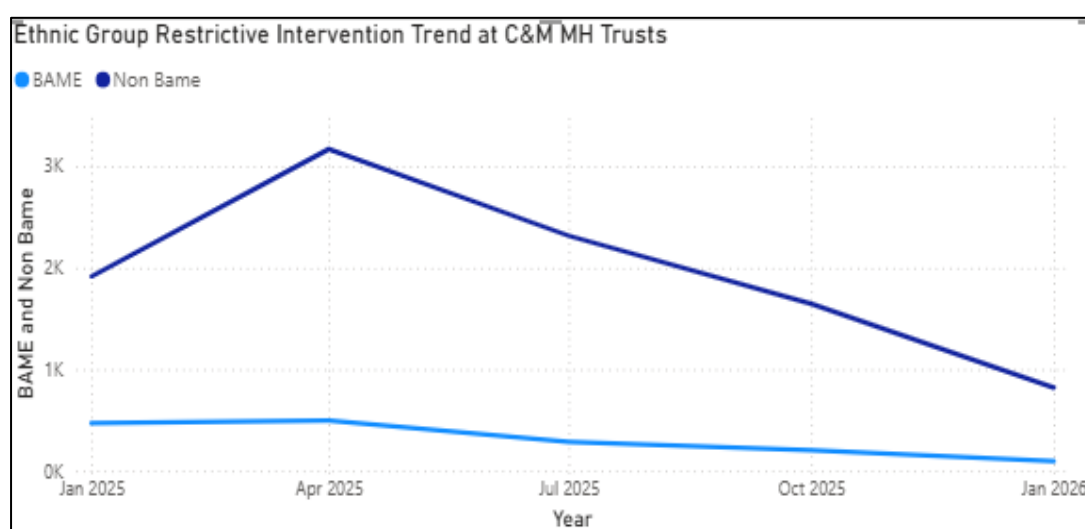
Work has taken place in 2025/26 to reduce disparities in access, experience, and outcomes for individuals and communities affected by mental health conditions. Work has been undertaken to develop, test and roll out the Patient and Carer Race Equality Framework (PCREF) to improve access, experience and outcomes for racialised communities. This work is now gathering momentum with NHS mental health providers now having a nominated executive board lead and improvement priorities identified.

Meeting the psychological needs of patients with physical health conditions has also been a priority in 2025/26. A project was undertaken to address identified gaps in psychosocial provision for people affected by cancer and to strengthen integration between cancer and mental health services in line with national priorities. Key achievements include the development of a digital psychosocial support toolkit and referral directory, the establishment of Cancer Champions across all NHS Talking Therapies providers, the creation of a standardised referral pathway, and the introduction of specialist cancer supervision and training resources. The projects have also created opportunities to extend learning into other long-term conditions, supporting wider ambitions for integrated care across the system.

8.2 inequalities in rates of restrictive interventions in inpatient services

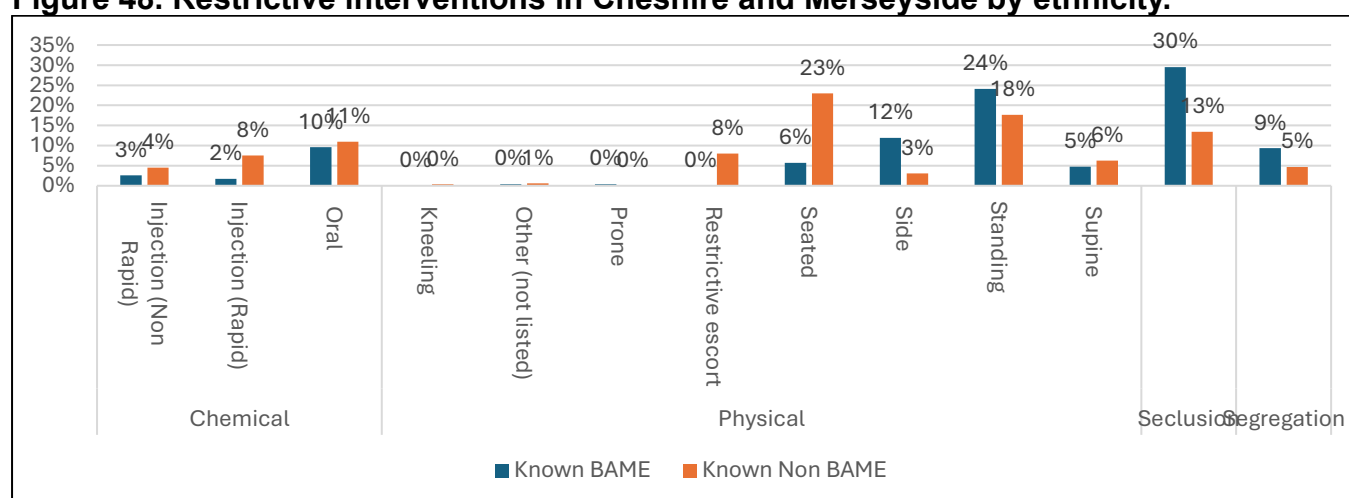
There is a reduction in the number of restrictive interventions for both Black and Minority Ethnic Group patients and White patients over the last 12 months. Mersey Care has a much higher proportion of restrictions (18% of their total) used on BAME patients. This would need to be checked against their distribution of all patients to draw any conclusion on inequalities though. Cheshire and Wirral Partnership have a comparatively higher percentage of patients with an unknown ethnicity status.

Figure 47. Restrictive interventions in Cheshire and Merseyside by ethnicity between January 2025 and January 2026.



It is clear from the data that BAME patients are more likely to be secluded, segregated and have physical restraints of side and standing than non BAME patients, they are also less likely to have chemical restrictions.

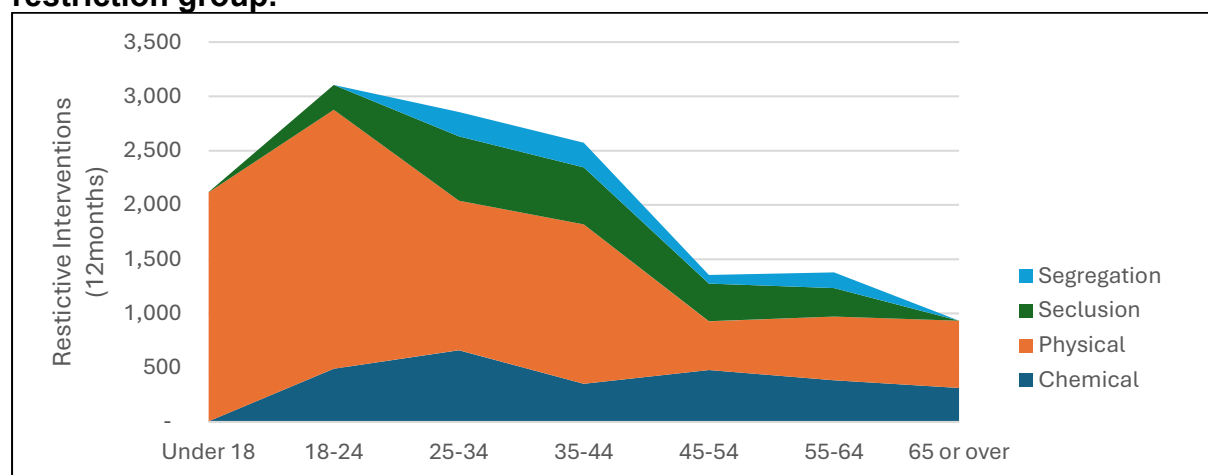
Figure 48. Restrictive interventions in Cheshire and Merseyside by ethnicity.



Eight-four percent of restrictive interventions are seen in patients under 45, with the age of 18 to 24 being the highest number. Sixty-three percent of all restrictions take

the form of a physical category and most commonly seated or standing. This is more heavily weighted as seated in younger patients and switches to a greater weighting on standing for the older ages. Physical Supine restrictions are more a less common form of restriction more likely used for patients aged 25-44.

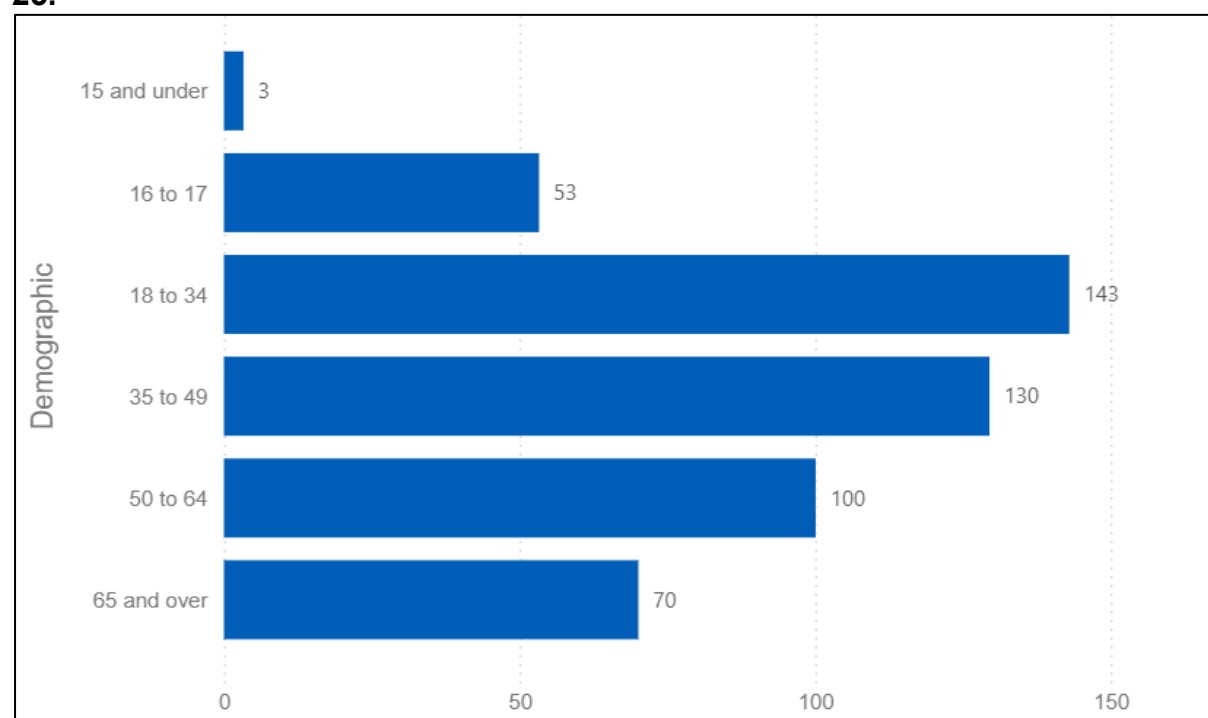
Figure 49. Restrictive interventions in Cheshire and Merseyside by age and restriction group.



8.3 inequalities in use of the mental health act including use of community treatment orders (CTOs)**

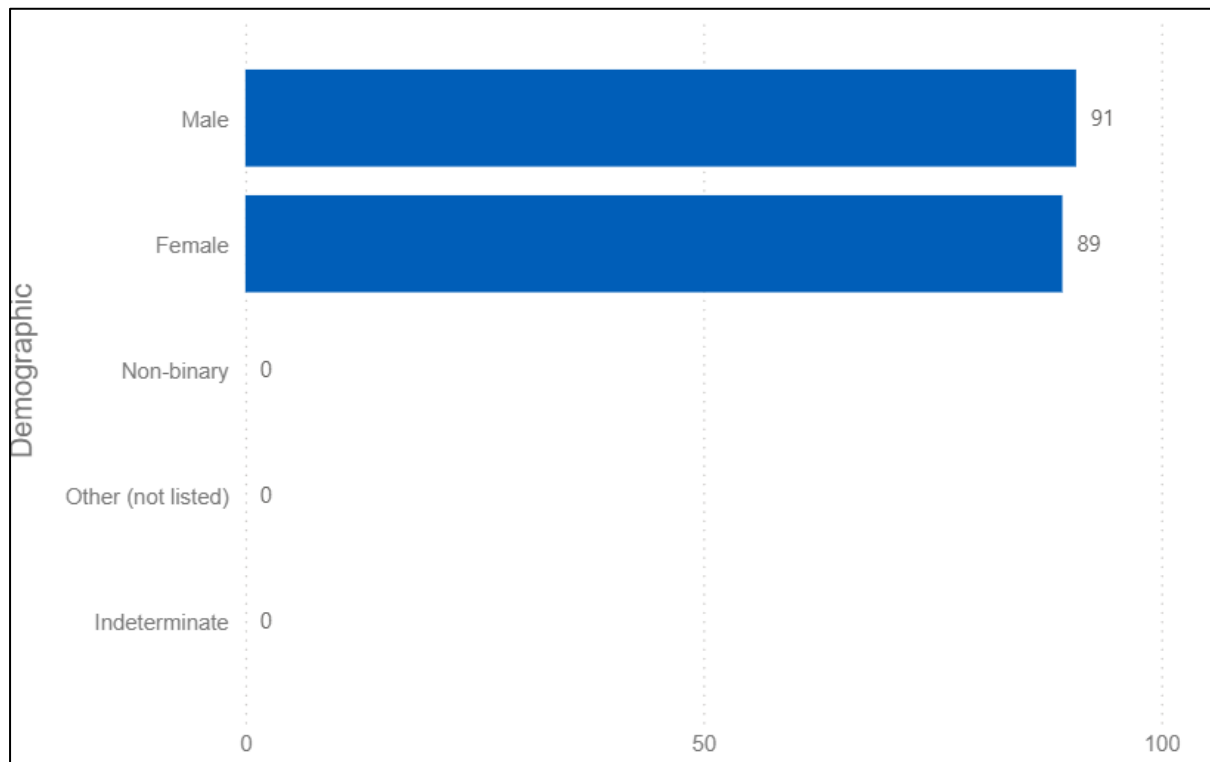
The data below demonstrates the crude rate of detentions under the Mental Health Act in NHS Cheshire and Merseyside by age. It shows clear inequalities in rates of detention under the mental health act by age with the rates being highest among those aged 18-34 and lowest among those under 15.

Figure 50. Crude Rate of Detention for Cheshire and Merseyside by age 2024-25.



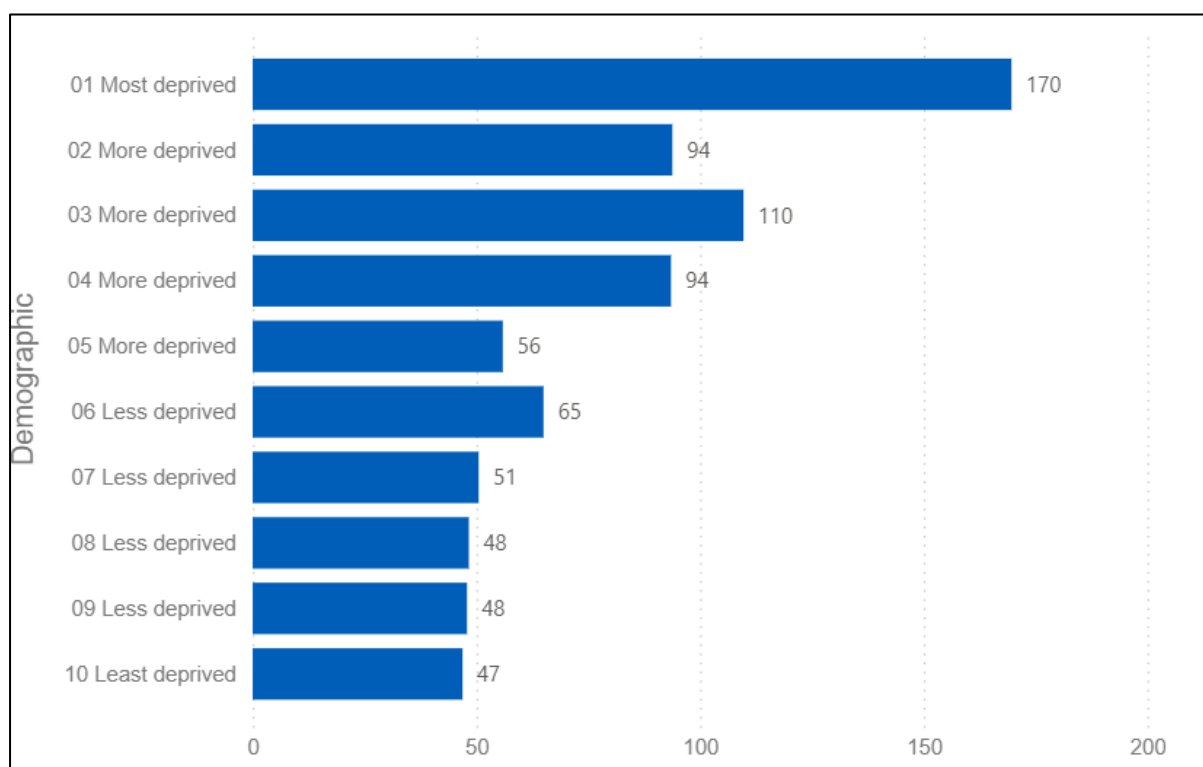
There is a small difference in the crude rate in detentions under the Mental health Act by Gender in Cheshire and Merseyside with males having slightly higher detention rates at 91 per 100,000 compared to 89 per 100,000 for females.

Figure 51. Crude Rate of Detention for Cheshire and Merseyside by Gender 2024-25.



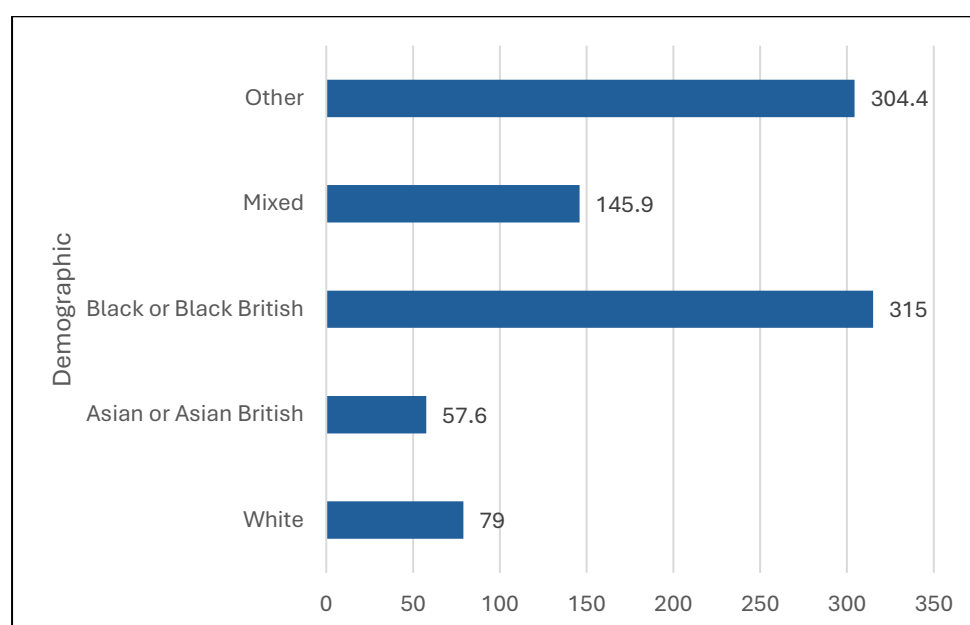
The data for Cheshire and Merseyside shows Mental Health Act detentions in Cheshire and Merseyside are strongly linked to deprivation with rates rising among those living in more deprived communities with people from deprived communities being over 3,5 times more likely to be detained than those in the least deprived areas with rates of 170 per 100,000 compared to 47 per 100,000 in the least deprived areas.

Figure 52 Crude Rate of Detention for Cheshire and Merseyside by Deprivation 2024-25.



There are significant disparities in the crude rate of Mental Health Act detentions based on ethnicity with black people nearly 4 times more likely to be detained than white people in Cheshire and Merseyside.

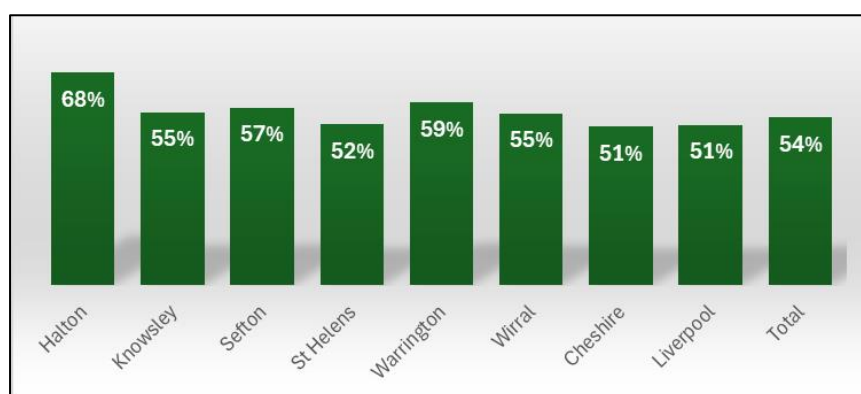
Figure 53. Crude Rate of detention for Cheshire and Merseyside by Ethnic Group 2024-25.



8.4 rates of eligible patients with severe mental illness (SMI) receiving an annual physical health check and action plan

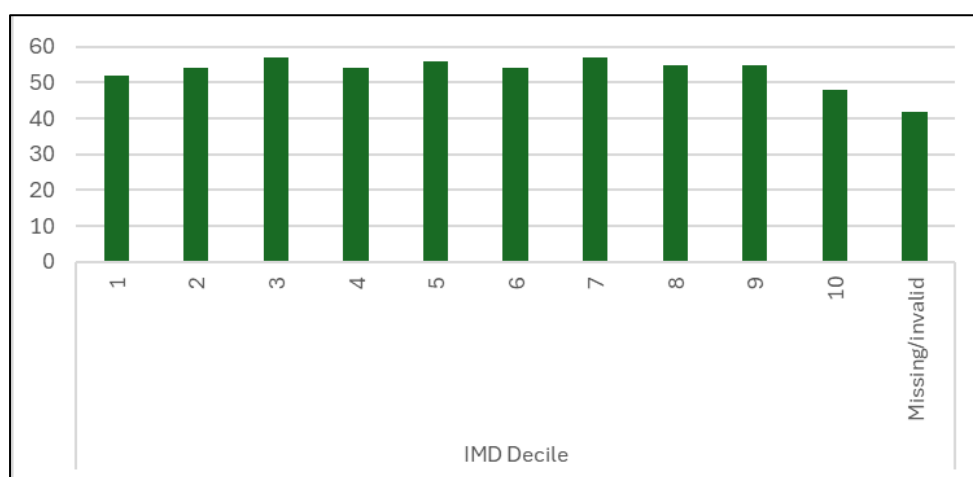
Data is only currently available up to the end of quarter three in 2025/26 and compared to the same quarter in 2024/25 there has been a 2% increase in the number of patients with Severe Mental illness who have received all six health checks. Overall NHS Cheshire and Merseyside have achieved a rate of 54% against a target of 60%. To date only one Local Authority (Halton) has achieved the 60% target out of all nine Local Authority areas.

Figure 54. Patients with SMI who have received a full physical health check by Local Authority



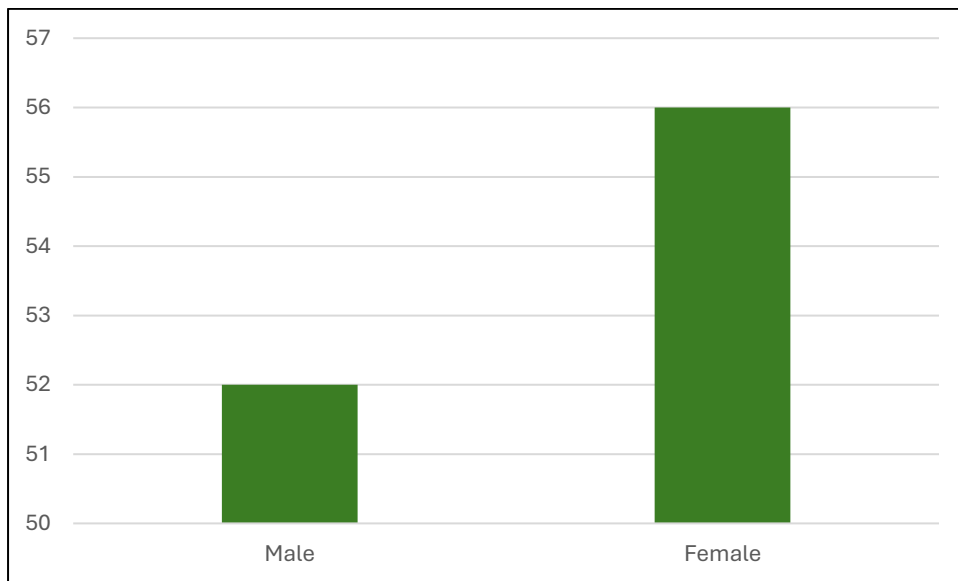
Of the 13,110 full health checks undertaken rates were similar across the deprivation deciles.

Figure 55. Patients with SMI who have received a full physical health check by Deprivation Decile



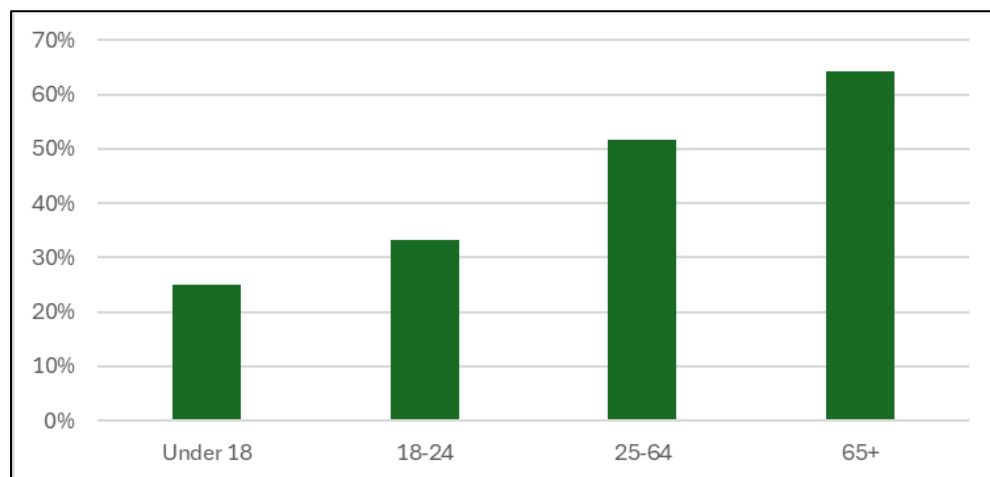
Uptake of physical health checks in patients with SMI is slightly higher in higher in females (56%) compared to males (52%).

Figure 56. Patients with SMI who have received a full physical health check by Gender.



Analysis of health checks by age range does, indicate inequalities across the age groups with 64% of people over the age of 65 receiving full health checks compared with 25% of under 18-year-olds, suggesting young people are not being reached by current primary care-led models.

Figure 57. Patients with SMI who have received a full physical health check by Age



9. Respiratory disease

9.1 inequalities in non-elective bed days occupied by asthma, chronic obstructive pulmonary disease (COPD) and community-acquired pneumonia (CAP)

Between February 2025 and January 2026 there were 23,754 non-elective admissions for Asthma, COPD and Pneumonia, this is a 17% reduction on the previous period with 28,513 (2024/25). Average Length of stay for admissions is approximately 7.7 days, a slight increase on the previous year with 7.4 days., suggesting that more people with less severe illness are being managed outside of a hospital setting. The reduction in admissions across all three of the most frequent causes of Respiratory admissions to hospital is encouraging.

Table 2. Asthma, COPD and Pneumonia Emergency Hospital Admissions in Cheshire and Merseyside.

Reporting period	Asthma	COPD	Pneumonia	Total
2024/25	2,779	6,661	19,073	28,513
Last 12m Feb 25-Jan 26	1,999	5,901	15,854	23,754
				-17%

Overall, more females (55%) are admitted to hospital with Asthma, COPD and Pneumonia than males. However, when broken down by age group more males under the age of 18 are admitted than females under 18 (7.1% and 5.1% respectively). Whereas in the 55-64 years age group more males are admitted than females (14.1% and 13.1% respectively).

Table 3. The age and gender breakdown of Asthma, COPD and Pneumonia emergency hospital admissions.

	Males					
	Under 18	18-25	26-39	40-45	55-64	65+
2024/25	926	197	485	1144	1811	8133
Last 12m Feb 25-Jan 26	762	144	343	901	1510	7065
	Females					
	Under 18	18-25	26-39	40-45	55-64	65+
2024/25	854	271	908	1568	2279	9934
Last 12m Feb 25-Jan 26	658	246	623	1082	1707	8711

Almost half (46.3%) of patients admitted to hospital are from the Quintile 1 – the most deprived areas of Cheshire and Merseyside compared to 11.4% from the least deprived. It is unsurprising that Respiratory ill health disproportionately affects people from Quintile 1 and this highlights that there is much work needed to reduce the inequalities in respiratory health across our population.

Table 4. Breakdown of Asthma, COPD and Pneumonia emergency hospital admissions by deprivation quintile.

	1	2	3	4	5	Total
20245/25	12,160	4,112	3,523	3,606	3,150	26,551
Last 12m Feb25-Jan 26	10,458	3,570	2,907	3,068	2,581	22,584

The majority of people admitted to hospital with Asthma, COPD or Pneumonia are of White British origin (90.5%) 2.8% are from Black and Asian Minority Ethnic backgrounds and 5% of records have ethnicity status as unknown. The ethnic profile of patients admitted to hospital with respiratory disease broadly reflects the ethnic profile of the population of Cheshire and Merseyside.

Table 5. Breakdown of Asthma, COPD and Pneumonia emergency hospital admissions by ethnic group.

	Asian	Black	Mixed	Other	Unknown	White	#N/A	Total
20245/25	214	128	128	330	1,354	25,788	571	28,513
Last 12m Feb25-Jan 26	168	120	106	271	1,189	21,486	414	23,754

There are multiple pieces of work underway taking a population health management approach to preventing respiratory related emergency hospital admissions. These approaches are using a risk stratification methodology to identify those at increased risk of hospitalisation and optimise their outcomes through a combination of medication optimisation, behavioural change relating to smoking and physical activity as well as tackling the wider determinants of health such as housing quality and indoor air quality.

During 2025/25 the Respiratory Network in partnership with Health innovation North West Coast and NHS Cheshire and Merseyside brought together partners to identify the opportunities for prevention within the respiratory programme. The workshop clearly identified the following key approaches:

- Smoking cessation
- Pulmonary rehab
- Physical activity
- Housing
- Air quality
- Vaccination uptake

The network is now working in partnership with a range of wider programmes across Cheshire and Merseyside to address these prevention priorities including:

- All Together Smokefree programme
- Housing and Health Partnership
- All Together Active
- Screening and Immunisation Group

Planned areas of work in 2026/27 include the delivery of a housing and health webinar delivered jointly by respiratory health and housing. The integration of respiratory patients as a priority group within a new Locally Enhanced Services

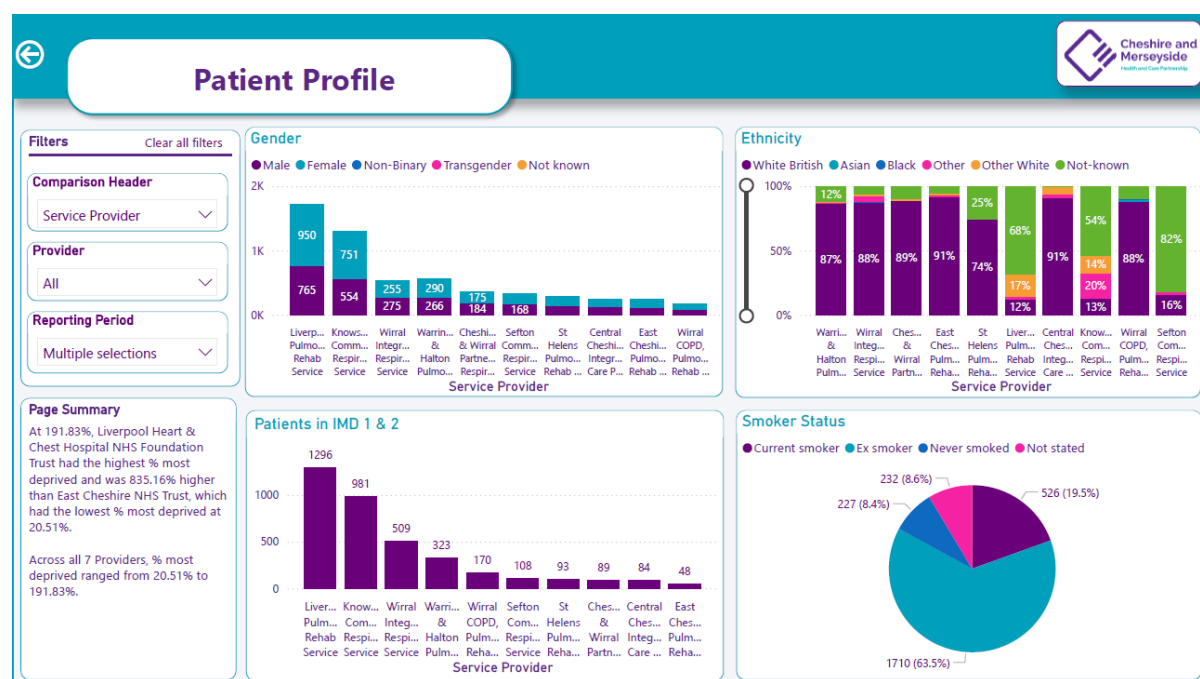
commission in primary care. Further work on improving the quality of respiratory reviews.

9.2 inequalities in pulmonary rehab completion rates

It is well evidenced that pulmonary rehabilitation completion rates can be significantly influenced by a number of patient and service characteristic, such as gender, ethnicity, smoking status, age, level of breathlessness, service location and level of deprivation. Patients living in more deprived communities are much less likely to complete pulmonary rehabilitation programmes, this is reflected in national pulmonary rehabilitation data sets.

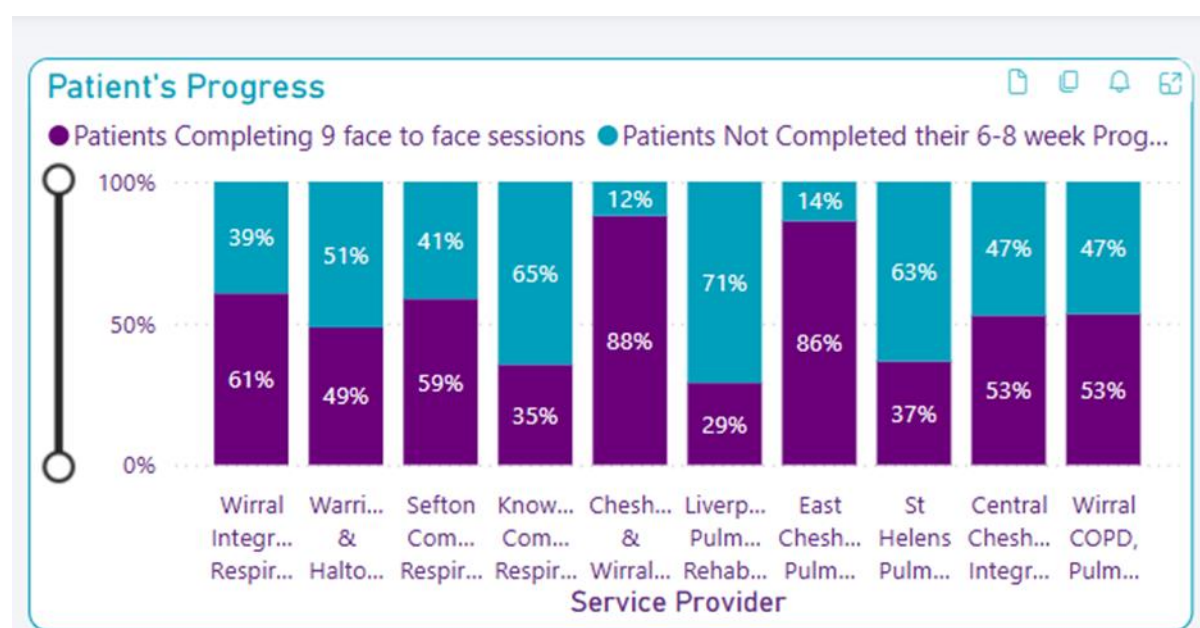
Pulmonary rehabilitation services across Cheshire and Merseyside have been submitting data to a region dashboard for several years, this has enabled services and commissioners to understand the profile of patients being referred into services, such as ethnicity, gender and deprivation.

Figure 58. Gender, Ethnicity and Deprivation profile of Pulmonary Rehabilitation referrals.



Currently completion rates for pulmonary rehabilitation in Cheshire and Merseyside are only available by provider. We can see from the data that there is a relationship between deprivation and completion rates as Liverpool and Knowsley have the highest number of referrals from the most deprived communities and the lowest proportion of patients completing nine face-to-face sessions.

Figure 59. Pulmonary rehabilitation completion rates by service provider.



To improve uptake and completion rates pulmonary rehabilitation teams now provide a menu of options for how patients can access the service, this includes the traditional class-based programme, a modified programme, home programme and a digital programme.

All pulmonary rehabilitation services have been asked to complete a Health Equity Assessment Tool to systematically assess health inequalities and identify actions to help reduce them. Some of the actions that have been implemented as a result of this work include:

- Removing opt-in letters which disadvantage people with literacy problems or who struggle to read English.
- Using population health dashboard to identify high risk patients
- Pro-actively working with fuel poverty projects
- Working with homelessness groups
- Building links and providing bespoke support in addiction services
- Targeting education to primary care networks with low referral rates
- Quality improvement project to understand DNA rates in patients who live in the most deprived communities

10. Smoking cessation

10.1 Inequalities in inpatients making a supported quit attempt with an in-house tobacco dependence treatment service

In-house treating tobacco dependency services are crucial services for supporting inpatients to remain smokefree during their hospital stay. They also offer patients who are motivated to quit due to their hospital stay an opportunity to access specialist treatment for their tobacco addiction. The services also supports patients to adhere to smokefree hospital policies during their stay as well as offering significant health benefits during a period of illness.

The data by age, ethnic group, deprivation decile and gender is reflective of users of secondary care hospital services. We know these patients are often older and from more deprived communities. The data clearly demonstrates that populations with poorer health outcomes such as ethnic minority groups and those living in deprived communities are engaging with the treating tobacco services and making a quit attempt. When we compare the proportion of people identified as a smoker with the proportion who have then commenced a quit attempt we can clearly demonstrate the proportion of quit attempts is higher in those living in the most deprived communities as well.

Figure 60. Inpatients identified as smokers, referred to tobacco dependency services, seen by the service and making a quit attempt by deprivation decile.



Figure 61. Percentage of inpatients commencing a quit attempt by age

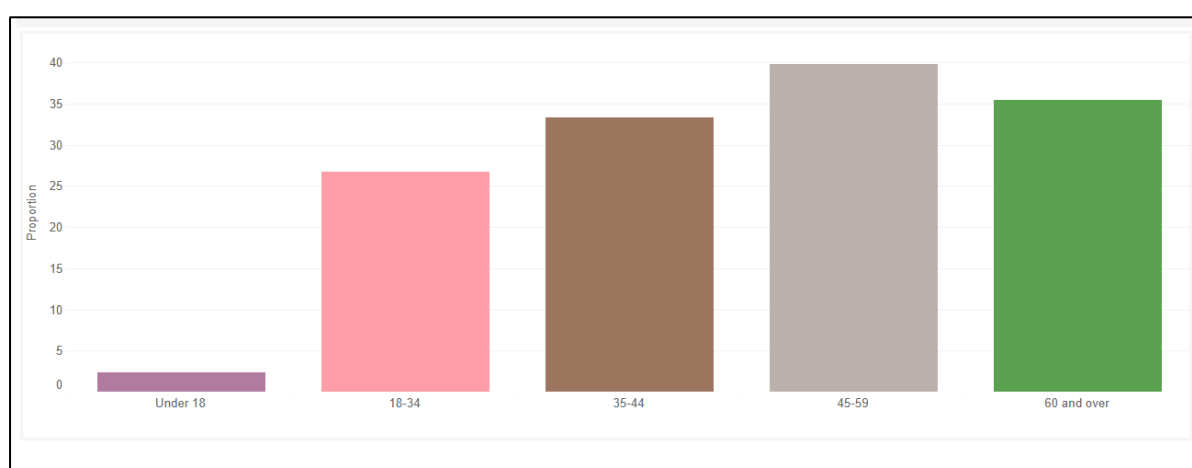


Figure 62. Percentage of inpatients commencing a quit attempt by Ethnic Group.

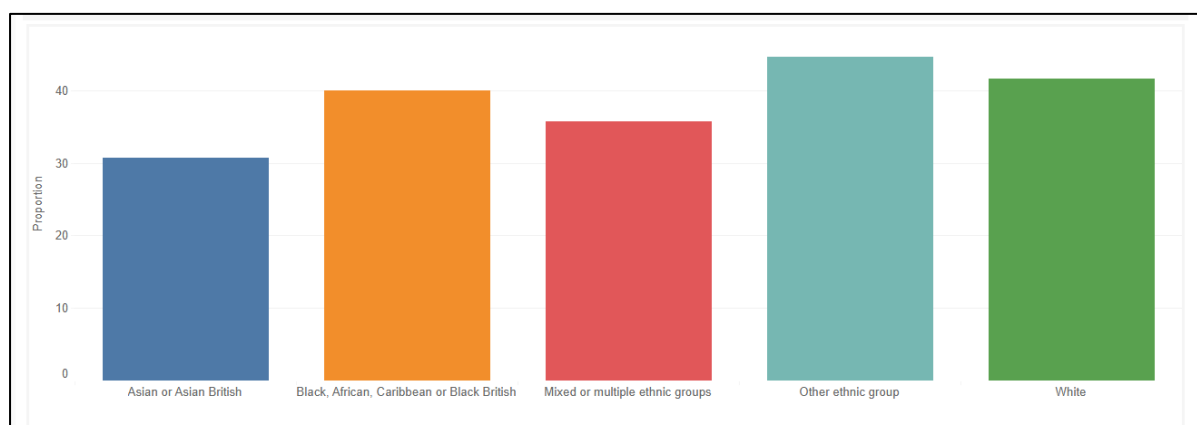
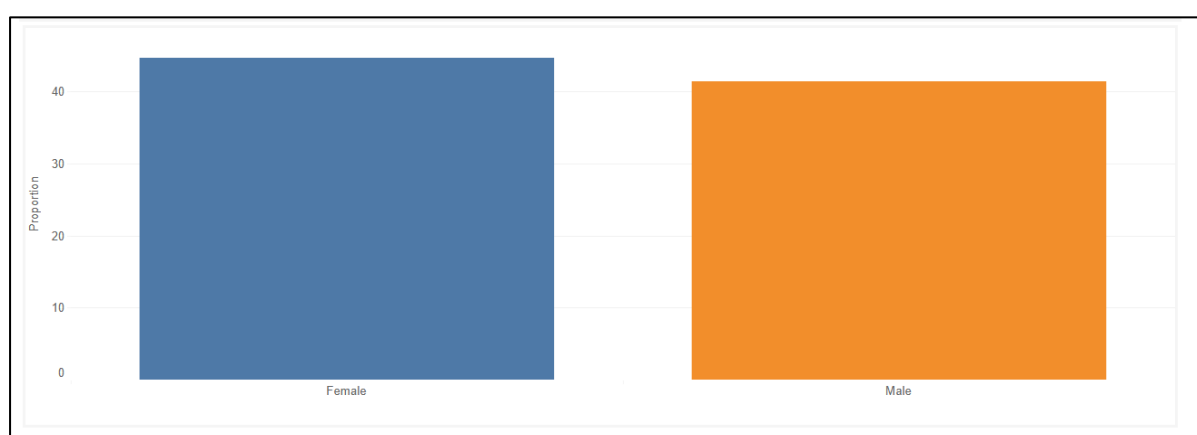


Figure 63. Percentage of inpatients commencing a quit attempt by gender



We recognise that capacity within our Treating Tobacco Dependency services is extremely challenging and that the capacity available to support all inpatient smokers is not sufficient. Despite this the data is demonstrating uptake and engagement by those populations who are at greatest risk of experiencing inequalities. As part of the approach to addressing capacity issues within the services the All Together Smokefree programme has commissioned a system review to identify how we use the entire capacity within the stop smoking system to support all smokers in Cheshire and Merseyside as effectively as possible. We are

10.2 Inequalities in inpatients who successfully quit smoking as measured at 28 days after commencing a supported quit attempt

The data on the proportion on patients who have successfully quit 28 days after commencing a quit attempt does demonstrate inequalities by deprivation decile with a higher proportion of smokers successfully quitting from deprivation quintile 5 (least deprived) compared to deprivation quintile 1 (most deprived) despite the overall number of quits being higher in deprivation quintile 1. It is recognised that there have been challenges in securing outcome data from community services so there is a risk this is a reporting issue rather than a true inequality. This is also reflected in the ethnic group data where the proportion of patients who have successfully quit

smoking as measured at 28 days after commencing a supported quit attempt is much lower in all other ethnic groups compared to the white ethnic group. Again this could be a reporting issue rather than a true picture of 28 day quit rates across different ethnic groups.

Figure 64. Inpatients identified as smokers, referred to tobacco dependency services, seen by the service, making a quit attempt and successfully quitting after 28 days by deprivation decile.



Figure 65. Percentage of inpatients who have quit smoking as measured at 28 days after commencing a supported quit attempt by age

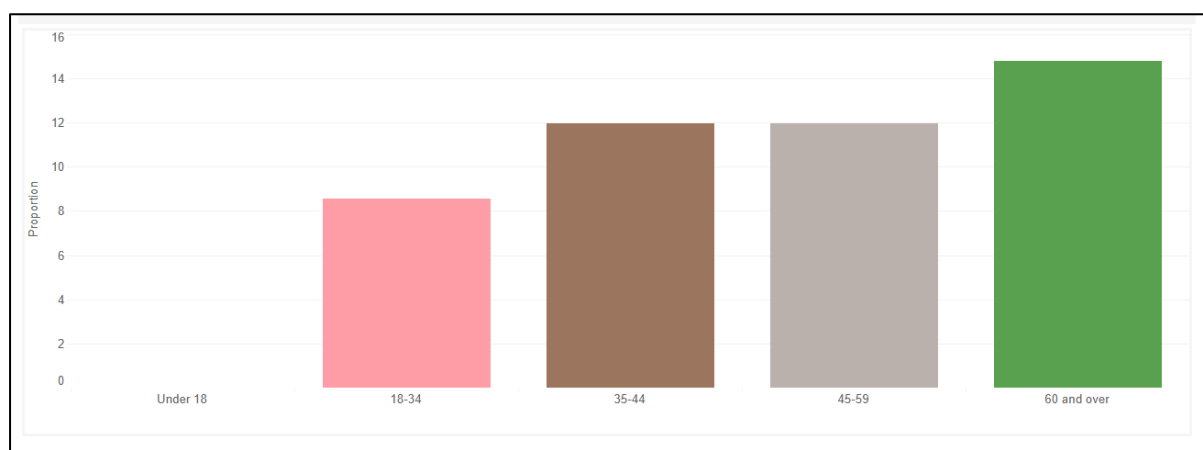


Figure 66. Percentage of inpatients who have quit smoking as measured at 28 days after commencing a supported quit attempt by ethnic group

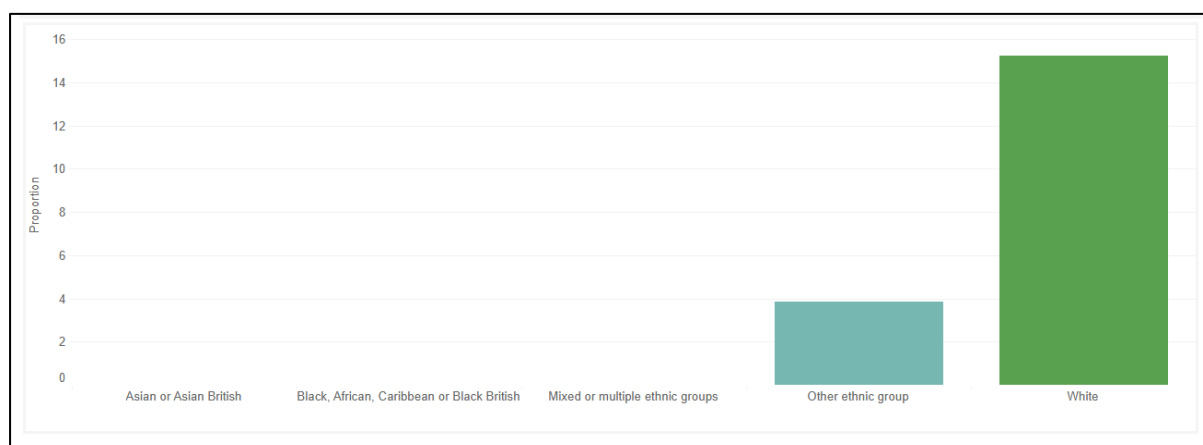
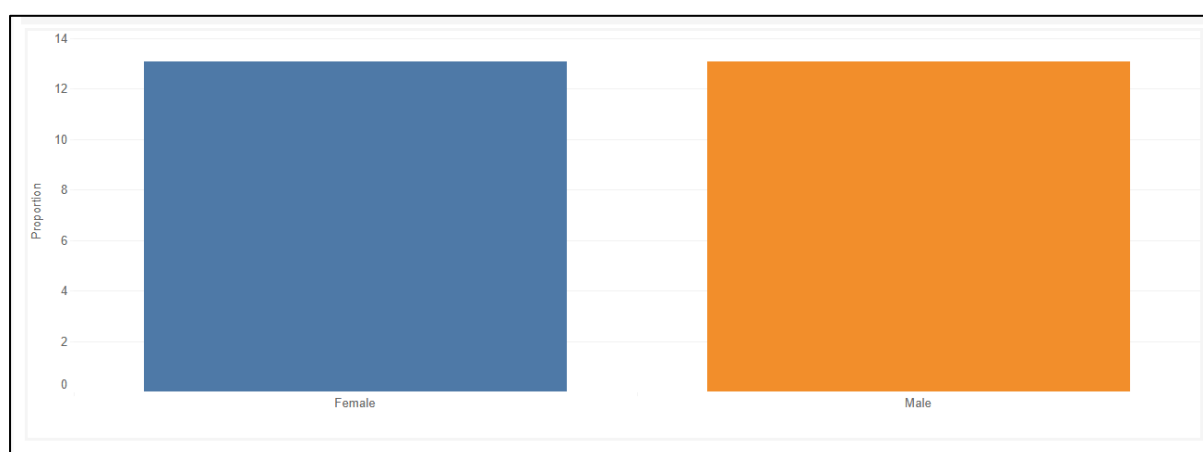


Figure 67. Percentage of inpatients who have quit smoking as measured at 28 days after commencing a supported quit attempt by gender

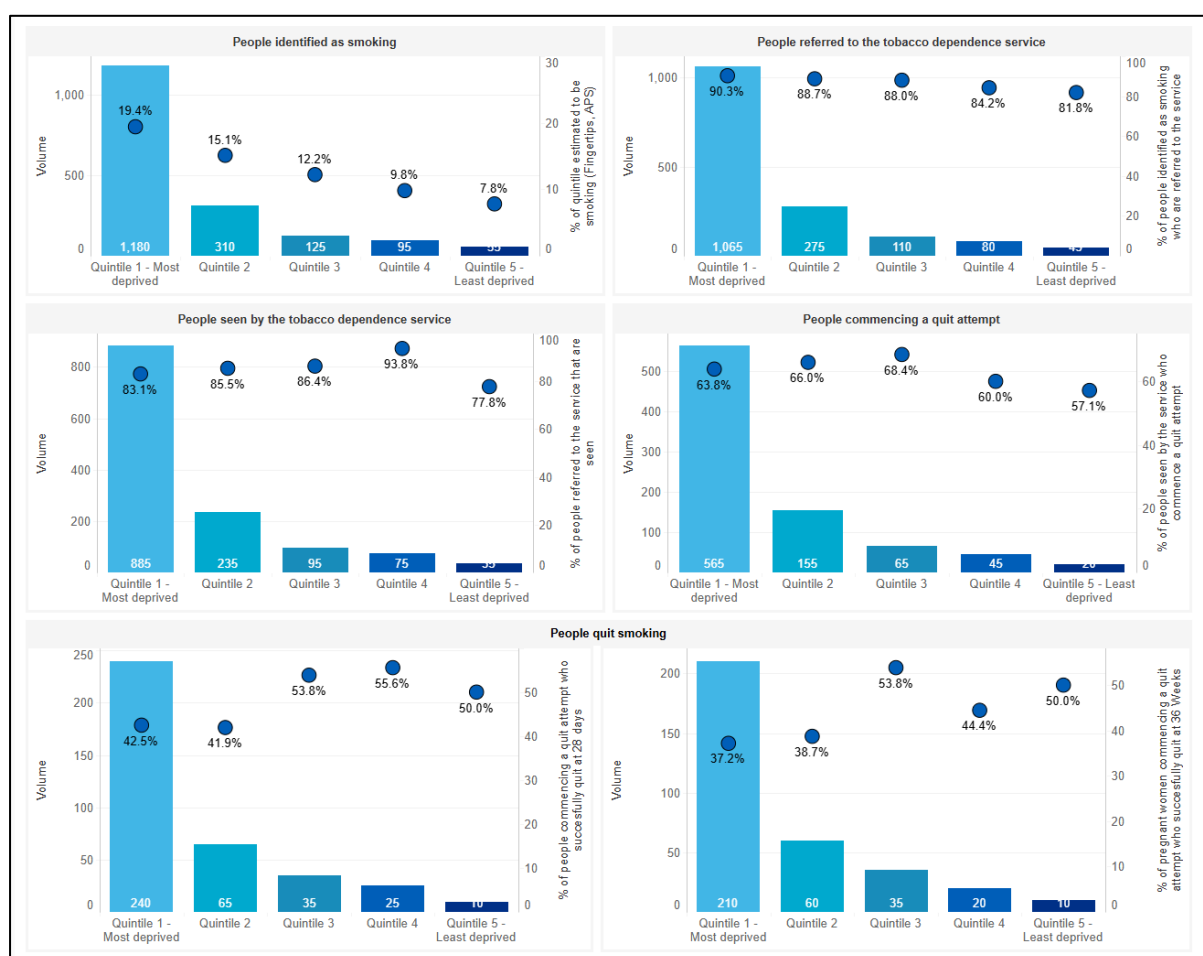


10.3 Inequalities in percentage of pregnant women identified as smokers at antenatal booking who are identified as non-smokers at 36 weeks gestation*

The data in the chart below clearly demonstrates that the highest proportion of pregnant women identified as smokers live in quintile one most deprived (19.4%) compared to quintile five least deprived (7.8%). Referral rates are then highest in quintile one where 90.3% of the identified smokers are referred for support compared to 81.8% in quintile five. The proportion of pregnant women seen by the TTD service then remains high in quintile one (83.1% compared to quintile five (77.8%) and when making a quit attempt (63.8% in quintile one compared to 57.1% in quintile five). But converting quit attempts into quit rates is where inequalities start to develop with only 42.5% of pregnant smokers in quintile one beginning at 28 days compared to 50% in deprivation quintile five and this then reducing further by 36 weeks to 37.2% of pregnant smokers remaining quit in deprivation decile one compared to 50% still quit in deprivation decile five.

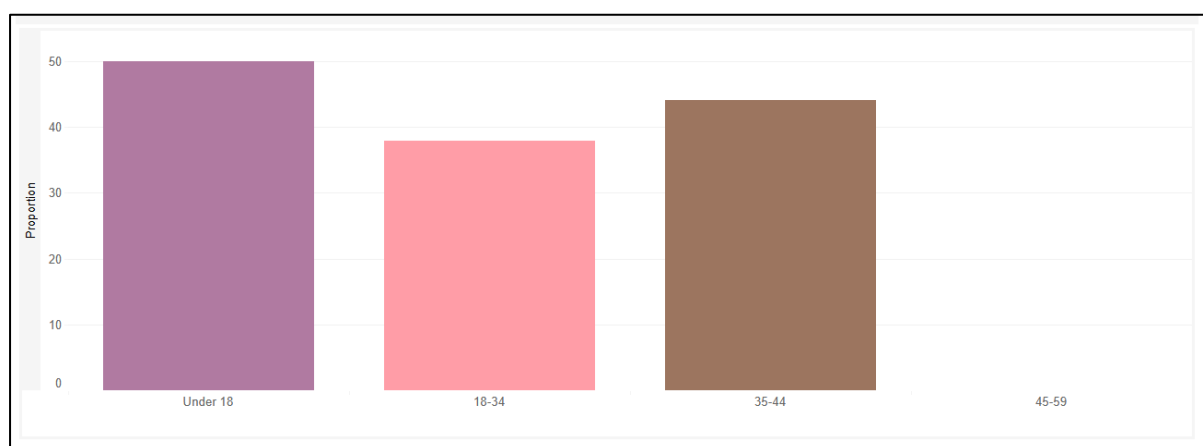
It should be recognised that overall the number of pregnant women who have successfully quit at 28 days and 36 weeks is much higher in quintile one at 240 and 210 respectively compared to 10 in quintile five and quitting smoking can be challenging when living in a complex social situation which many of the pregnant women in deprivation decile one will find themselves in. Overall quit rates in pregnant smokers have improved significantly and this is due to the hard work of the inhouse maternity TTD services and the support and guidance of the NHS Cheshire and Merseyside Women's and Maternity programme.

Figure 68. Percentage of pregnant women identified as smoking, referred to TTD services, seen by TTD services, commencing a quit attempt and being quit at 28 days and 36 weeks by deprivation decile.



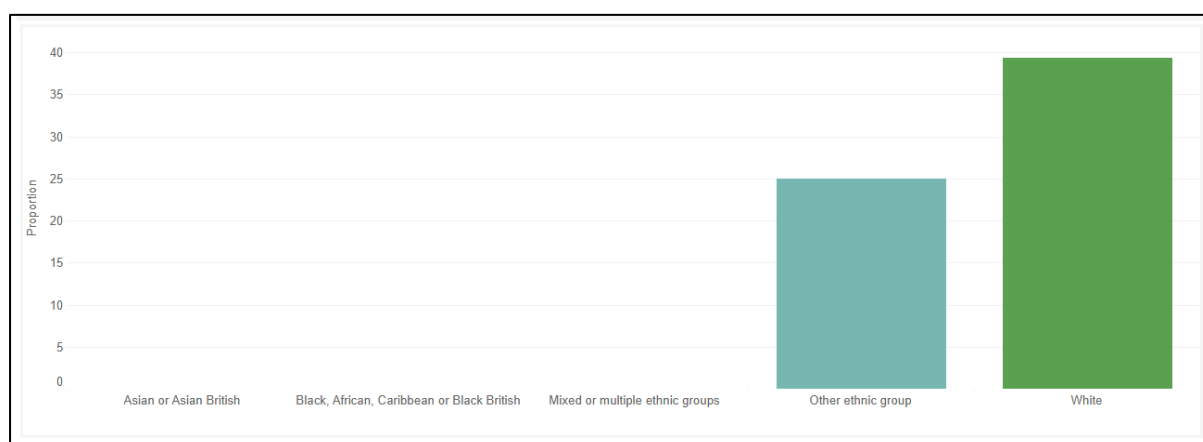
The quit rate for pregnant women at 36 weeks is highest among the under 18s (50%) followed by women aged 35-44 at 44.1% and then women aged 18-35 at 37.9%.

Figure 69. Percentage of pregnant women quit at 36 weeks by age.



The quit rate for pregnant women at 36 weeks is highest among white women at 39.4% followed by other ethnic group at 25%.

Figure 70. Percentage of pregnant women quit at 36 weeks by ethnic group.

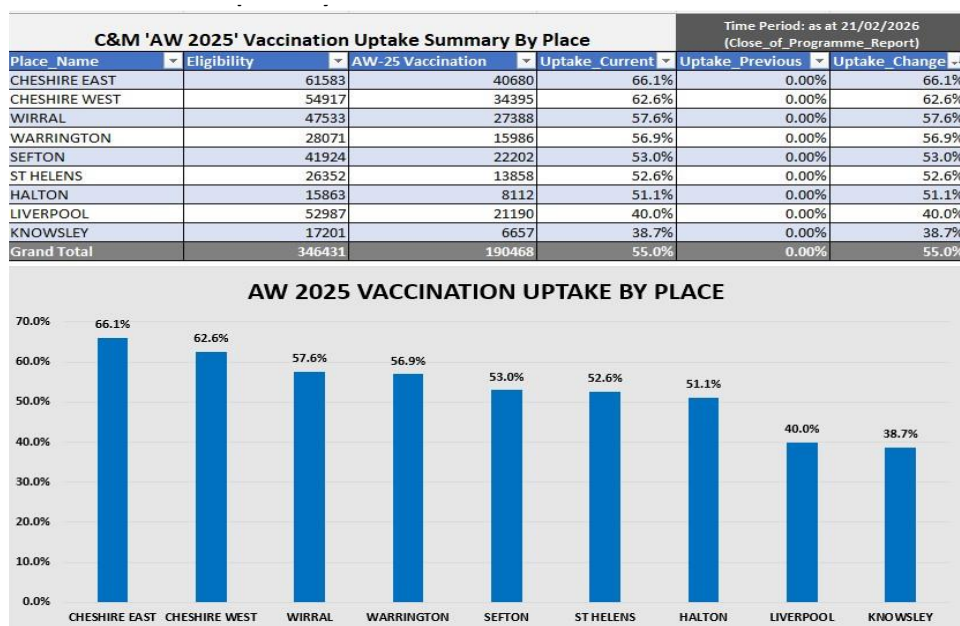


11. Vaccines

11.1 inequalities in uptake of COVID and flu vaccines

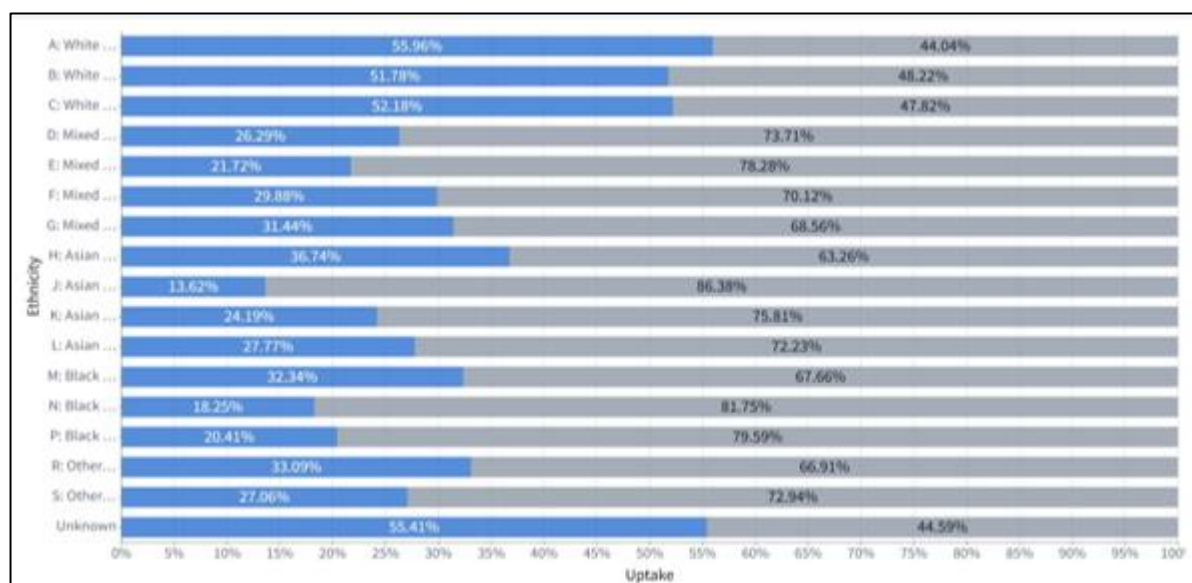
COVID-19 vaccination uptake during the Autumn and Winter period of 2025/26 has identified significant variation in across different groups and geographical areas. COVID-19 vaccination uptake ranged from 38.7% in Knowsley, one of our most deprived Places to 66.1% in Cheshire East one of our most affluent Places; however, it should be noted that there is also variation within Places. There is also wide variation in the absolute numbers needed to be vaccinated in each Place with activity ranging from 6,657 in Knowsley to 40,680 in Cheshire East.

Figure 71. COVID-19 Vaccination Uptake Autum and Winter 2025 by Local Authority.



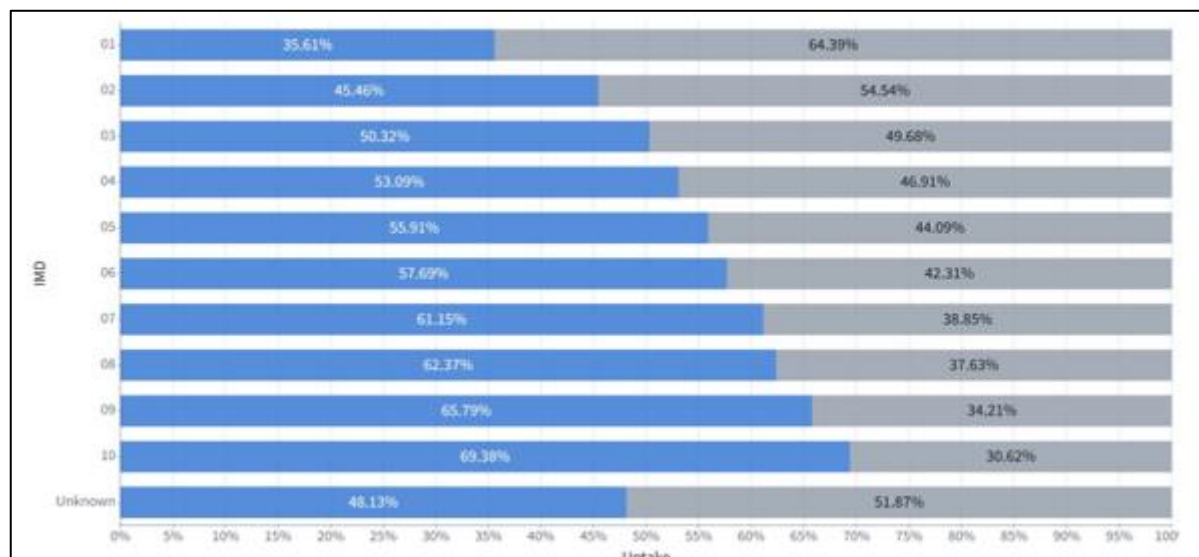
There was wide variation in COVID-19 vaccination uptake between ethnic groups. The highest uptake (where ethnicity is known) occurs in White British, White Irish, White Others and Asian/ Asian British Indian populations and the lowest uptake occurs in Asian/ Asian British Pakistani, Black/Black British African and Black/Black British Other.

Figure 72. COVID-19 vaccination uptake Autumn and Winter 2025 by ethnicity.



Where deprivation decile is known there is a direct correlation between uptake, with the least deprived populations having much higher vaccination uptake rates than the most deprived.

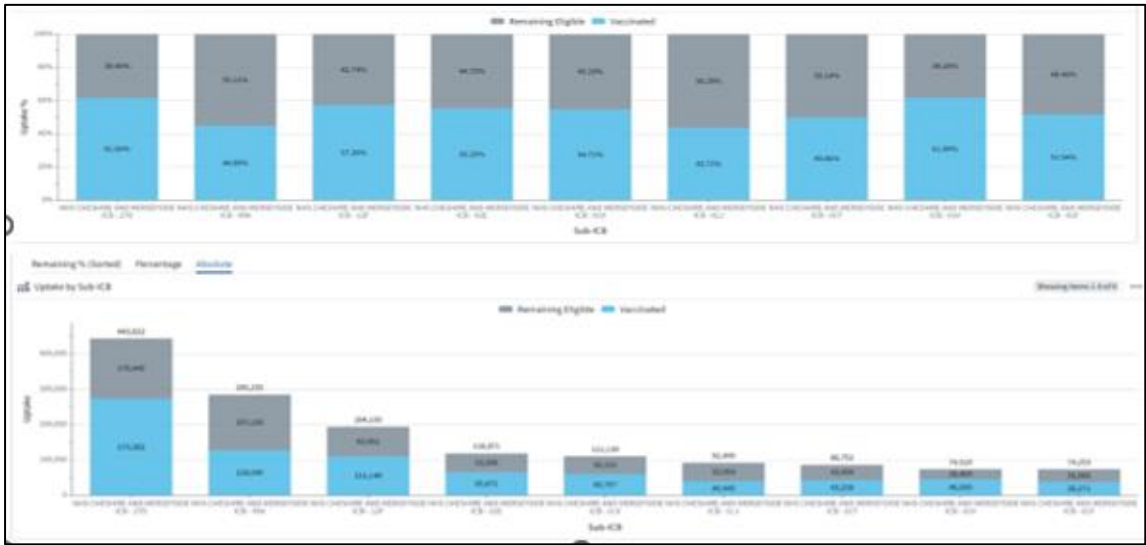
Figure 73. COVID-19 vaccination uptake Autumn and Winter 2025 by deprivation decile.



COVID-19 vaccination uptake in Autumn and Winter 2025 differs by ethnicity, Place and deprivation decile. Uptake has not significantly changed when compared to Autumn and Winter 2024. Whilst there is clearly room for improvement, it is encouraging that uptake has not decreased from the previous year particularly as local insight has shown that there is vaccine hesitancy for some of our population in relation to the COVID-19 vaccination.

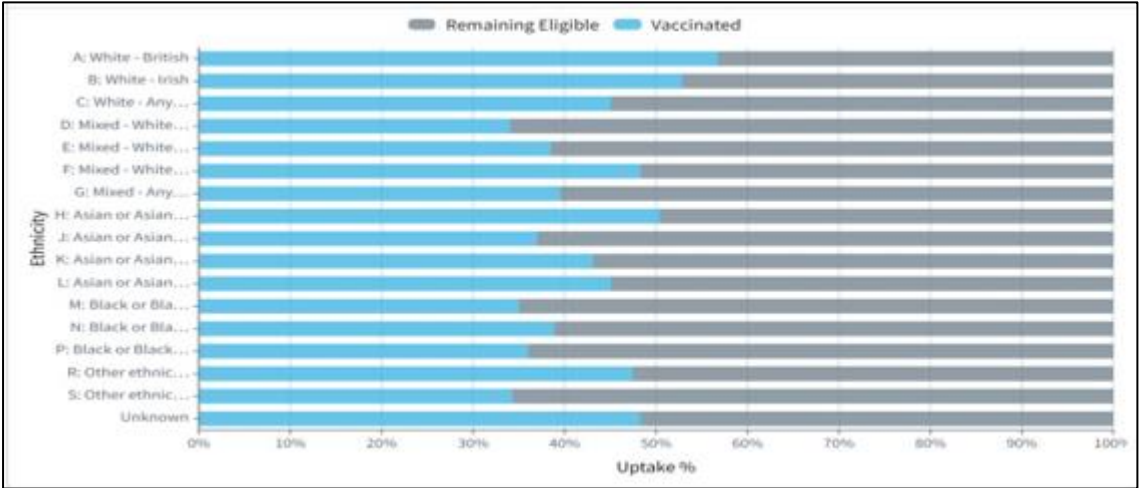
There is wide variation in Flu vaccination uptake between Places, uptake ranges from 43.7% (01J: Knowsley) to 61.8% (01V: Sefton). Whilst percentage uptake targets are helpful it is also helpful to look at absolute numbers. For example, whilst Cheshire has one of the highest vaccination uptake rates at 61.6%, it also has the highest number of unvaccinated people at 170,440.

Figure 74. Flu Vaccination Uptake Autumn and Winter 2025 by Local Authority.



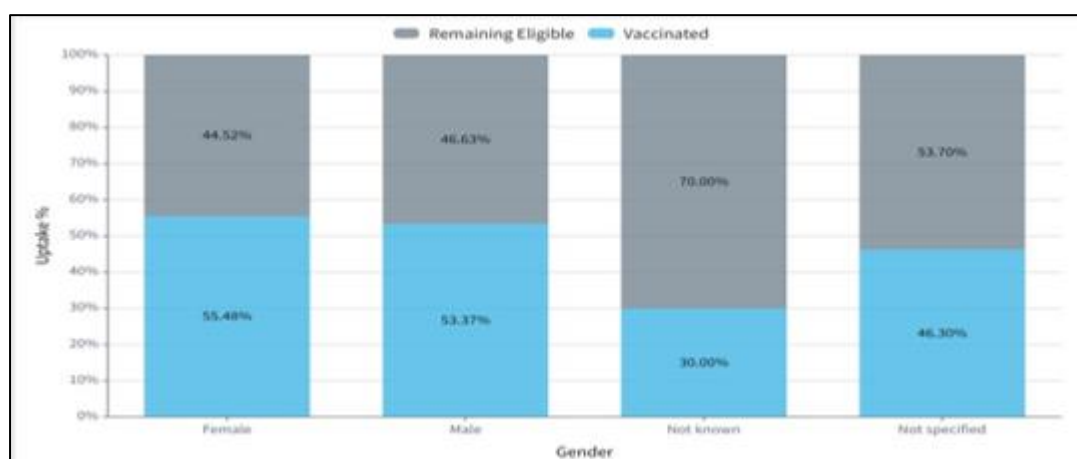
There is wide variation in Flu vaccination uptake in Cheshire and Merseyside between ethnic groups. The highest uptake (where ethnicity is known) occurs in White British, White Irish, White Others and Asian/ Asian British Indian populations and the lowest uptake occurs in Mixed White and Black Caribbean, Asian/ Asian British Pakistani and Black/Black British Other and Caribbean.

Figure 75. Flu Vaccination Uptake Autumn and Winter 2025 by Ethnicity.



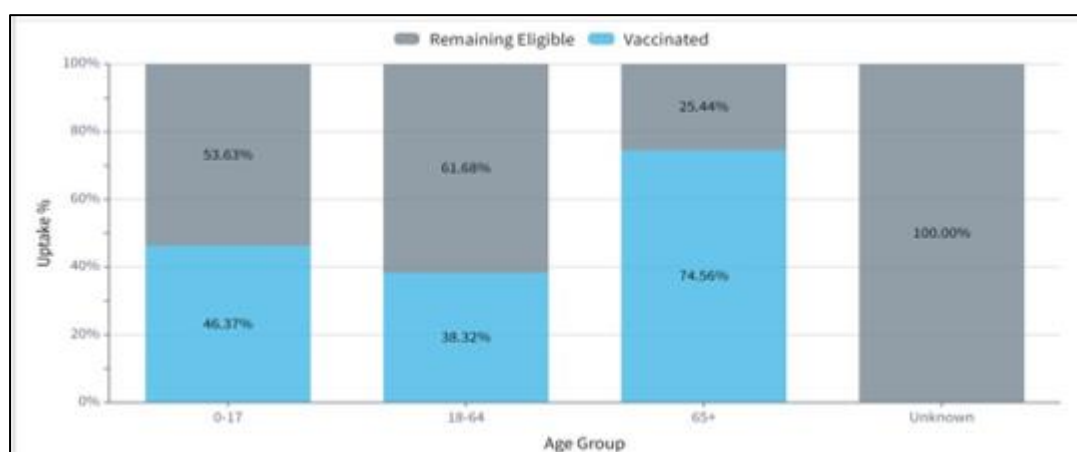
Where the gender of the patient is known uptake of the flu vaccination is slightly higher among females and males.

Figure 76. Flu Vaccination Uptake Autumn and Winter 2025 by Gender.



There is variation in uptake of the flu vaccination by age, highest uptake is in the older age groups with the lowest uptake in the 18-64 group which will typically include those who are clinically at risk and who are pregnant.

Figure 77. Flu Vaccination Uptake Autumn and Winter 2025 by Age.



Compared to the 24/25 winter campaign, flu vaccination uptake has improved across all ethnicities and in both genders which is encouraging. Whilst there has been little change in uptake for those aged 0-17 and 65 and over, there has been improvement in the 18–64-year-old age group from 32.6% in 24/25 to 38% in 25/26. Whilst this group includes those who are clinically at risk which has seen an increase on last year, this group also includes pregnant women; this year's uptake is 44% compared to 24/25 which was 25%.

Every season NHS Cheshire and Merseyside develop comprehensive COVID-19 and Flu vaccination plans to address variation in uptake and undertake targeted work alongside our NHS and Local Authority partners. Those delivering vaccinations are offered VaxChat training to support those who may be vaccine hesitant.

Focussed work was undertaken ahead of the last Flu vaccination campaign with all Maternity Providers to support vaccination of their patients. Whilst there is still more work to be done rates have significant improvement. The Lead Midwife for Health

Inequalities at the Cheshire and Merseyside Women’s Health and Maternity (WHaM) Programme, the Population Health team and NHSE as commissioners of the Flu vaccination programme will work together in 2026/27 to build on this work.

Vaccinations continue to be available in primary care as well as schools for the children and young people’s flu vaccination programme and are well publicised ahead of the campaign. Targeted communication work is undertaken with our colleagues in Local Authorities, Places and with the VCSFE sector to encourage uptake in all of our communities. In addition to this the Living Well bus offers an outreach model of vaccinations in various community venues throughout the season providing opportunistic vaccination delivery.

Throughout the season, the Population Health and Business Intelligence team have made COVID-19 and Flu vaccination uptake data available to Place and Local Authority partners in order for them to support local vaccination efforts and direct resources where they are most needed.

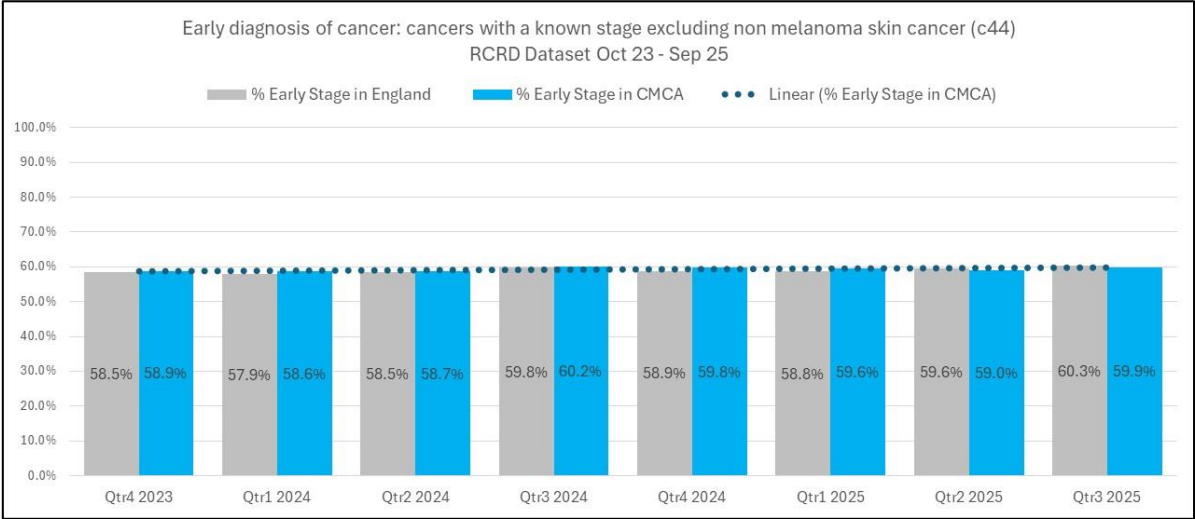
12. Cancer

12.1 inequalities in percentage of cancers diagnosed at stage 1 and 2

The NHS 10 Year Cancer Plan sets an ambition that by 2035, there will be at least a 20-percentage point increase above the 2019 level (54.2% for Cheshire and Merseyside) in people diagnosed with cancer at an early stage (stage one or two).

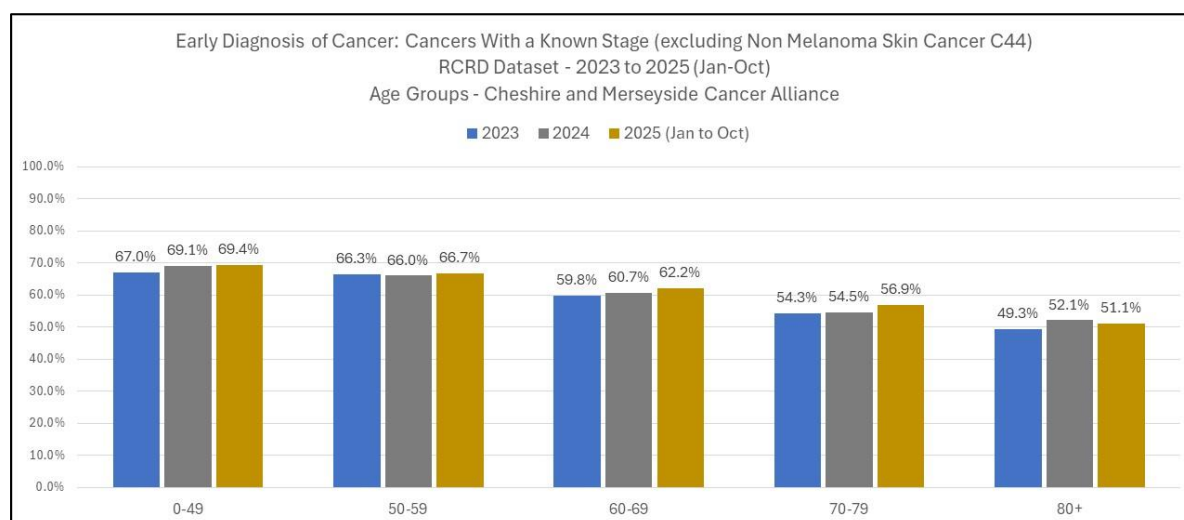
Over the past two years quarterly early diagnosis proportions have increased overall, **59%** of cancers in Cheshire and Merseyside were diagnosed at an early stage in the last two years, this is **statistically similar** to England (59%). Early diagnosis in Cheshire and Merseyside has increased from 58.9% in quarter four 2023 to 59.9% in quarter three of 2025 (calendar years).

Figure 78. Early Diagnosis of Cancer Over Time.



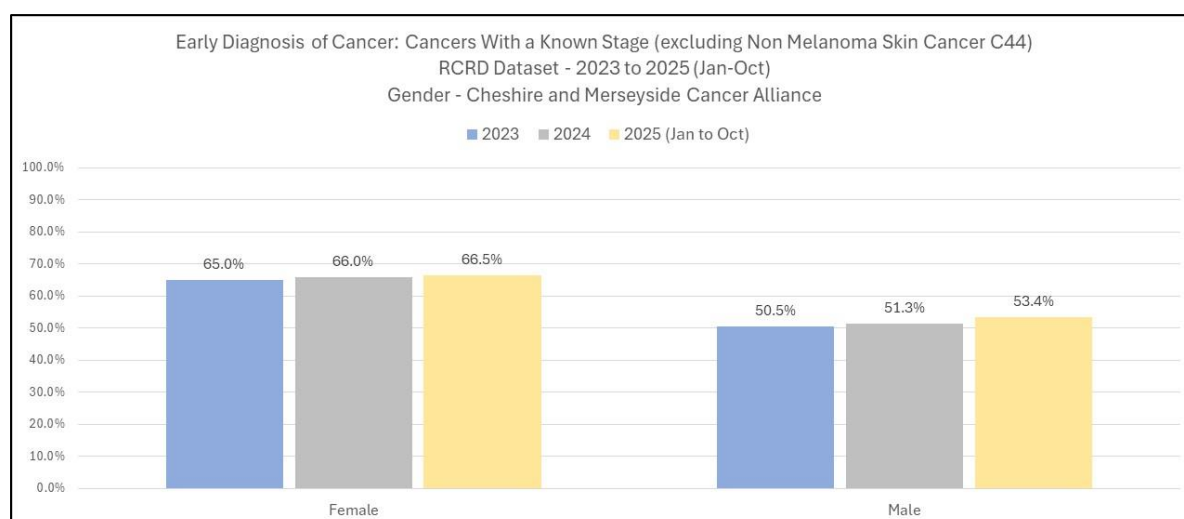
Early-stage cancer diagnosis is generally higher in younger age groups. This is strongly linked to the case mix of cancer types that differs by age. Whilst early-stage cancer diagnoses appear to be increasing in most age groups, this is less apparent for people aged 50-59 and people aged 80+.

Figure 79. Early Diagnosis of Cancer by age.



Early-stage cancer diagnosis is generally higher in females than in males. Again, this is linked to the case mix of cancer types that differs by gender. Whilst early-stage cancer diagnoses appear to be increasing for both males and females, this is more apparent for males.

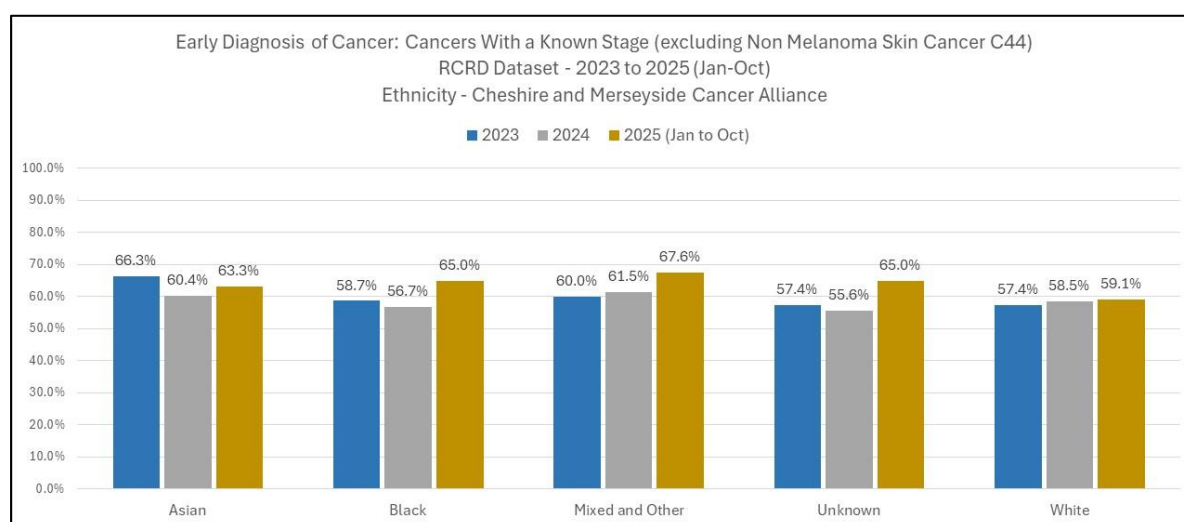
Figure 80. Early Diagnosis of cancer by gender.



Early-stage cancer diagnosis appears to be higher in non-white ethnic groups. Whilst early-stage cancer diagnoses appear to be increasing in black and mixed and other ethnic groups, care should be taken interpreting early stage cancer diagnoses by ethnicity, due to the lower case volumes for non-white ethnicities. These data are based on Rapid Cancer Registrations and more complete ethnicity data with will be

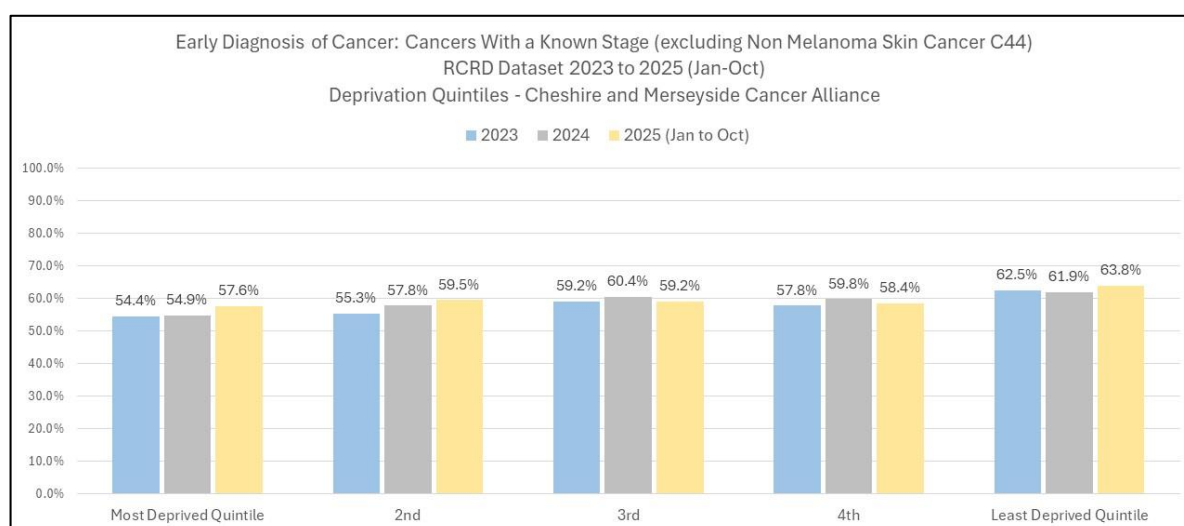
available in Annual Cancer Registrations (2023 annual data expected to be published late March 2026).

Figure 81. Early Diagnosis of Cancer by Ethnic Group.



Early-stage cancer diagnosis is generally higher in less deprived areas. Early-stage cancer diagnoses appear to have increased more in the most and second most deprived quintiles.

Figure 82. Early diagnosis of cancer by deprivation.



Cheshire and Merseyside Cancer Alliance and its partners have several data-led, action-focussed programmes and projects that are centred on increasing early-stage cancer diagnoses and reducing inequalities in early stage cancer diagnoses.

The **PRACTICE Dashboard** was developed by Cheshire and Merseyside Cancer Alliance to improve health outcomes through earlier cancer diagnosis and reduced health inequalities using intelligence-led action. This has allowed, for the first time, people working in the health system to access near real time data and triangulate

key cancer, demographic, deprivation and health inclusion data (such as learning difficulties, severe mental illness, asylum status, homelessness), enabling identification of inequalities and the assessment of the impact of improvement initiatives. PRACTICE has delivered measurable improvements in cancer screening access and uptake by enabling targeted, intelligence led action. For example, a PCN undertook a targeted cervical screening improvement project where analysis showed low rates of coverage, particularly amongst those who had never attended screening. This informed the introduction of extended access clinics across multiple GP clinics, supported by targeted social media advertising, resulting in a clear improvement in screening uptake in the PCN.

Cancer Awareness Campaigns have been developed and delivered for the Alliance's most at-need populations. Each campaign utilised in-depth insight from local stakeholders to create tailored messaging intended to elicit meaningful behaviour change. Areas of population inequality and tumours identified to be at greatest need included:

- Lung cancer screening,
- Bowel, breast and cervical screening,
- Anal cancer awareness for people living with HIV (for both black communities and for men who have sex with men),
- Head and neck cancer.

The campaign "Two Minutes of Chat and an Early Screening" (featuring actors Will Mellor and Ralf Little) ran in Halton – an area identified through data as having lower early diagnosis rates, high deprivation and inequality. The campaign encouraged people to talk about cancer screening and reduce fear associated with cancer. The campaign won multiple awards and evaluation found it had been seen by 58% of people in Halton, with up to 25% gaining increased knowledge of what is involved with NHS cancer screening.

The **Lung Cancer Screening** programme is now live in 7 of 9 Cheshire and Merseyside Places and plans are in place to mobilise in the remaining 2 Places. Rollout has been informed and prioritised by intelligence on areas with greatest inequalities, as lung cancer risk is strongly linked to deprivation and smoking. Over 700 lung cancers have been detected, with over 80% found at an early stage – compared with 34% prior to the Lung Cancer Screening Programme (2019). This switch enables substantially more patients to receive curative treatment and improves the lives of patients and their families.

The **Screening and Immunisation Collaboration and Insights Group** continued to operate as a sub-group of the NHS Cheshire and Merseyside Population Health Partnership. The group took a key leadership role in increasing uptake and reducing inequalities in the national cancer screening programmes (bowel, breast and cervical) and HPV vaccination, through shared intelligence from the PRACTICE dashboard and provided a forum for sharing evaluations of projects to improve screening rates. These included:

- A project to improve screening rates amongst people experiencing homelessness in Liverpool – in response to a need identified through examining PRACTICE dashboard data.
- A project to improve HPV vaccination uptake in females up to the age of 25 and men who have sex with men up to the age of 45. Substantial work has enabled access to near real time data (via GP records, Child Health Information Systems and proxy measures through local sexual health clinics) which will be used to inform health inequality-led implementation of initiatives to improve uptake.

PCN-led multi-modal working and system collaboration (MASC) focussed on driving earlier cancer detection in identified high-risk populations experiencing overweight and obesity. In Central and West Warrington PCN, patients living with these high-risk symptoms of cancer who would not normally engage with health services were identified and engaged via alternative interactions, such as one-stop clinics. This was coupled with clinical and non-clinical education to PCN staff to raise awareness of obesity-related cancer risk factors.

The **Community Partnerships Programme** worked directly with Community and Voluntary Sector organisations and Social Action Leads in communities of highest inequality for nearly three years. There was specific focus on working with grassroots networks (such as art groups, schools and libraries) to empower local people to take ownership of cancer messaging, including signs and symptoms messaging, cancer screening, and prevention. There is ongoing quantitative and qualitative reporting of engagement, including using case studies of directly measurable impact and around 48,000 meaningful interactions with community members attained over the past two years. The Community Partnerships Programme won the “Best Health Creating Cross-Sector Programme” at the 2025 Health Creation Alliance awards.

The **impact of patient storytelling** by CMCA Patient Representatives has been measurable in a variety of settings. Storytelling at events ranging from local wellbeing events to NHS boards and away days led to media coverage, service reviews to ensure more inclusive services and actions such as more accessible blood tests and screening appointments for people with mobility issues. Some participants who experienced storytelling then report booking outstanding cancer screenings. CMCA were winners of the Personalisation of Care Picker Experience Network Award for using patient storytellers to create significant change and deliver identifiable improvements to patient experience.

13. Cardiovascular disease

Cardiovascular disease is a major contributor to premature mortality and health inequalities in Cheshire and Merseyside. In line with the NHS 10-Year Health Plan, the ICB has made CVD prevention a core priority, with a clear ambition to improve outcomes through systematic action on Atrial Fibrillation, Blood Pressure and Cholesterol (ABC). By shifting focus from reactive treatment to proactive prevention, and targeting support to communities at highest risk, the ICB aims to reduce avoidable heart attacks and strokes, narrow inequalities, and improve cardiovascular health across the population over the next decade.

13.1 inequalities in emergency admissions for stroke

In the last 12 months (Feb 25 – Jan 26) there were 5,175 non-elective emergency admissions for stroke, a 6.4% reduction on the previous period. The average length of stay is approximately 17.7 days – 3% reduction on last year's activity (2024/25).

Table 6. Number of non-elective emergency admissions for Stroke.

	Total NEL	Total LoS	Average LoS
2023/24	5,476	96,993	17.7
2024/25	5,527	100,405	18.2
Last 12m Feb25-Jan 26	5,175	91,649	17.7
% change from previous year	-6.4%		-3%

More men (52.7%) were admitted into hospital with stroke than females (47.3%). However, when split by age group, 79% of females aged 65+ are admitted compared to 68.1% of males aged over 65 years.

Table 7. Number of non-elective emergency admissions for Stroke by gender and age group.

	Male						Female					
	under 18	18-25	26-39	40-54	55-64	65+	under 18	18-25	26-39	40-54	55-64	65+
2023/24	5	8	57	270	504	2034	4	3	23	153	296	2119
2024/25	7	3	51	267	549	1992	4	3	40	213	301	2097
Last 12m Feb25-Jan 26	3	6	58	295	507	1858	7	6	38	175	287	1934
%	0.1%	0.2%	2.1%	10.8%	18.6%	68.1%	0.3%	0.2%	1.6%	7.2%	11.7%	79.0%

More than a quarter (28%) of those admitted for stroke live in the most deprived areas in Cheshire and Merseyside. The proportions vary for quintile 2-5 with the second highest proportion of stroke admissions seen in quintile 5 with 22%.

Table 8. Number of non-elective emergency admissions for Stroke by deprivation Quintile.

	1	2	3	4	5	N/A	Total
2023/24	1536	747	711	886	1166	430	5476
2024/25	1487	721	669	852	1241	557	5527
Last 12m Feb25-Jan 26	1467	708	641	779	1117	463	5175
%	28%	14%	12%	15%	22%	9%	100%

Table 9. Number of non-elective emergency admissions for Stroke by ethnic group.

	Asian	Black	Mixed	Other	Unknown	White	#N/A	Total
2023/24	21	36	16	57	380	4,762	204	5,476
2024/25	31	35	17	57	499	4,687	201	5,527
Last 12m Feb25-Jan 26	28	33	19	77	476	4,327	215	5,175
%	1%	1%	0%	1%	9%	84%	4%	100%

Eighty-four percent of those who are admitted with stroke are of White British origin; 13% of inpatient records have ethnic origin status as either unknown or not available to code.

13.2 inequalities in emergency admissions for myocardial infarction

In the last 12 months (Feb 25 – Jan 26) there were 3,281 non-elective emergency admissions for myocardial infarction (heart attack), a 5.9% reduction on the previous period. The average length of stay is approximately 6 days 0.4% increase from last year's activity (2024/25).

Table 10. Number of non-elective emergency admissions for myocardial infarction.

	Total NEL	Total LoS	Average LoS
2023/24	2,866	18,002	6.3
2024/25	3,488	20,700	5.9
Last 12m Feb25-Jan 26	3,281	19,548	6.0
% change from previous year	-5.9%		0.4%

Almost two thirds (65%) of myocardial infarction emergency admissions are males compared to 35% females and similarly more females aged over 65 years 69.6% compared to 57.2% males

Table 11. Number of non-elective emergency admissions for myocardial infarction by gender and age group.

	Male					Female				
	18-25	26-39	40-54	55-64	65+	18-25	26-39	40-54	55-64	65+
2023/24	1	28	226	419	1114	1	10	81	191	795
2024/25	1	39	337	568	1287	1	15	107	271	862
Last 12m Feb25-Jan 26	0	34	341	538	1221	0	10	97	242	798
%	0.0%	1.6%	16.0%	25.2%	57.2%	0.0%	0.9%	8.5%	21.1%	69.6%

Similar patterns are evident in those admitted for myocardial infarction broken down by IMD quintile with (28%) residing in Quintile 1 and again the second highest proportion can be seen in quintile 5 (least deprived).

Table 12. Number of non-elective emergency admissions for myocardial infarction by deprivation Quintile.

	1	2	3	4	5	N/A	Total
2023/24	780	432	336	475	643	200	2866
2024/25	1046	498	390	533	706	315	3488
Last 12m Feb25-Jan 26	919	531	389	511	666	265	3281
%	28%	16%	12%	16%	20%	8%	100%

Eight four percent of patients admitted with Myocardial Infarction are of White British origin; 14% inpatient records of ethnic origin status is either unknown or not available to code

Table 13. Number of non-elective emergency admissions for MI by ethnic group.

	Asian	Black	Mixed	Other	Unknown	White	#N/A	Total
2023/24	21	8	6	40	167	2,498	126	2,866
2024/25	23	12	8	47	169	2,935	294	3,488
Last 12m Feb25-Jan 26	29	11	12	37	158	2,743	291	3,281
%	1%	0%	0%	1%	5%	84%	9%	100%

There is a higher percentage of Stroke and Myocardial Infarction admissions in males than females. However, the percentage is higher for females when looking at admissions for those aged 65 and over. This can be explained by a combination of higher life expectancy in females, loss of the protective effect of oestrogen post menopause, some under recognition of CVD earlier on in women and higher rates of premature mortality in men. Earlier this year the Population Health team presented at a global Stroke conference which had spotlight sessions on CVD prevention and women and the importance of raising awareness of symptoms and early diagnosis.

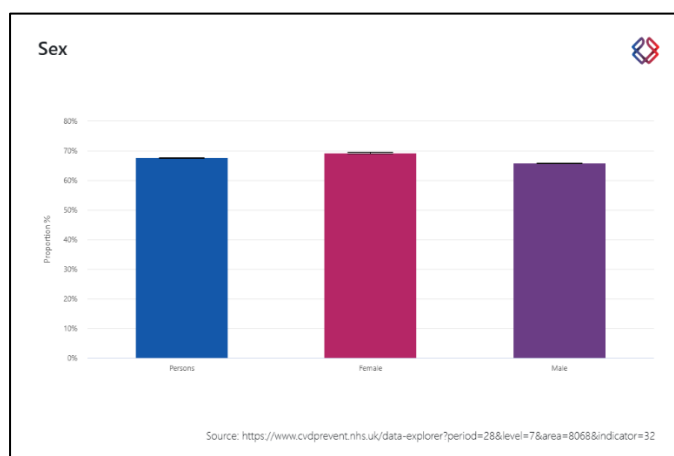
The data also demonstrates that both deprived and more affluent populations experience the burden of CVD. The more deprived because of higher prevalence of lifestyle risk factors such smoking, poor diet and obesity and modifiable clinical risk factors such as atrial fibrillation (A), hypertension (B – blood pressure) and high cholesterol (C). High blood pressure is considered one of the strongest predictors for stroke, heart failure, and coronary heart disease if it is not appropriately detected, managed and treated to target.

13.3 inequalities in percentage of hypertension patients treated to target

The Cheshire and Merseyside CVD Prevention programme has focussed on the management of high blood pressure and cholesterol in primary care as a key workstream during 25/26.

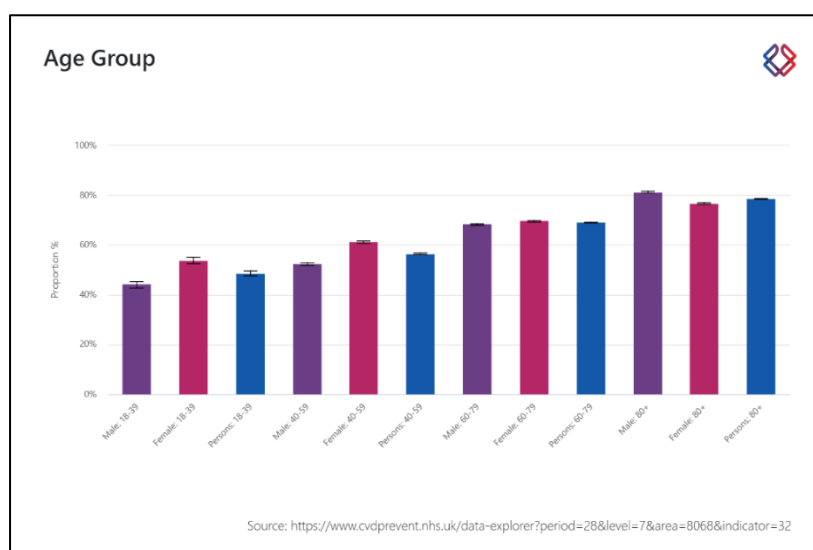
In Cheshire and Merseyside more than two thirds (67.4%) of people with hypertension are treated to appropriate thresholds in the previous 12 months. The achievement varies slightly when split by gender with slightly more females (69.6%) treated to target compared to males (65.7%).

Figure 83. CVDP007HYP: Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months.



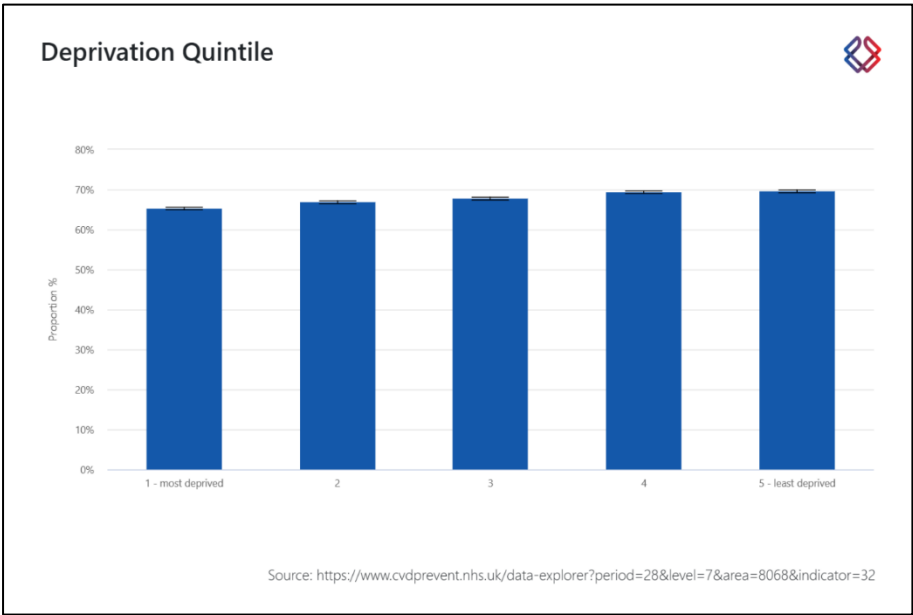
When exploring treated to target threshold by age group, the highest achievement can be seen in those aged 80+ with 78.4% with more males (81%) than females (76.3%) achieving this target. The younger age groups i.e. 18-39 years have the lowest achievement score with 43.9% for males and 53.7% for females.

Figure 84. CVDP007HYP: Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months by age group.



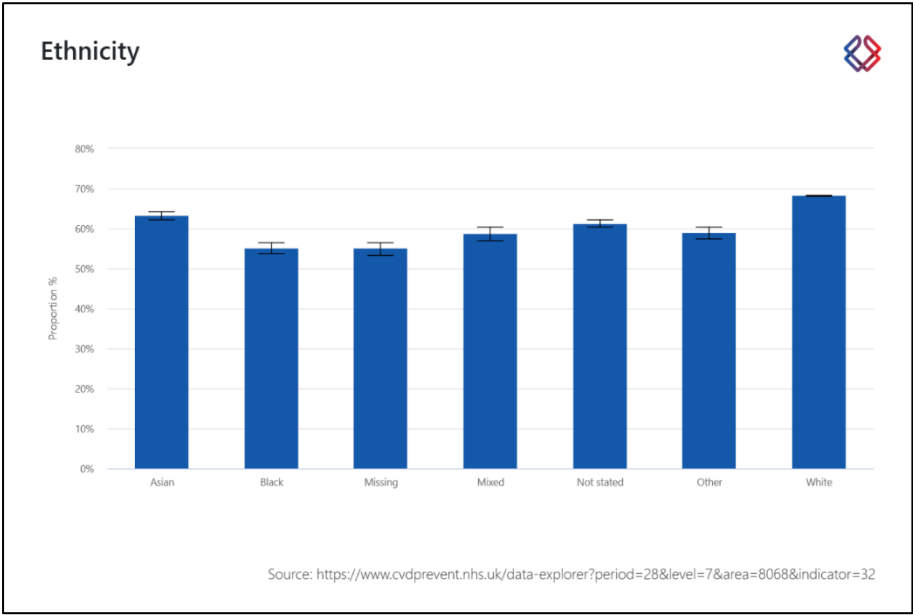
The data below data describes that people who live in the most deprived areas of Cheshire and Merseyside have the lowest treatment to target with 65.2% in Quintile 1 compared to 69.5% in the Quintile 5 (least deprived)

Figure 85. CVDP007HYP: Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months by IMD.



People with hypertension and treated to target split by ethnicity shows some variation with the highest proportion (68.1%) treated to target observed in the White British ethnic group, the second highest achievement scores can be seen in the Asian British population with 63.1% treated to appropriate thresholds. The lowest can be seen in the Black British Caribbean/African ethnic group with 55.1% achievement.

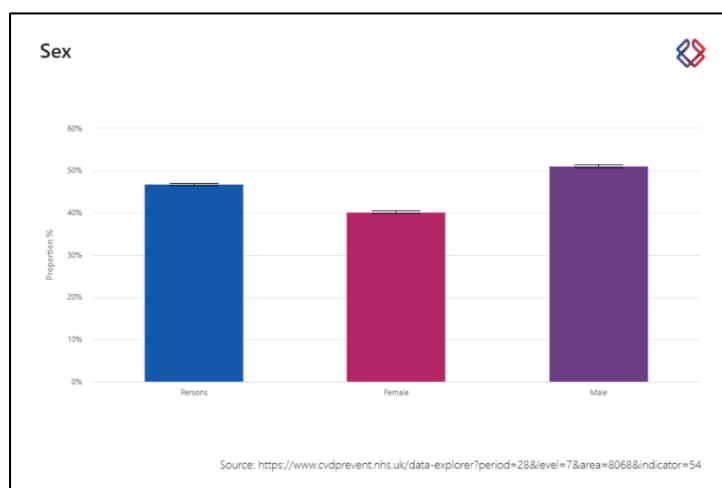
Figure 86. CVDP007HYP: Patients with GP recorded hypertension, whose last blood pressure reading is to the appropriate treatment threshold, in the preceding 12 months by ethnic group.



13.4 inequalities in percentage of hypertension patients managed to target for cholesterol

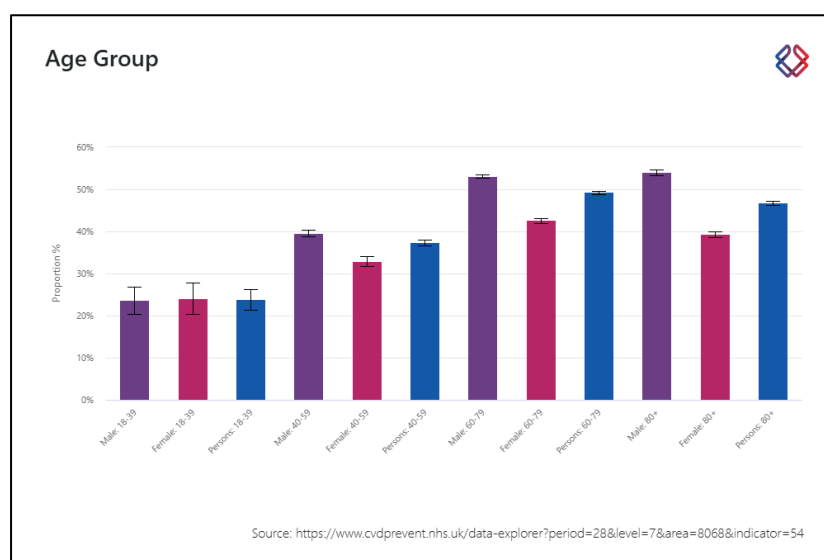
In Cheshire and Merseyside less than half (46.7%) of all people with CVD have their cholesterol treated to the target threshold. When split by gender, performance achievement is higher in males with 51% and in females it is 40%

Figure 87. CVDP012CHOL: Patients treated to cholesterol threshold.



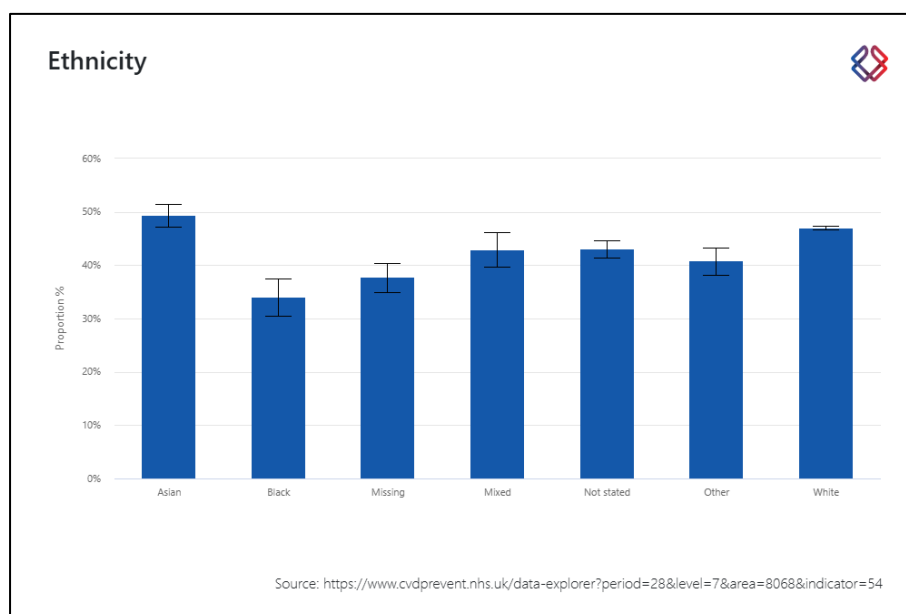
When split by age group males aged 80+ have the highest performance with 54% whereas, females across all age groups consistently have the lowest performance; in particular the 18–39-year group (24%) are not treated to the target threshold.

Figure 88. CVDP012CHOL: Patients treated to cholesterol threshold by age group.



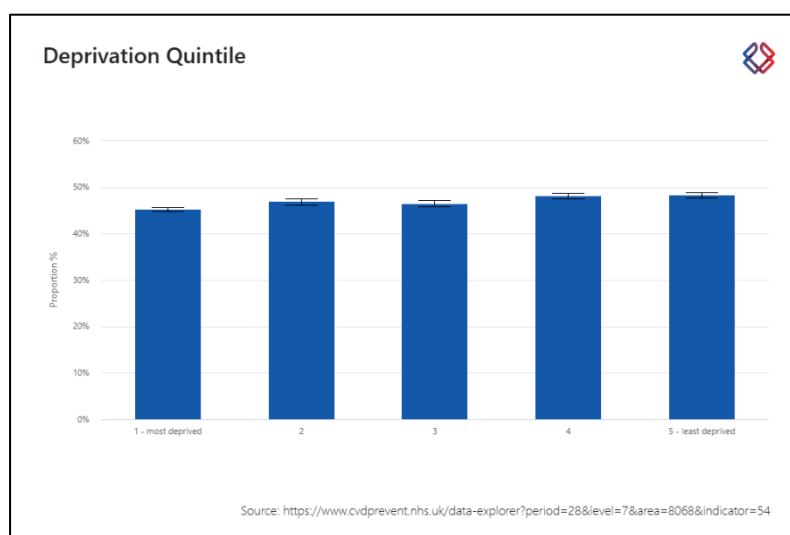
People who are Asian British have the highest performance with 49.3% treated to the target threshold. Those from Black British Caribbean/African ethnic group have the lowest achievement score with 34%. It is important to note that for 40% of records ethnicity is either missing or not stated.

Figure 89. CVDP012CHOL: Patients treated to cholesterol threshold by ethnic group



Those that live in the most deprived parts of Cheshire and Merseyside have the lowest cholesterol treated to target threshold at 45% with those who reside in the least deprived at 48.3%.

Figure 90. CVDP012CHOL: Patients treated to cholesterol threshold by IMD Quintile



13.5 inequalities in percentage of patients who are managed to target for atrial fibrillation

In Cheshire and Merseyside over 90.6% of patients with Atrial Fibrillation are treated with a Direct-acting Oral Anticoagulant (DOAC). When split by gender the achievement scores are similar with 90.4% for females and 90.7% for males.

Males ages 18-39 years who are prescribed a DOAC have a higher achievement score with 82.6% compared to females of the same age group (51.4%). However, it

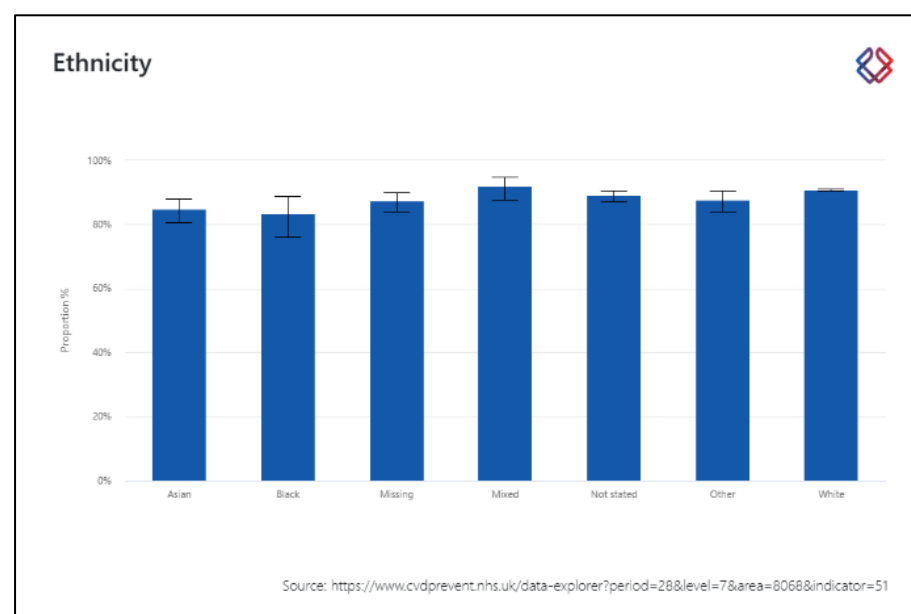
is important to note the numbers are relatively small for this cohort accounting for the variation in performance. 85.9% of males aged 40-59 have a higher achievement score compared to females 80.6% conversely, both males and females in the older age groups 60+ have similar performance.

Table 14. CVDP005AF: Patients Atrial Fibrillation treated with DOAC by age group

	Male	Female
18-39	82.6	51.4
40-59	85.9	80.6
60-79	91.3	91.5
80+	90.3	90.2

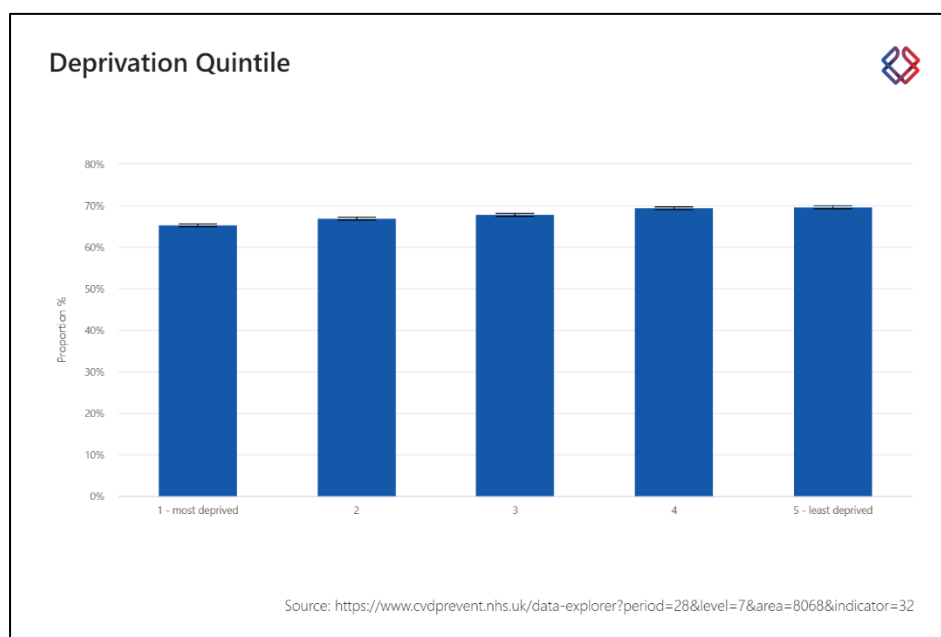
When exploring persons with AF and prescribed a DOAC by ethnic group, performance does vary. The mixed ethnic group has the highest performance with 92% prescribed a DOAC, and people from the Black British Caribbean/ African ethnic group have the lowest performance with 83.2%.

Figure 91. CVDP005AF: Patients Atrial Fibrillation treated with DOAC by ethnic group.



There is limited variation in those who are prescribed a DOAC by deprivation quintile ranging from 90.5% in Quintile 1 compared to 90.2 in Quintile 5.

Figure 92. CVDP005AF: Patients Atrial Fibrillation treated with DOAC by IMD Quintile



As per the data there are inequalities in key CVD metrics relating to ABC. During 25/26 targeted efforts have been undertaken in relation to hypertension with a particular focus on reducing inequalities relating to deprivation.

There is lots of work being undertaken in general practice, community pharmacy, our VCSFE sector and local communities to detect people with hypertension in pockets throughout Cheshire and Merseyside. Using local data priority has been to those GPs/ PCNs where inequalities are greatest and where expected prevalence is lower than the system average.

The Health Inequalities Hypertension Detection and Treatment to Target (TtT) in General Practice programme targeted the poorest performing practices in IMD 1-3. Themes included

- Coding – incorrect or missing codes, too much choice from coding library
- Staffing – Pharmacy and other roles under utilised
- Leadership – practices with a CVD Prevention lead do much better
- Lack of awareness of Population Health Management tools

Following participation, practices had on average a further 5 – 10% patients that were prescribed and treated for hypertension but not on the register or on the register and not prescribed medication. This was easy to rectify, and plans drawn up to scale this work up.

A hypertension case finding pilot in high street opticians targeted those opticians using both prevalence, demographic and IMD data, to target areas with lower numbers of known hypertensive patients and those at the highest risk.

To date over 1200 tests have been undertaken and the numbers detected so far are in line with the predicted prevalence of hypertension indicating that this is proving to be an acceptable venue for people to have their blood pressure initially checked. The next phase (during 26/27) is evaluating how many of those detected have been followed up in GP and are now being treated to target.

14. Learning disability and autism

14.1 number of people in a mental health inpatient setting who have a learning disability or are autistic

In December 2025 there were 36 adults with a learning disability and 40 autistic adults in mental health inpatient settings. From a learning disability perspective this is an over 20% reduction since March 2024. Unfortunately, the same level of progress has not been seen among autistic people with the number increasing since March 2024.

To help achieve improvements in the number of people with learning disabilities and autism in a mental health inpatient setting all Places across Cheshire and Merseyside have a Learning Disability Adult Intensive Support Function (ISF) to support people in the community when they are in crisis. Opportunities to develop an Autism ISF provision for adults has been piloted by a provider and is now operational. The expectation is that commissioners will roll out this model into all other ICB areas. These services will help to identify people with Autism who are in crisis and reduce the number of people with Autism needing to be admitted to general mental health wards.

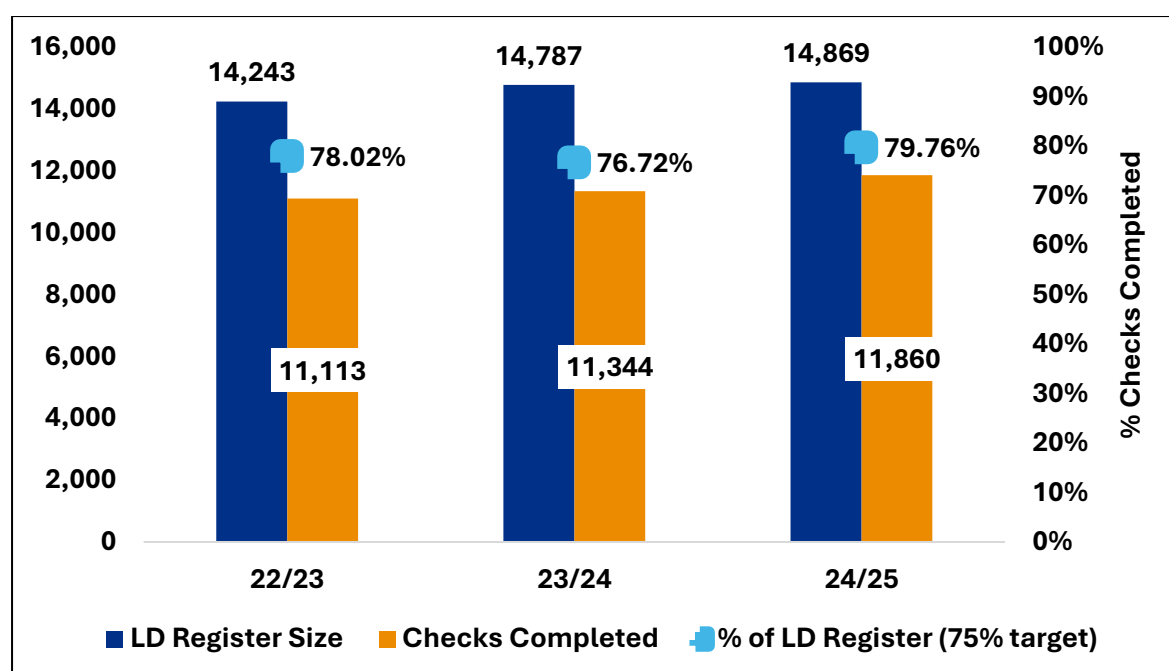
A Housing Lead continues to solve accommodation issues with the support of two housing options navigators, who support people clinically ready for discharge. They also continue to map those individuals clinically ready for discharge with housing difficulties. Several successful Capital bids have been approved to ensure bespoke accommodation can be built/refurbished to ensure the safety of our more complex learning disability and autistic people population.

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 being admitted to mental health beds. As many are not previously known to services, it is often difficult to find an alternative to admission. However, throughout 2025 - 2026, people with suspected autism or a diagnosis of autism who had been admitted to adult mental health wards with a primary mental health disorder were identified quickly and those who required escalation reviewed on system calls is continuing.

14.2 percentage of patients aged 14+ on GP learning disability registers who have had an annual health check

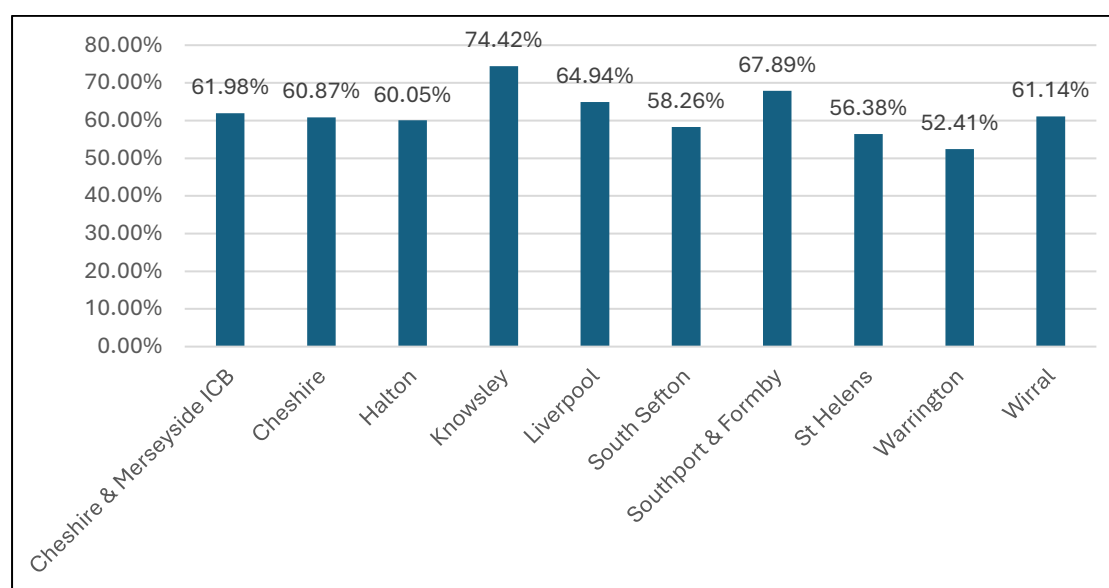
Across Cheshire and Merseyside between April 2025 and January 2026, 61.98% of patients aged 14 plus who are on a GP learning disability register have had their annual health check completed. It is recognised that this data does not reflect the full year activity and the proportion of health checks completed could increase by the end of March 2026. In previous years the national target of 75% has always been exceeded in Cheshire and Merseyside.

Figure 93. The proportion of people aged 14+ on a GP learning disability register who have had an annual health check in Cheshire and Merseyside by year.



The proportion of patients 14+ with a learning disability who have had an annual health check does vary by place. Completion rates are highest in Knowsley at 74.42% and lowest in Warrington at 52.41%.

Figure 94. The proportion of people aged 14+ on a GP learning disability register who have had an annual health check by ICB Place.

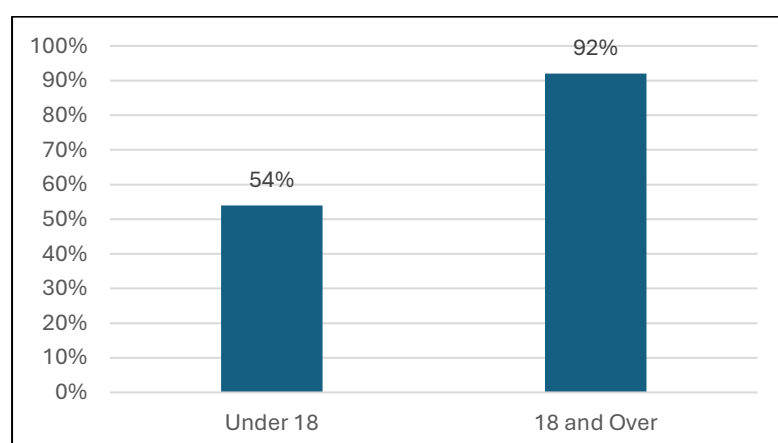


This data is not currently available by age, gender or ethnicity but work will be undertaken over the next 12 months to ensure we can report on uptake across these demographic groups in the 2027/28 report.

14.3 percentage of people with suspected autism waiting more than 13 weeks for contact

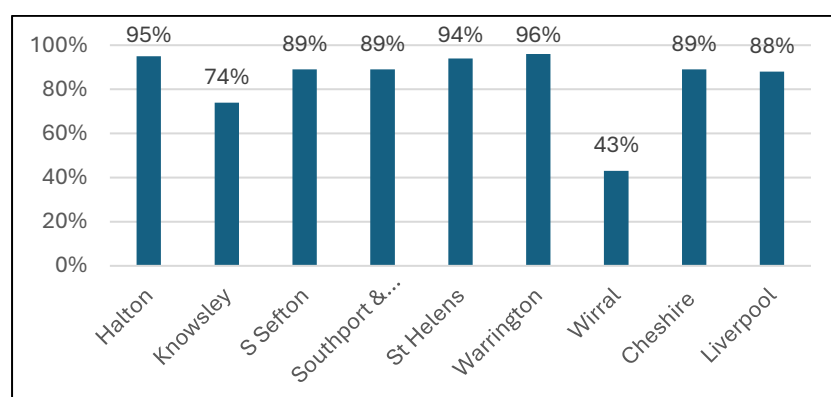
Using data from the current patient waiting list as of December 2025 overall 78% of patients who have been referred with suspected autism have waited more than 13 weeks for contact. Overall, more people over 18 (92%) have waited more than 13 weeks (92%) compared to 54% of people under 18.

Figure 95. Percentage of people with suspected autism waiting more than 13 weeks by age.



There is variation in this indicator by Place as well with Wirral have the lowest proportion of patients waiting more than 13 weeks for contact at 43% and Warrington have the highest at 96%.

Figure 96. Percentage of people with suspected autism waiting more than 13 weeks by place.



Discussions are due to commence shortly on how the ICB supports adults waiting for an autism diagnosis. Currently there is limited community support available commissioned through the third sector, but this is not consistent across all Places. As an example, in Cheshire West there is an autism hub delivered through Dial House who provide peer support for those with autism and those waiting for a diagnosis. We are also looking to undertake a small pilot in 2026/27 regarding building the skills and capacity in primary care for assessment as an intermediate tier service.

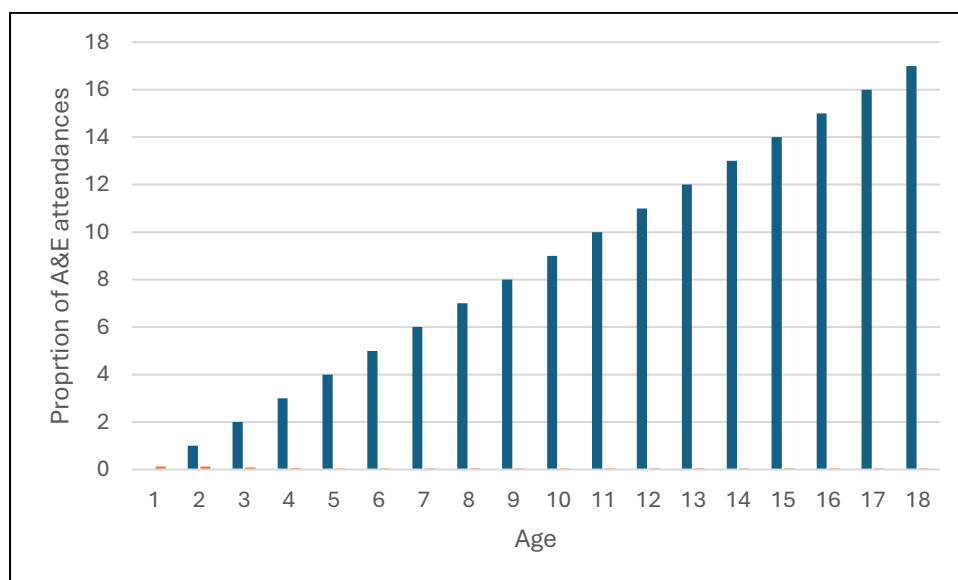
15. Children and Young People

15.1 Urgent, emergency and community care

15.1.1 inequalities in children and young people (CYP) emergency department attendances

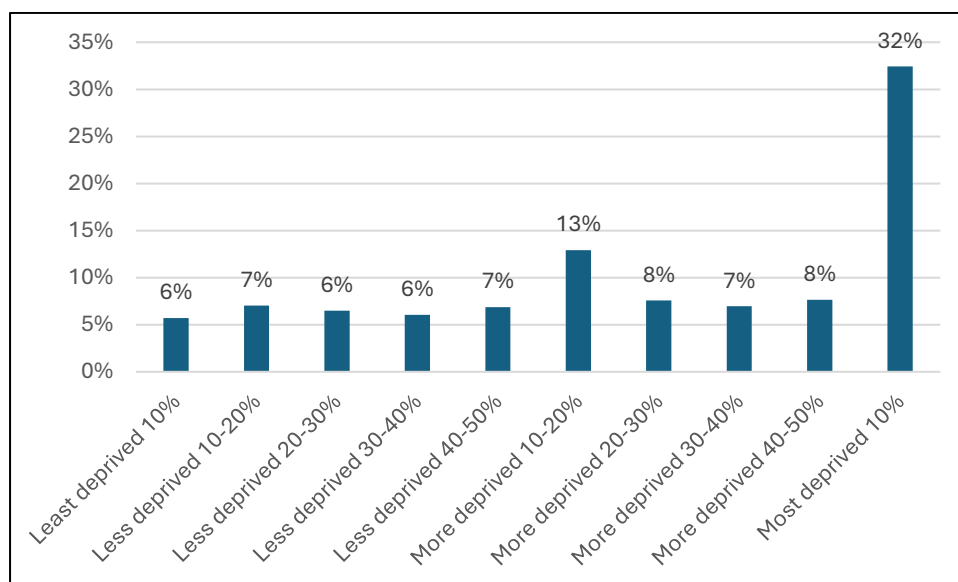
In the past 12 months there were 184,280 emergency department attendances by under 18s. Fifty four percent of attendances were male and 46% were female, and the majority of attendances were from a white British background (76%), 7% of attendances were recorded as ethnicity not stated. Attendances were higher among the under 5s which accounted for 40% of overall attendances.

Figure 97. Emergency department attendances in Cheshire and Merseyside by age



Attendances by deprivation decile identify that the highest proportion of attendances (32%) lived in deprivation decile one the most deprived.

Figure 97. Emergency department attendances in Cheshire and Merseyside by deprivation decile



15.1.2 inequalities in accessing specialist paediatric and multidisciplinary support for CYP in community settings

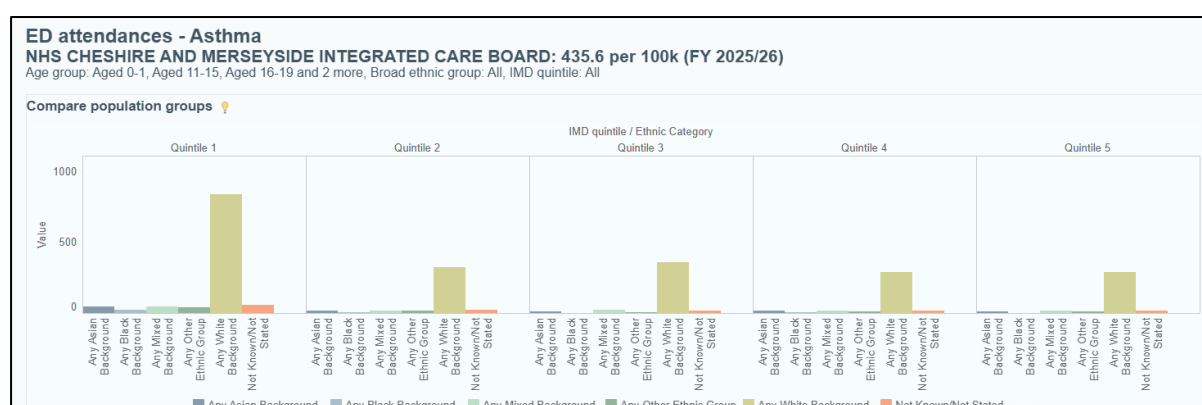
Currently we are not able to report on the inequalities in accessing specialist paediatric and multidisciplinary support for children and young people in community settings, but we will be working towards achieving this in preparation for the 2026/27 annual report.

15.2. Asthma

15.2.1 inequalities in CYP asthma, including emergency department admissions and dispensing of reliever only inhalers

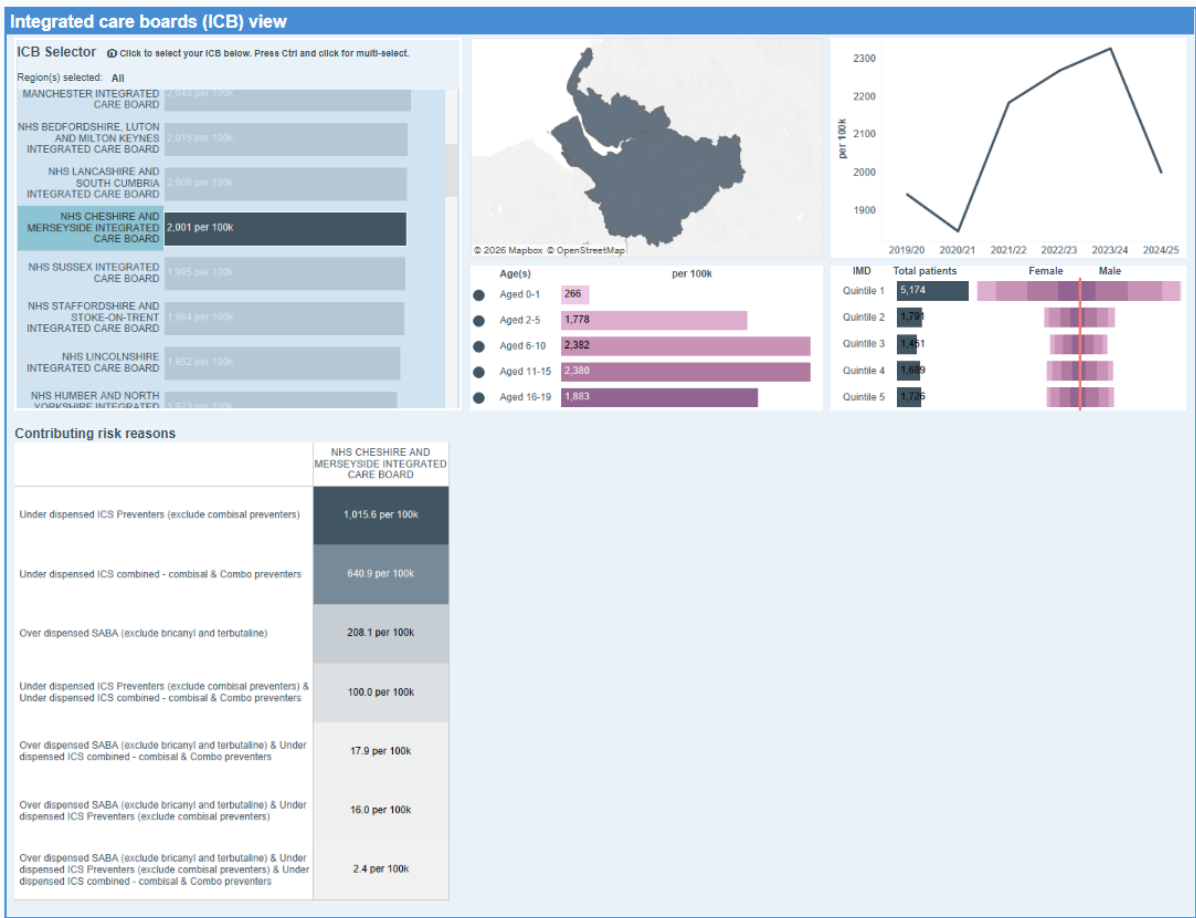
Data for Cheshire and Merseyside clearly shows rates of emergency department attendances among 0–19-year-olds in Cheshire vary by deprivation and ethnicity with rates highest amongst those living in the most deprived quintile and those from any white background.

Figure 98. Emergency department attendances for Asthma in 0–19-year-olds in Cheshire and Merseyside by ethnicity and deprivation quintile.



Rates of high-volume prescribing for children and young people with Asthma show that Cheshire and Merseyside has a rate of 2,001 per 100,000. Rates are highest among children aged 6-10 years old, the highest number of patients is in deprivation quintile 1 (most deprived).

Figure 99. High volume prescribing for Children and Young people with asthma in Cheshire and Merseyside by age and deprivation quintile.



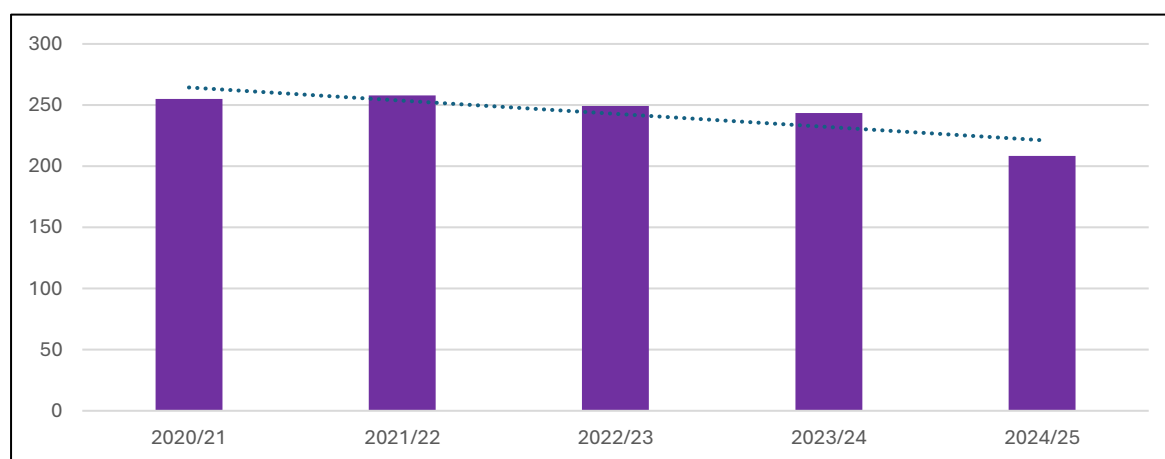
The NHS Cheshire and Merseyside Children and Young Peoples Transformation Programme (Beyond) have undertaken a range of preventative and risk-reduction interventions that have resulted in a reduction in emergency attendances resulting in admission for asthma exacerbations between 2024/25 and 2025/26 during the autumn and winter periods.

Contributing factors include targeted primary care respiratory training, proactive risk stratification of higher-risk children and young people, optimisation of medicines management including increased use of maintenance and reliever therapy regimens, and the implementation of the Too Much Blue – Get a Review approach. Collectively, these measures are supporting improved asthma control, earlier intervention, and reduced escalation to emergency care. Continued embedding of these interventions is expected to further reduce admissions and seasonal peaks going forward.

In Cheshire & Merseyside, there has been a sustained reduction in CYP at very high risk due to over-dispensing of SABA inhalers, with a clear downward trajectory since 2021/22 and the most significant improvement in 2024/25. This reflects targeted system-wide respiratory safety work, including the introduction of the Too Much Blue, Get A Review programme in quarter two, primary care respiratory training delivered throughout the year, and increased use of **Maintenance and Reliever Treatment (MART) regimens** for appropriate children and young people to reduce SABA

reliance. Furthermore, during the year, **34 GP practices undertook risk-stratification searches**, reviewing CYP prescribed six or more SABA inhalers and implementing medication optimisation. This activity has focused on practices within Knowsley due to the level of deprivation.

Figure 100. Rate of Children and Young people in Cheshire and Merseyside over-dispensed SABA between 2020/21 and 2024/25.



Ongoing pilots to see the removal of SABA weaning plans, strengthened asthma reviews, risk stratification of children and young people aged 12+ medicines management pilot, continued primary care engagement and embedding of Too Much Blue, Get A Review are expected to sustain and further improve this trajectory into **2026/27**.

Short-Acting Beta Agonist (SABA) weaning: SABA discharge plans reviewed; symptom-led weaning toolkit shared; implementation commenced across three early adopter pilot sites with staff training underway, children and young people/parent/carer resources available, and remaining district general hospitals preparing to initiate as fast followers. Implementation has been prioritised in areas with high proportion of children and young people within the Core 20 population (20% most deprived).

Enhancing Asthma Care in Primary Care: A pilot has been launched across three Liverpool Primary Care Networks (PCN), offering diagnostic testing and monitoring for children and young people aged 12+, identified through risk stratification searches as part of by Adult Respiratory medicine management project. These young people will now receive enhanced annual reviews and a PAAP. In Knowsley (the area of highest deprivation in Cheshire and Merseyside), all primary care practices have been trained, completed risk stratification searches, and are reviewing 1,298 children and young people identified in the searches.

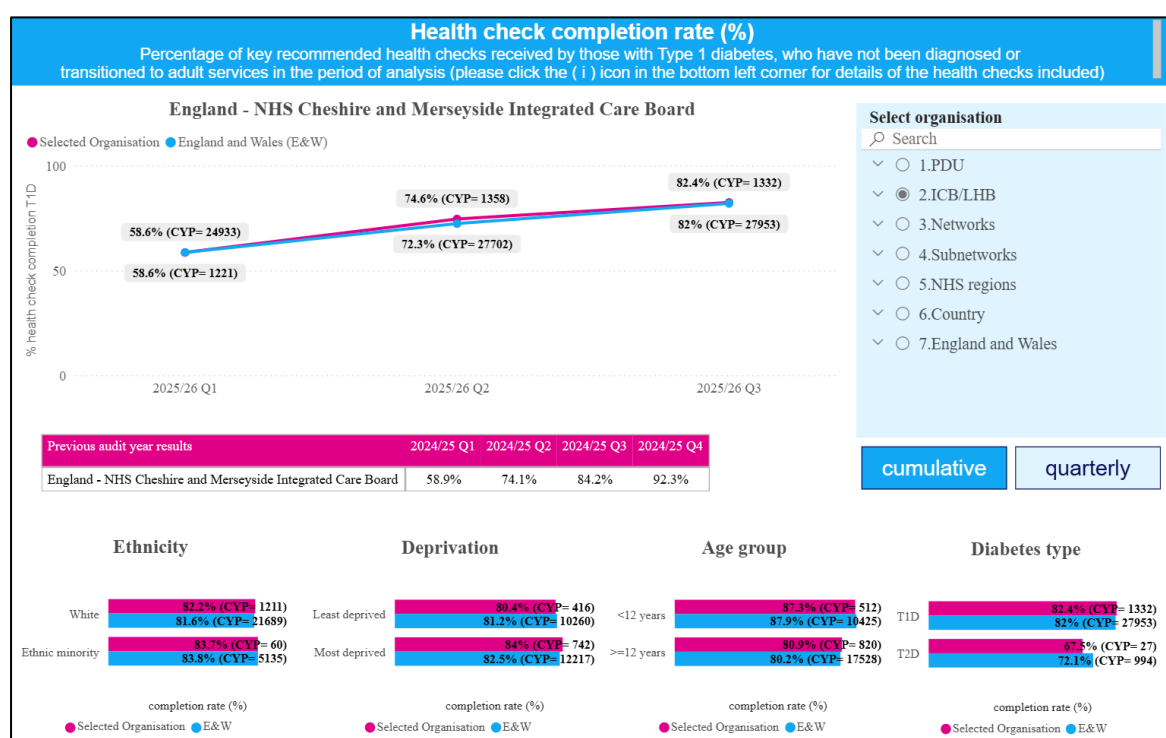
15.3. Diabetes

15.3.1 inequalities in percentage of CYP with type 1 and 2 diabetes receiving all the recommended NICE care processes

In Cheshire and Merseyside by quarter three of 2025/26 82.4% of children and young people with type 1 diabetes had received the recommended NICE care process. Uptake was higher among ethnic minority groups and those living in the most deprived communities although differences in uptake rates were minimal between white and ethnic minority patients. A higher proportion of patients with type 1 diabetes who are under 12 had received the NICE care process.

The data below also shows that only 67.5% of those with type 2 diabetes have received their recommended care process compared to 82.4% of those with type 1 diabetes. Data on the ethnicity, deprivation and age of the type 2 diabetes cohort and their uptake of the recommended care processes is not currently published as part of the National Paediatric Diabetes Audit.

Figure 101. Children and Young People with Type 1 Diabetes who have received the NICE recommended Care Process.



Key programmes of work being undertaken to improve the inequalities in outcomes for children and young people with diabetes includes:

Getting it Right First Time (GIRFT): Addressing variation in care and outcomes across ICSs. The review was held in October 2024 and was attended by over 120 representatives across the ICB and provider colleagues. The recommendations were received in January 2025 and align with the Diabetes Right Care Toolkit, with a focus on four key priority areas:

- Addressing diabetes health inequalities in children and young adults.
- Reducing variation in treatment, care and outcomes across health systems.
- Improving treatment and care for people transitioning from paediatric to adult services.
- Improving treatment and care for children and young adults with Type 2 diabetes.

Type 2: Data reviewed to understand annual care process delivery for children and young with type 2 diabetes in cheshire and Merseyside with the aim of increasing the proportion receiving NICE-recommended care processes.

Autism spectrum disorder (ASD)/Learning difficulties (LD) in CYP with Type 1

Diabetes: A service evaluation was undertaken in partnership with Alder Hey to explore the prevalence and impact of autism spectrum disorder (ASD) and other learning difficulties among children and young people (CYP) with diabetes, and to assess how these conditions influence diabetes management and outcomes. A patient and family survey was developed to capture lived experience and support data collection. To date, 330 children and young people and families have completed the survey, providing a robust evidence base to inform future service improvement and more tailored support for this cohort.

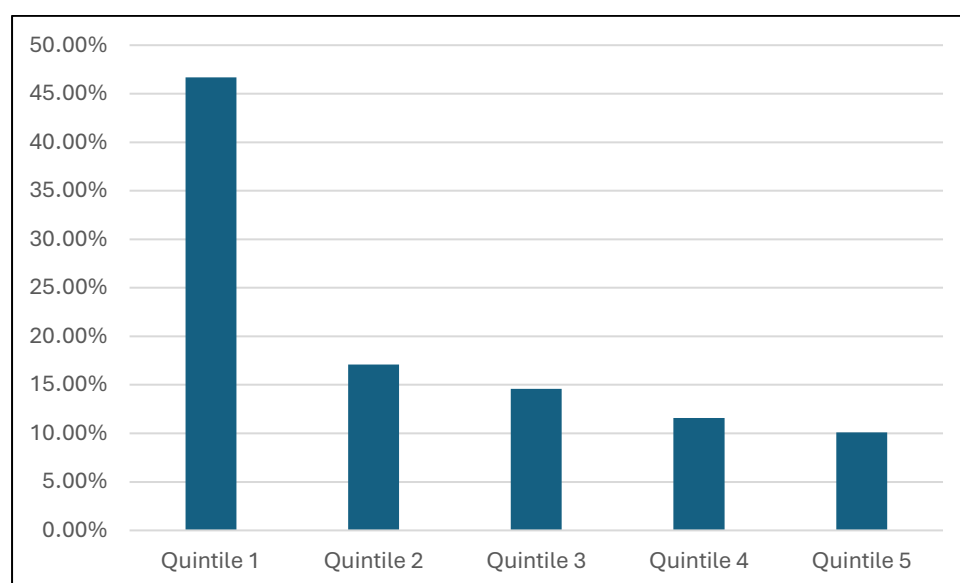
Diabetes Tech Project: Improving technology access for the most deprived children and young people with Type 1 diabetes to address the health inequalities and improve the outcomes. Phase 1 delivery with Warrington & Halton Hospitals NHS Trust and Arrowe Park (Wirral University Teaching Hospital NHS Foundation Trust) completed with 224 children and young people supported onto Diabetes technology. 55% of those children and young people are from the most deprived (CORE20) areas. Phase 2 included Mersey and West Lancashire Teaching Hospitals NHS Trust (Whiston Hospital) where 85 children and young people were started on Diabetes Technology. 49.3% of these children and young people were from the most deprived (CORE20) areas. As a result of this project, patients are now offered Continuous Glucose Monitoring and Hybrid Closed Loop (HCL) as part of ongoing care.

15.4. Epilepsy

15.4.1 inequalities in access to epilepsy specialist nurses in the first year of care for those with a learning disability or autism

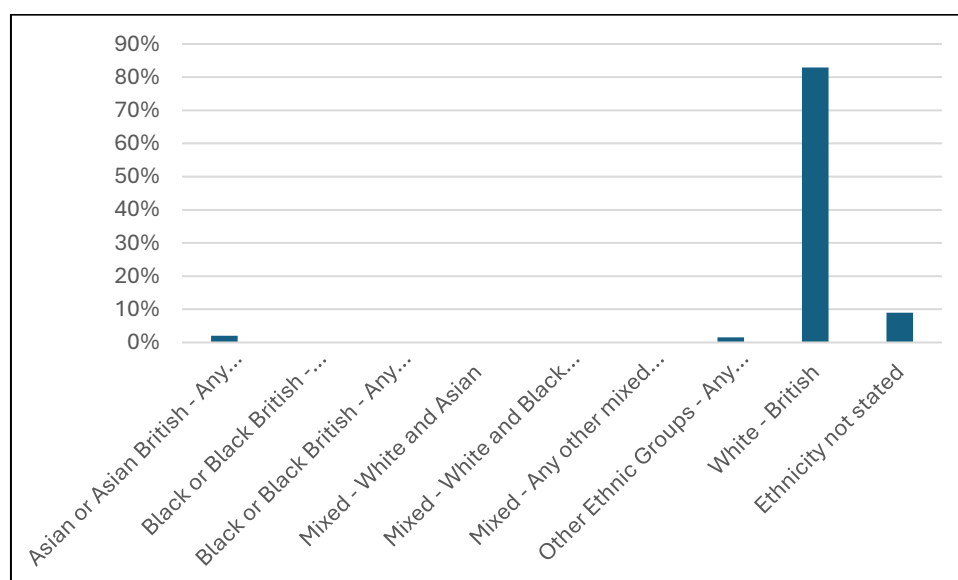
Currently data on access to epilepsy specialist nurses in the first year of care for those with a learning disability or autism is currently not available. We do have inequalities data for all children and young people with Epilepsy though and the data shows that a higher proportion of children and young people with Epilepsy live in deprivation quintile 1.

Figure 102. Children and Young People with Epilepsy that live in Cheshire and Merseyside by deprivation.



The data also shows that the majority of children and young people with Epilepsy are White British although it should be noted that 9% of cases do not have ethnicity recorded.

Figure 103. Children and Young People with Epilepsy that live in Cheshire and Merseyside by ethnic group.



Key programmes of work being undertaken to improve the inequalities in outcomes for children and young people with epilepsy includes:

Addressing Variation in Care via Youth Workers: Youth workers employed in two areas based on level of deprivation and unplanned emergency attendances,

highlighting the need to provide holistic support to children with epilepsy. Two youth workers recruited in two pilot sites.

- Mersey and West Lancashire Teaching Hospitals NHS Trust: The youth worker started in role October 2024 and has created standard operating procedures and referral pathways. Sixteen children and young people were offered support over six weeks. Ten children and young people and their parent/carers were offered one-off transition sessions. Group sessions were offered to young people with Epilepsy or Diabetes in collaboration with The Comedy Trust. The Youth Worker has been attending general clinics to introduce themselves to children and young people and parent/carers to increase engagement, providing ad hoc support to a further 20 young people.
- Mid Cheshire Hospital NHS Foundation Trust: The youth worker started in role January 2025, providing 1 to 1 sessions over a 6 week period for 27 Young People. Sixty-three young people have been supported through their routine epilepsy clinics. Ten young people and parent/carers have been supported through transition sessions.

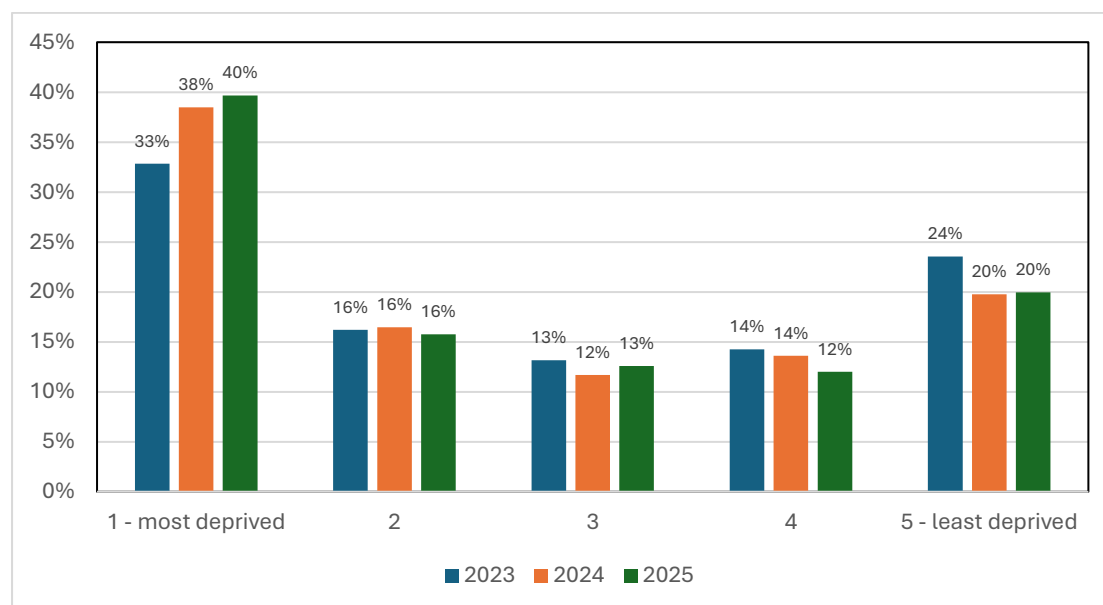
Integrated Epilepsy Specialist Nurse (ESN): NHS Cheshire and Merseyside continue to deliver the epilepsy bundle of care. Integrated Epilepsy Specialist Nurses strengthened access to specialist neurology advice, improving medicines governance, enhancing data quality, and reducing variation in care. This enabled hospitals across the region to access timely tertiary expertise through monthly case reviews and helped establish a new Complex Epilepsy Panel. Extensive epilepsy data analysis improved system intelligence, while work on the Epilepsy Friendly Schools pilot progressed, with ten schools expressing interest. Collectively, these efforts improved equity, safety, and support for children and young people with epilepsy.

15.5. Oral Health

15.5.1 inequalities in elective admissions of hospital-based tooth extractions due to dental caries

Over the past three years those children living in the most deprived communities continue to make up the highest proportion of under 16s who are having hospital based tooth extractions due to dental caries. Overall in deprivation quintile one 749 children were admitted with 40% of all admissions in 2025 due to tooth extraction living in the most deprived quintile.

Figure 104. Hospital based tooth extractions in under 16s by deprivation quintile.



All Together Smiling has implemented evidence-based supervised toothbrushing programmes (STP) for 2-7-year-olds across CORE20 communities in Cheshire and Merseyside, alongside the distribution of over 350,000 oral health packs containing fluoride toothpaste. By increasing daily exposure to fluoride and embedding consistent brushing habits from an early age, the programme directly tackles the underlying drivers of dental caries.

Evidence shows that fluoride application is key to preventing caries and that STP participation rates above 50% are required to achieve measurable reductions in decay. The programme has achieved this, with over 280 early years settings, childminders and primary schools participating, and more than 14,500 children brushing daily.

This targeted, preventive approach is helping to reduce oral health inequalities and is expected, in the longer term, to contribute to fewer hospital admissions for tooth extractions due to dental caries.

NHS Cheshire and Merseyside have also been working on improving access to dental services for children and young people. A proof-of-concept Dental Neighbourhood Health Centre was established to engage with the local community including providing access to NHS dental care for vulnerable groups. Children, pregnant and breast-feeding women have all been able access dental care. On average the centre has seen over 300 patients per month and 88% of appointments booked resulted in attendance. Commissioners matched financial incentives and flexible commissioning principles to ensure that those with the highest oral health needs had a service they could access and be referred into by external agencies.

15.6 Mental Health

15.6.1 inequalities in access rates to CYP mental health services for 0–17-year-olds*

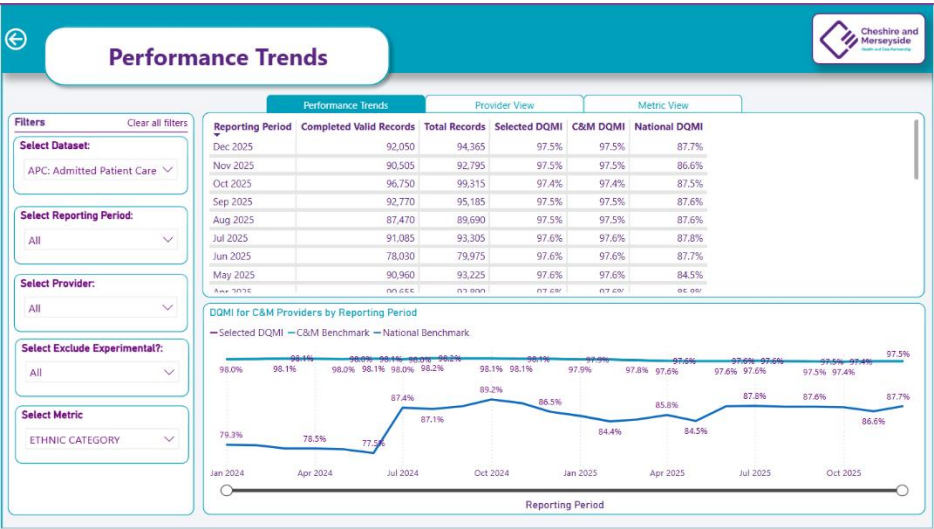
Currently we are not able to demonstrate inequalities in access rates to children and young people’s mental health services for 0-17 year olds, but we will be working towards achieving this in preparation for the 2026/27 annual report.

16. Data Quality – Ethnicity recording

Accurate and complete ethnicity data is essential to understanding and addressing inequalities in access, experience and outcomes. During 2025–26, the 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 the ICB monitors data completeness by setting, provider and over time.

Figure 105. Inpatient data completeness by month in Cheshire and Merseyside.



Ethnicity coding in Cheshire and Merseyside is of particularly good quality, and significantly above national averages.

Table 15. 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

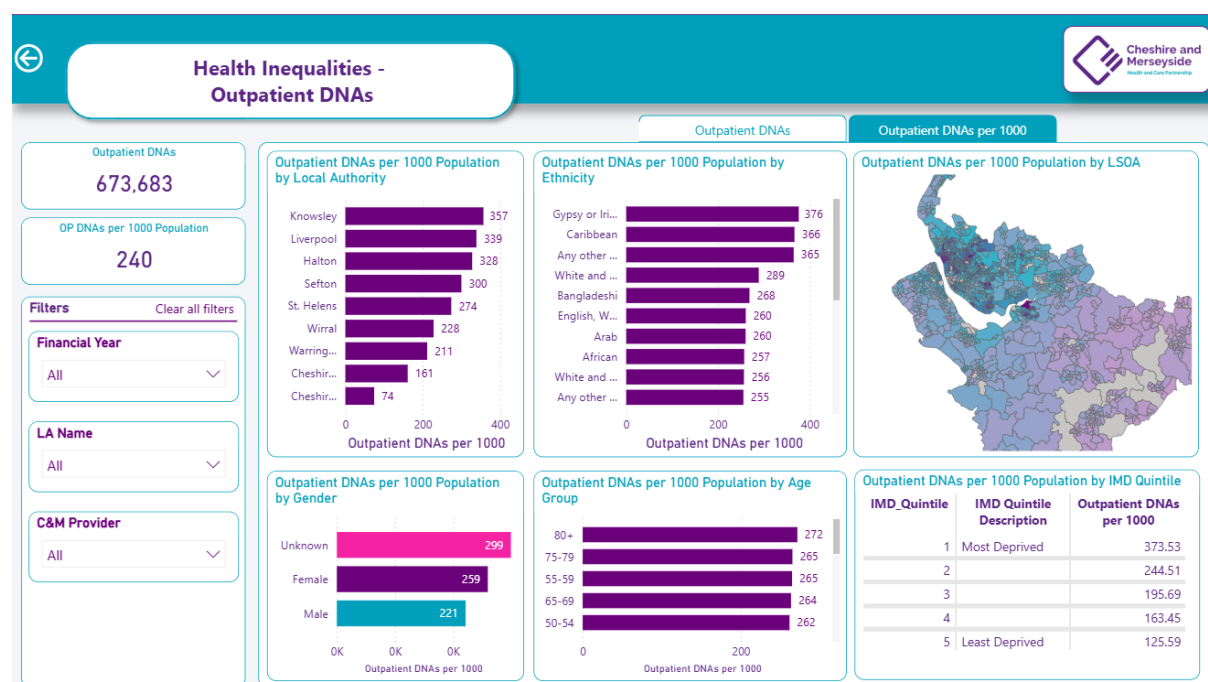
Source: NHS Digital, Data Quality Maturity Index publication

Whilst not part of national DQMI publications, we also monitor data completeness in the local primary care records that are shared with the NHS Cheshire and Merseyside by General Practice for Population Health purposes. Over 90% of records contain an ethnicity category, and this is in line with national average (albeit a slightly different data set coverage from the General Practice Extraction Service (GPES)) of 90-91% coverage.

Variation in data completeness can constrain the ability to consistently assess inequalities by ethnicity across all commissioned services and whilst levels of completeness across Cheshire and Merseyside are good, we monitor variation at lower levels of geography and know where there is improvement required.

Where ethnicity data is sufficiently complete, it has been used to monitor performance in priority areas such as maternity, cancer pathways, vaccination uptake and mental health services, supporting targeted improvement actions and alignment with national frameworks such as Core20PLUS5 and the Patient and Carer Race Equality Framework (PCREF). At a provider and place level we can monitor indicators such as outpatient DNA rates across a number of demographic categories including deprivation and ethnicity for example.

Figure 106. Outpatient DNAs in Cheshire and Merseyside split by Place, Ethnicity, Gender, Age and Deprivation.



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.