NHS
Cheshire and Merseyside

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

29 May 2025
09:00am

Authority Chamber
No 1 Mann Island,
Liverpool,
L3 1BP
Sitemap details:

Public Notice: Meetings of the Board of NHS Cheshire and Merseyside are business meetings which for transparency are held in public. They are not 'public meetings' for consulting with the public, which means that members of the public who attend the meeting cannot take part in the formal meetings proceedings. The Board meeting is live streamed and recorded.

Compassionate Inclusive Working Together Accountable

Leading integration through collaboration

Public Speaking Time: 09:00am
Further detail at: https://www.cheshireandmerseyside.nhs.uk/get-involved/upcoming-meetings-and-events/nhs-cheshire-and-merseyside-integrated-care-board-may-2025/

Agenda

AGENDA NO & TIME	ITEM	Format	Lead or Presenter	Action / Purpose	Page No
09:30am	**Preliminary Business**				
ICB/05/25/01	Welcome, Apologies and confirmation of quoracy	Verbal	Raj Jain *ICB Chair*	For information	-
ICB/05/25/02	Declarations of Interest *(Board members are asked to declare if there are any declarations in relation to the agenda items or if there are any changes to those published on the **ICB website**)*	Verbal		For assurance	-
ICB/05/25/03	Chairs announcements	Verbal		For information	-
ICB/05/25/04	Experience and achievement story	Film	-	For Information	-
09:40am	**Leadership Reports**				
ICB/05/25/05	Report of the ICB Chief Executive	Paper	Graham Urwin *Chief Executive*	For approval	Page 5
ICB/05/25/06 **09:55am**	NHS Cheshire and Merseyside Finance Report Month 12	Paper	Mark Bakewell *Director of Finance*	For assurance	Page 47
ICB/05/25/07 **10:05am**	Highlight report of the Chair of ICB Finance, Investment and Our Resources Committee	Paper	Erica Morriss *Non-Executive Member*	For assurance	Page 83
ICB/05/25/08 **10:10am**	NHS Cheshire and Merseyside Integrated Performance Report	Paper	Anthony Middleton *Director of Performance & Planning*	For assurance	Page 87
ICB/05/25/09 **10:20am**	Highlight report of the Chair of ICB Quality and Performance Committee • *Incl update of Safety report development*	Paper	Tony Foy *Non-Executive Member*	For assurance	Page 128
ICB/05/25/10 **10:25am**	Highlight report of the Chair of ICB Audit Committee	Paper	Tony Foy *Non-Executive Member*	For assurance	Page 134
ICB/05/25/11 **10:30am**	Highlight report of the Chair of System Primary Care Committee	Paper	Erica Morriss *Non-Executive Member*	For assurance	Page 137

AGENDA NO & TIME	ITEM	Format	Lead or Presenter	Action / Purpose	Page No
ICB/05/25/12 **10:35am**	Highlight report of the Chair of ICB Women's Hospital Services in Liverpool Committee	Paper	Prof. Hilary Garratt *Non-Executive Member*	For assurance	Page 141
10:40am	**BREAK**				
10:50am	**ICB Business Items**				
ICB/05/25/13	Proposal regarding ICB funded Gluten Free Prescribing across Cheshire and Merseyside	Paper	Prof. Rowan Pritchard-Jones *Medical Director*	For decision	Page 145
ICB/05/25/14 **11:05am**	Post COVID Syndrome Review and Options Development	Paper	Dr Fiona Lemmens *Medical Director*	For decision	Page 281
ICB/05/25/15 **11:20am**	Cheshire and Merseyside Sub Fertility Clinical Policy Status and Options for consideration	Paper	Prof. Rowan Pritchard-Jones *Medical Director*	For decision	Page 341
ICB/05/25/16 **11:35am**	2025/26 Operational and Financial Delivery Plan Update	Paper	Mark Bakewell *Director of Finance*	For assurance	Page 431
ICB/05/25/17 **11:50am**	Cheshire and Merseyside Polypharmacy Programme Briefing	Paper	Dr Fiona Lemmens *Medical Director*	For assurance	Page 448
ICB/05/25/18 **12:00pm**	NHS Cheshire and Merseyside Integrated Research and Innovation System (IRIS): Research and Innovation Priorities	Paper	Prof. Rowan Pritchard-Jones *Medical Director*	For support	Page 455
ICB/05/25/19 **12:15pm**	NHS Staff Survey results 2024/25 and next steps	Paper	Mike Gibney *Chief People Officer*	For endorsement	Page 469
12:25pm	**Meeting Governance**				
ICB/05/25/20	Minutes of the previous meeting: • 27 March 2025.	Paper	Raj Jain *ICB Chair*	For approval	Page 488
ICB/05/25/21	Board Action Log	Paper	Raj Jain *ICB Chair*	To consider	Page 504
12:30pm	**Reflection and Review**				
ICB/05/25/22	Closing remarks and review of the meeting	Verbal	Raj Jain *ICB Chair*	For information	-
12:35pm	**CLOSE OF MEETING**				

Consent items

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

AGENDA NO	ITEM	Reason for presenting	Page No
ICB/05/25/23	Board Decision Log **(CLICK HERE)**	For information	-
ICB/05/25/24	Q4 2024-2025 Board Assurance Framework	No changes to the risks scores as presented to January 2025 Board. For assurance	**Page 506**
ICB/05/25/25	Q4 2024-2025 Corporate Risk Register	For assurance	**Page 552**
ICB/05/25/26	Confirmed Minutes of ICB Committees: • Audit Committee – March 2025 • Finance, Investment and Our Resources Committee – March 2025 • Finance, Investment and Our Resources Committee – April 2025 • Quality and Performance Committee – March 2025 • Quality and Performance Committee – April 2025 • System Primary Care Committee – Feb 2025 • Women's Hospital Services in Liverpool Committee – March 2025	For assurance	**Page 505**

Date and start time of future meetings

19 June 2025, 09:00am – online meeting via MS Teams
31 July 2025, 09:00am, 40/Twenty Lounge, Halliwell Jones Stadium, Mike Gregory way, Warrington, WA2 7NE
25 September 2025, 09.00am, No 1 Mann Island, Liverpool, L3 1BP
27 November 2025, 09:00am, 40/Twenty Lounge, Halliwell Jones Stadium, Mike Gregory way, Warrington, WA2 7NE

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

Following its meeting held in Public, the Board will hold a meeting in Private from 13:00pm

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

29 May 2025

Report of the Chief Executive

Agenda Item No: ICB/05/25/05

Responsible Director: Graham Urwin, Chief Executive

Report of the Chief Executive (May 2025)

1. Introduction

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

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

2. Ask of the Board and Recommendations

2.1 **The Board is asked to:**

- **consider** the updates to Board and seek any further clarification or details
- disseminate and cascade key messages and information as appropriate
- **approve** the proposed amendments to the ICBs Operational Scheme of Reservation and Delegation.

3. The Cheshire and Merseyside System

3.1 NHS Cheshire and Merseyside has worked hard to make one of the country's largest and most complex regional health and care systems both easier to work with and to work within. Enormous progress has been made to simplify the way hospital services work.

3.2 The inception of NHS University Hospitals of Liverpool Group brought together adult acute services in Liverpool, while the introduction of shared leadership models at NHS Trusts in Warrington and Wirral is helping to create seamless relationships between acute and community care - helping to both prevent unnecessary hospital admissions and safely discharge people from hospital sooner.

3.3 For the first time ever – cancer survival rates in Cheshire and Merseyside have risen above the all-England average. This is largely due to a combination of targeted work, for example via the lung health check programme, and a step-change in access to early diagnosis.

3.4 Strong performance continues to be achieved in diagnostics more generally too. Cheshire and Merseyside was the first Integrated Care System to re-achieve (post-COVID-19) the key waiting list target for 90% of patients to receive a diagnostic test within six weeks.

3.5 I am proud to report that access to primary care – a key priority for local people – continues to be significantly improved. There were more than 500,000 additional primary care appointments in 2024-25 compared to the previous 12-

month period - including an increase in both in-person appointments and those supported by digital technology.

3.6 Cheshire and Merseyside is also delivering outstanding stroke outcomes – with Whiston Hospital ranked 1st and Aintree Hospital 3rd in the country– due to collaboration across providers to deliver increasingly joined-up specialist care.

3.7 As has been widely acknowledged, waiting lists rose to an unacceptable level during the COVID-19 pandemic and it remains both a local and national priority to reduce the time people wait for planned care - in particular for those who have waited longest. Tireless work throughout 2024-25 enabled more than 47,000 people who would have otherwise waited 65 weeks or more to be treated sooner.

3.8 Despite these achievements, the Cheshire and Merseyside health and care system continues to consume more than its share of resources and a significant financial challenge remains within our system.

3.9 However, we look forward to the upcoming launch of the Government's 10-Year Health Strategy, the opportunity to build models of neighbourhood health for the future and the prospect of further embedding initiatives which will help to deliver the 'three shifts' identified by the Government, namely:

- moving care from hospitals to communities
- making better use of technology
- focusing on preventing sickness, not just treating it.

3.10 In Cheshire and Merseyside, I am pleased to report that this challenge will begin with strong foundations – not least due to our already innovative use of data and technology to improve both patient and staff experience.

3.11 This is my last Board meeting as Chief Executive of NHS Cheshire and Merseyside therefore my last report to Board. I would like to wish my successor Cathy Elliott all the very best and to thank all of the dedicated staff who work across all parts of the local NHS for their compassion, dedication and commitment.

3.12 It has been an honour to end my career serving the people of Cheshire and Merseyside.

4. Financial regime

4.1 The NHS Financial regime, whilst not entirely straight forward, is based on the principles of providers being reimbursed through a tariff-based system or block contracts from commissioners. This approach was suspended during the Covid-19 Pandemic where providers were reimbursed with the costs that they incurred but the NHS is now returning to a pre-Covid financial regime and is now in the transition period.

4.2 The ICB has both a statutory duty to break even and has done this (or better) in each of the years of its existence, and also to co-ordinate achievement of an agreed system control total as set by NHS England. For the 2025-26 period, that control total was based on the ICBs published allocation plus an additional £178m deficit support. Confirmation of this was required by 28 March 2025 to NHS England. On this date the ICB was one of seven systems that were unable to meet this requirement and became of one of four systems that NHS England invited to a Board to Board meeting. The outcome of that Board to Board was that there would be no additional support to the Cheshire and Merseyside system above the support funding and if we were unable to submit a compliant plan then the £178m deficit support would be withdrawn. Additionally, it was stated that the Cheshire and Merseyside system must also ensure that it returns to balance within three years, meaning that system expenditure must not exceed allocation.

4.3 On 30 April 2025 the ICB submitted a compliant plan which has resulted in both the ICB and every Cheshire and Merseyside Trust provider taking on additional cost improvement requirements (resulting in an aggregate deficit across the 16 NHS providers of c£228m offset by a surplus for the ICB of £50m). This compliant plan will enable us to spend our allocation, plus the additional £178m of deficit support funding (equivalent of 2.2% of our allocation) during the 2025/26 financial period. Whilst agreeing a plan was essential to securing the deficit support and cash to underpin this, our attention must turn now to the effective delivery of the plan and effectively mitigating the risks.

4.4 As you can see the system has an immediate financial problem that is associated with overspends in our NHS providers and the speed at which they can adjust from the Covid period financial regime back to a more regular NHS contracting process. However, the ICB has a medium-term problem in that we consume more than our fair share of the overall NHS resource and under the present NHS national policy our funding is being reduced by 0.5% per annum to address this. We remain deeply concerned that NHS England will accelerate this movement to a fair share allocation in all parts of the country and we expect that the reduction in our allocation for the 2026/27 financial period will be greater than the 0.5%. In summary, we have a short-term provider deficit problem that the system must collectively address, and a medium-term resource allocation problem which we as a commissioner must address.

4.5 NHS England has implemented the requirement for a weekly system return through which the Cost Improvement Programme (CIP) progress will be tracked. This return is sent to the ICB and NHS England region and the information it contains supports the following arrangements that have been put in place:

- starting from April Alternate weekly meetings between the ICB and All Trusts (Financial Control & Oversight Group). At this meeting progress is reviewed on savings programmes within the ICB and also nine thematic areas across the wider system. This is attended by Executive and Senior Manager leads
- from June, a new Monthly System Leadership Meeting across the two devolution footprints, with the purpose being to review progress being made

on plans, issues and risks. Chaired by the ICB Chief Executive and attended by each Trust Chief Executive Officer, Trust Chair and core Executives.
- from June, there will be regular meetings for all Trusts that trigger deficit and risk thresholds. This meeting will review progress on the whole financial plan. Each Trust Chief Financial Officer is asked to attend with the ICB Executive Director of Finance and the ICB Chief System Improvement and Delivery Officer.

5. Contracting with Providers

5.1 The ICB is currently in the process of negotiating contracts with all providers for the 2025/26 financial year, in line with the newly published NHS Standard Contract. The Contract has gone through two rounds of open consultation and the original intent to implement 'payment limits' with providers has been abandoned as part of the second consultation period, in favour of a strengthened activity management approach.

5.2 Therefore, for this financial year the ICB will be implementing 'activity planning assumptions' and corresponding 'indicative activity plans' in contracts that have a variable activity and payment element. Activity planning assumptions will include those referenced in the national contract technical guidance and a range of local assumptions based on ICB priorities, including managing within our overall financial allocation and delivery of national elective recovery and delivery requirements.

5.3 The strengthened activity management process will not provide the ICB with as much control over activity and finance as the payment limits would have, which creates risk for the ICB. In addition, it will require significant resource to manage in-year but will be the main lever to manage contractual financial delivery in 2025/26.

6. Changes to the ICBs Operational Scheme of Reservation and Delegation

6.1 Given the financial position, and in part to meet national expectations that we obtain greater grip and control on our operational spend, and so as to be in line with the custom and practice of other systems that are in a form of financial control measures, a number of proposed temporary changes to the ICBs Operational Scheme of Reservation and Delegation (OSORD) (Appendix One) are being recommended to the Board for its approval. The main changes are:
- addition of the Chief System Improvement and Delivery Officer as a named role
- addition of the Care Package Assurance Panel and financial authority approval limits to make decisions on packages of care
- amended financial approval limits for Place Directors of up to £104k per annum for individual packages of care or Mental Health packages less than £500 per week. Any packages of care costing above the Place Director

approval limit will be required to be approved at the Care Package Assurance Panel. These amendments make no change to what is the current responsibility of health to fund and remains in line with our published policy

- amendments to financial approval limits for other named roles (inc Executive Directors / Other ICB Directors / Place Directors), which include:
  - Agency Spend down from £25k to £10k
  - Services outside of annual budgets (e.g. IT contracts) down from £250k to £100k
  - Non-Healthcare Payments (within agreed budgets) – down from £500k to £100k
  - New Business Cases (where funding is in agreed plan) – down from £1m to £100k
  - New Business Cases (where funding is not in the plan) – down from £250k to £20k
  - Signing Healthcare contracts inc s75, removing place director authorisation
  - Signing non-healthcare contracts, down from £1m to £100k
  - Other healthcare payments, down from £250k to £50k
  - Virements, down from £250k to £50k.

6.2 The OSORD outlines who (individual) or where (Committee/Board) decisions on financial commitments above the limits as outlined above can be determined, namely either the Chief Executive, Director of Finance, Chief System Improvement and Delivery Officer, Board or named Committees. There are no proposed changes to the decision making authority reserved to the Board.

6.3 These changes will be reviewed in August, with any subsequent changes being recommended to the Board at its September 2025 meeting.

The Board is asked to approve changes to the ICB Operational Scheme of Reservation and Delegation.

7. Model ICB Blueprint

7.1 On the 01 April 2025, Sir Jim Mackey, Chief Executive of NHS England, wrote to all ICBs and NHS trusts to provide further detail on the Government's reform agenda for the NHS.[1] The letter highlighted the significant progress made in planning for 2025/26 and emphasised a move to a medium-term approach to planning, to be shaped by the Ten-Year Health Plan and the outcome of the Spending Review. The letter stated that ICBs will be central to future plans as strategic commissioners, playing a critical role in realising the ambitions of the Ten-Year Health Plan; however, all ICBs would be required to reduce their management (running and programme) costs by an average of 50%.

7.2 The letter outlined that in delivering the cost reductions, it will be essential to maintain some core staff, and to maintain or invest in strategic commissioning functions, building skills and capabilities in analytics, strategy, market

[1] https://www.england.nhs.uk/long-read/working-together-in-2025-26-to-lay-the-foundations-for-reform/

management, and contracting. The need for ICBs to commission and develop neighbourhood health models was also set out. Additionally, NHS providers were also instructed to reduce their corporate cost growth by 50% by quarter three of 2025/26, with savings reinvested locally to enhance frontline services. The reform programme will also bring together NHS England and the Department of Health and Social Care to create a single aligned centre.

7.3 On 02 May 2025 the Draft Model ICB Blueprint version 1.0 document was shared with all ICBs (Appendix Two). The Blueprint outlines the future role and functions of ICBs as strategic commissioners within the NHS. Developed collaboratively by ICB leaders and NHS England, the blueprint provides a clear direction for the evolution of ICBs, ensuring they are well-equipped to improve population health, ensure access to high-quality services, and manage health budgets effectively. It recognises the need to build strong strategic commissioning skills to improve population health and reduce inequalities and focus on the delivery of the three strategic shifts – sickness to prevention, hospital to community, analogue to digital. A useful summary of the blueprint, produced by Carnall Farrar, can be found in Appendix Three.

7.4 Alongside the publication of the blueprint NHS England informed ICBs that the indicative management cost per head of the population is £18.76, and ICBs are expected to use the Model ICB Blueprint to create bottom-up plans for a new operating model for the ICB that are affordable within the reduced running cost envelope. These plans need to be submitted to NHS England by 30 May 2025 and implemented during quarter three 2025/26 (and by December 2025). For our ICB to meet this cost per head target this equates to a 31% reduction in management costs. ICBs are encouraged to expedite these changes as any in-year savings can be used on a nonrecurrent basis to address in-year transition pressures or risks to delivery in wider system operational plans.

7.5 The ask of the ICB this year is significant. We are required to maintain effective oversight of the delivery of the 2025/26 plans, build the foundation for neighbourhood health and manage the local changes with ICB redesign, including supporting staff through engagement and consultation. Over the coming months we will be going through an organisation redesign process, which involves an organisation review throughout quarter one, implementation in quarter two and transitioning into the new ICB form in quarter three of this financial year.

7.6 To effectively respond to the ICB Blueprint, we have mobilised a programme of work that will provide the necessary support structure to meet the requirements set within the document. It is a function-led approach to make sure the new form of our organisation is appropriate for delivering the future purpose of the ICB, and it is clear that a fundamental change of this nature will result in a very different structure for the organisation than what is currently in place.

7.7 One of the key requirements of the blueprint was to establish a Transition Committee or equivalent to have oversight of the organisational change and duties transfer. We have established the NHS Cheshire and Merseyside

Reconfiguration and Transition Task and Finish Group to undertake this responsibility, and which now meets on a weekly basis. Its Terms of Reference can be seen in Appendix Four.

7.8 A high-level programme plan has been developed based on the guidance published by NHS England, namely the key milestones that we are required to deliver on through quarters one to three of the financial year 2025/26. This group will also be responsible for overseeing the population of the reform planning template that needs to be submitted on 30 May to NHS England.

7.9 Due to the sensitive nature of the content of this planning template, this will be shared with and discussed with Board members in the Boards Private meeting on the 29 May 2025, where the Board will be asked to support the proposed model and submission of the template.

8. Cheshire and Merseyside ranked as #1 ICB nationally for diagnostic performance

8.1 At the start of this financial year, NHS Cheshire and Merseyside holds the number one spot for diagnostics performance out of the 42 ICBs across the country, meaning more patients now have their health conditions diagnosed quicker in Cheshire and Merseyside than in almost any other area of England.

8.2 Cheshire and Merseyside ranked in the top spot as one of the only ICBs to report that 93.3% of patients were seen within 6 weeks (a +3.3% improvement over the past year) at the close of the financial year. This target encompasses 15 key test areas – many linked to cancer diagnosis – including CT and MRI scans, colonoscopy and gastroscopy.

8.3 Huge congratulations to all of the networks and providers each of which have gone above and beyond this past year to improve diagnostic services for our patients.

9. NHS England praise for Northwest Community Diagnostic Centres

9.1 NHS England recently sang the praises of the brilliant work being done by Community Diagnostic Centres (CDCs) in the North West. Citing the 25 CDCs across the North West, NHS England noted that benefits of CDCs include providing easier access, parking and greater choice for patients, in sites that include shopping centres, community hospitals, and acute hospital sites. In 2024, CDCs across the region contributed to 11.31% of all diagnostic tests delivered across the region in 2024/ 25. Between April 2024 and March 2025 CDCs 942,637 tests were delivered at CDCs in the North West, up from 655,247 between April 2023 and March 2024.

9.2 The article highlighted two of our CDCs in Cheshire and Merseyside including the Clatterbridge CDC, a partnership between The Clatterbridge Cancer Centre NHS

FT and Wirral University Teaching Hospital NHS FT, which is mentioned as one of the first CDCs in the country and Paddington CDC, known for its unique location at the former Rutherford Cancer Centre and the support it provides to our Mutual Aid programme.

9.3 The article is a testament to the hard work of all the teams and staff involved in making our CDCs such valuable assets.

9.4 Read the full article: https://www.england.nhs.uk/north-west/2025/05/07/thousands-more-people-in-the-north-west-getting-tests-and-scans-thanks-to-community-diagnostic-centres/

10. Virtual Ward Success

10.1 An increasing number of residents across Cheshire and Merseyside are now benefiting from hospital-level care without leaving the comfort of their own homes. Figures show that more than 10,600 admissions were made to the region's virtual wards within the last year, which would otherwise have been inpatient stays. In Cheshire and Merseyside, the virtual ward service can support up to 430 patients at any given time.

10.2 Cheshire and Merseyside's utilisation rate of virtual ward beds has increased significantly over the last year to an average of 89% with this frequently rising above 90%, taking the region from being one of the lowest performing Integrated Care Boards (ICB) in the country, into the top 10.

10.3 This is another example of the excellent care that is being made available across the region and which not only helps enhance the patients experience but also helps to reduce pressure on our hospitals, ensuring beds are available for those who need them most

11. Research and Innovation

11.1 At its May 2025 Board meeting, members will receive a detailed update on the work underway across Cheshire and Merseyside with regards Research and Innovation and the importance of it going forward as reorgnisation occurs across the NHS. I would like to use my report to congratulate NHS organisations and partners from across Cheshire and Merseyside who were recognised recently when winning seven out of 10 categories at the 2025 North West Coast Research and Innovation Awards. Hosted by Health Innovation North West Coast and Applied Research Collaboration North West Coast (ARC NWC), the awards recognise the best innovators and researchers in health and care across the region and attracted more than 100 entries this year.

11.2 Of note, NHS Cheshire and Merseyside's technology partner C2-Ai won the Industry Collaboration – Secondary Care category for its AI-targeted approach to identifying patients with an increased risk for post-operative complications, helping to improve their outcomes and reduce emergency

hospital admissions. Additionally, NHS Cheshire and Merseyside alongside the Cheshire and Merseyside Greener Practice Network, won the 2025 Sustainability Award, for driving improvements in sustainability through a number of pilot projects and initiatives aimed at reducing the carbon footprint of GP practices in the region.

11.3 Further details about the winners and finalists and can be found at the North West Coast Research and Innovation Awards website at https://www.nwcawards.co.uk/2025-winners.

12. Stronger Partnerships, Healthier Futures: Cheshire and Merseyside's Director of Population Health Annual Report for 2024/25

12.1 The *Stronger Partnerships, Healthier Futures* annual report and accompanying video highlights some of the fantastic successes that the Population Health Programme has celebrated this year. The report features a range of projects across the four Pillars of Population Health and the video has been shot in a variety of locations across the subregion, highlighting the diversity and breadth of our subregion. The video also features some of the fantastic people who are working directly with the local community to improve the health and wellbeing of the population. A short clip will be played at today's Board meeting, and you can watch the full version and download the full report on the NHS Cheshire and Merseyside and Champs Public Health Collaborative websites.

13. All Together Smiling Programme

13.1 Children and families across Cheshire and Merseyside will have the chance to learn about oral health in a fun and interactive way as part of a special oral health engagement roadshow taking place during National Smile Month.

13.2 The roadshow is part of the All Together Smiling Programme funded by NHS Cheshire and Merseyside and delivered through Beyond – the Cheshire and Merseyside children and young people's transformation programme in collaboration with Public Health teams. The programme aims to boost awareness of good dental hygiene and reduce tooth decay in the region's most vulnerable communities.

13.3 Tooth decay remains the leading cause of hospital admission for children aged five to nine, with those living in the most deprived communities 3.5 times more likely to have a decaying tooth extracted than children in more affluent areas

13.4 During National Smile Month (12 May-12 June 2025), the programme will take to the road using the Alder Hey mobile unit to visit all nine places across Cheshire and Merseyside. The oral health roadshow features stops in community hubs, shopping centres, and family-friendly venue. Further details can be found at: https://champspublichealth.com/all-together-smiling-roadshow/. This outreach builds on the success of the wider All Together Smiling

Supervised Toothbrushing Programme, which has already distributed more than 238,000 dental care packs to children across the region.

14. Decisions taken at the Executive Committee

14.1 Since the last Chief Executive report to the Board in March 2025, the following items have been considered by the Executive Team for decision:

- **ICB Estates** – the Executive Committee received a report on the current status of the ICBs Corporate premises and which outlined current costs, lease arrangements, break clauses, options for better utilisation and cost saving options to supports the ICBs cost reduction plans. Following review and discussion its was decided that the ICB would look to progress breaking the leases of those building where the option to do so was in year, progress work to look at how and when best to dispose of other corporate premises when the opportunity arises, establish two core ICB premises with one situated within each devolution region and progress establishing hot desking arrangements across all 9 places utilising existing partner estates.

- **Post-COVID Syndrome Review & Options Development** – the Executive Committee received an update paper that outlined the outcomes of the recent review of Post Covid service support options, as well as the findings of the recent engagement exercise across Cheshire and Merseyside. The Executive Committee considered a series of options that had been developed based on the results of the engagement as well as national and international research. The Executive Committee review gave support towards recommending Option 3 to the Board but requested that the commissioner leads for this programme should undertake further work to explore in more detail how the proposals effectively balances meeting the needs of patients alongside delivering the most cost effective option.

14.2 At its meetings throughout April and May 2025, the Executive Committee has also considered papers on or discussed the following areas:

- Annual Report and Accounts 2024-25
- Model ICB development work and change management arrangements
- Implementation of NICE Technology Appraisal for Tirzepatide
- Findings from the Gluten Free Public Consultation
- Senior Leadership Forum
- All Age Continuing Care Programme Update
- Financial Recovery and Financial Planning LGA suicide prevention situational analysis report.
- Section 117 aftercare
- Population Health Management.

14.3 At each meeting of the Executive Team, there are standing items on quality, finance, urgent emergency care, non-criteria to reside performance, industrial action, primary care access recovery, and Place development where members are briefed on any current issues and actions to undertake. At each meeting of

the Executive Team any conflicts of interest stated are noted and recorded within the minutes.

15. Officer contact details for more information

Graham Urwin
Chief Executive

Megan Underwood, Executive Assistant,
megan.underwood@cheshireandmerseyside.nhs.uk

Appendices

ALL APPENDICES CAN BE ACCESSSED BY CLICKING HERE

Appendix One: draft Operational Scheme of Reservation v1.4

Appendix Two: Model ICB Blueprint NHS England Document

Appendix Three: Carnall Farrar Summary of the Model ICB Blueprint

Appendix Four: Terms of Reference - NHS Cheshire and Merseyside Reconfiguration and Transition Task and Finish Group

Section	Description	Reserved By:																				
		Integrated Care Board (ICB)	Audit Committee	Remuneration Committee	Finance, Investment & Resources Committee	Strategy & Transformation Committee	Quality & Performance Committee	System Primary Care Committee	Shaping Care Together Joint committee	Place Committees	Children and Young Peoples Committee	Womens Hospital Services in Liverpool Committee	Research and Innovation Committee	Pharmacy Services Regulations Committee	Northwest Specialised Commissioning Services Joint Committee	Care Package Assurance panel	ICB Chief Executive	ICB Executive Director of Finance	ICB Chief System Improvement & Delivery officer	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	Place Directors	Other named ICB Officer (or as per ICB authorised signatory list)
A	**ACCEPTANCE OF GIFTS, HOSPITALITY & SPONSORSHIP** (Governance Lead to maintain a register of declared gifts and hospitality received)																Gifts over £50	Gifts over £50	Gifts over £50		Gifts up to £50	Gifts up to £50	Gifts up to £50	As delegated by Chief Executive / DoF at the limits outlined within the Authorised Signatory List
B	**LITIGATION CLAIM PAYMENTS** Medical negligence and other litigation payments made on the advice of NHS Resolution	Over £1,000,000															Up to £1,000,000	Up to £500,000						
C	**LOSSES & SPECIAL PAYMENTS** (CFO to maintain a register of losses and special payments (including bad debts to be written off). All payments to be reported to the Audit Committee.	Over £500,000			Up to £500,000												Up to £100,000	Up to £50,000		Up to £5,000				
D	**PETTY CASH FLOAT**																							
D1	Authorisation to set up float																Over £300	Over £300		Up to £300				
D2	Replenish petty cash float																							Head of Financial Services (or equivalent role)
D3	Issue petty cash																	Up to £50		Up to £50				Associate Director of Finance (Place)
E	**CREDIT CARD**																							
E1	Account signatories (who can make changes to the account, authorise additional card holders, amend card limit)																x	x		x				
E2	Authorise single transaction (single transaction limit £2,500)																x	x		x	x	x	x	x
F	**REQUISTIONING GOODS & SERVICES: NON-HEALTHCARE**																							
F1	Utilisation of External Agency Staff (based on total expected cost as per below notes) Supporting Notes: a) Prior approval from the ICB Vacancy Panel must be sought for all consultancy requests regardless of value. b) Prior approval from NHSE must be sought for: - Any appointments over £600 per day; or any appointments for over a 6 month period, or - any appointment with significant influence (e.g. ICB roles). c) prior to recruitment HR must conduct and sign off with relevant Director acknowledgement of IR35 compliance and/or status confirmation and in line with agreed ICB IR35 policy	Over £500,000			Up to £500,000												Up to £150,000	Up to £150,000	Up to £150,000	~~Up to £25,000~~ Up to £10,000	~~Up to £25,000~~ Up to £10,000	~~Up to £25,000~~ Up to £10,000	~~Up to £25,000~~ Up to £10,000	

Section	Description	Reserved By:																					
		Integrated Care Board (ICB)	Audit Committee	Remuneration Committee	Finance, Investment & Resources Committee	Strategy & Transformation Committee	Quality & Performance Committee	System Primary Care Committee	Shaping Care Together Joint committee	Place Committees	Children and Young Peoples Committee	Womens Hospital Services in Liverpool Committee	Research and Innovation Committee	Pharmacy Services Regulations Committee	Northwest Specialised Commissioning Services Joint Committee	Care Package Assurance panel	ICB Chief Executive	ICB Executive Director of Finance	ICB Chief System Improvement & Delivery officer	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	Place Directors	Other named ICB Officer (or as per ICB authorised signatory list)
F2	Utilisation of Consultancy (based on total expected cost as per below notes). Supporting Notes a) Prior approval from the ICB Vacancy Panel must be sought for all consultancy requests regardless of value. a) Prior approval from NHSE must be sought for: Any expenditure above £50,000: or Any appointments over £600 per day; or - Any appointments for over a 6 month period, or - Any appointment with significant influence (e.g. ICB roles) b) prior to recruitment HR must conduct and sign-off with relevant Director acknowledgement of IR35 compliance and/or status confirmation and in line with agreed ICB IR35 policy	Over £500,000			Up to £500,000												Up to £150,000	Up to £150,000	Up to £150,000		Up to £10,000	Up to £10,000	Up to £10,000	
F3	Services including IT, maintenance, and support services (over lifetime of contract) where not included within agreed annual budgets	Over £2,000,000			Up to £2,000,000												Up to £1,000,000	Up to £500,000	Up to £500,000		~~Up to £250,000~~ Up to £100,000	~~Up to £250,000~~ Up to £100,000	~~Up to £250,000~~ Up to £100,000	
F4	Approval of non-healthcare payments within agreed budget *With appropriate consideration of procurement requirements																Over £2,000,000	Up to £2,000,000	Up to £2,000,000	Up to £100,000	Up to £500,000 Up to £100,000	Up to £500,000 Up to £100,000	Up to £500,000 Up to £100,000	As delegated by Chief Executive / DoF at the limits outlined within the Authorised Signatory List
G	**RELOCATION EXPENSES** In line with Policy approved by ICB Remuneration Committee																Over £8,500	Up to £8,500						
H	**DECISION TO APPROVE 'NEW' INVESTMENT BUSINESS CASES**																							
H1	Where funding is: a) available and identified within agreed financial plan or b) from additional notified resource allocations (e.g. new in-year) c) other identified income streams (e.g. other agencies / recharges)	Over £10,000,000			Up to £10,000,000	Up to £1,000,000		Up to £1,000,000 *Primary Care Related	Up to £10,000,000						Up to £10,000,000		Up to £5,000,000	Up to £3,000,000	Up to £3,000,000	~~Up to £1,000,000~~ Up to £100,000	~~Up to £1,000,000~~ Up to £100,000	~~Up to £1,000,000~~ Up to £100,000	~~Up to £1,000,000~~ Up to £100,000	As delegated by Chief Executive / DoF at the limits outlined within the Authorised Signatory List
H2	Where not included in approved financial plan (but still subject to ICB Executive / Place Leadership Team Approval) N.B any material underspend / variation from plan at individual budget holder level cannot be reinvested / redirected (see Virement Policy - Section L) without Executive team approval due to overall financial management requirements of the ICB.	Over £5,000,000			Up to £5,000,000	Up to £500,000 *Specialised services related		Up to £500,000 *Primary Care Related	Up to £5,000,000						Up to £5,000,000		Up to £500,000	Up to £500,000	Up to £500,000		~~Up to £250,000~~ Up to £20,000	~~Up to £250,000~~ Up to £20,000	~~Up to £250,000~~ Up to £20,000	
H3	Primary Care Capital Expenditure Approval (within ICB allocation) NB - Capital Plan to be approved by the ICB for each financial year	Over £1,000,000						Up to £1,000,000 *Primary Care Related									Up to £1,000,000 (in urgent cases)	Up to £500,000 (in urgent cases)						
I	**CONTRACTING**																							
I1	Signing of Healthcare Contracts including S75 agreements. S75 approval via place governance processes in line with S75 agreements operational policy. (Annual Contract Value)																Over £500,000,000	Up to £500,000,000		Up to £75,000,000				
I2	Approval of Healthcare Contract Payments All healthcare contract payments must be supported by signed contract (see I1).																As per agreed plan / budget value	As per agreed plan / budget value)	As per agreed plan / budget value)	As per agreed plan / budget value)		As per agreed plan / budget value	As per agreed plan / budget value	As delegated by Chief Executive / DoF at the limits outlined within the Authorised Signatory List
I3	Signing of Non-Healthcare Contracts (Annual Contract Value)																Over £3,000,000	Up to £3,000,000		Up to £1,000,000		~~Up to £1,000,000~~ Up to £100,000	~~Up to £1,000,000~~ Up to £100,000	

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J	**APPROVAL OF OTHER HEALTHCARE PAYMENTS WITHIN BUDGET** See authorised signatory list for approval limits for other officers.																Over £1,000,000	Up to £1,000,000	Up to £1,000,000	Up to £100,000	Up to ~~£250,000~~ Up to £50,000	Up to ~~£250,000~~ Up to £50,000	Up to ~~£250,000~~ Up to £50,000	As delegated by Chief Executive / DoF at the limits outlined within the Authorised Signatory List
K	**QUOTATIONS AND TENDERS HEALTHCARE / NON-HEALTHCARE**																							
K1	Approval of ICB Procurement Plan				X																			
K2	Procurement route decision - in line with the options contained within the Healthcare Provider Selection Regime (2023) Regulations (Annual Contract Value)	X (For Novel or Contentious issues escalated by F!R Committee)			X From £5,000,000 with Novel or Contentious Procurement route decisions to be escalated to the Board	Up to £3,000,000		Up to £3,000,000							Up to £5,000,00		Up to £5,000,000	Up to £3,000,000	Up to £3,000,000	Up to £1,000,000	Up to £663,000	Up to £663,000	Up to £663,000	
NEW	Decision to put Non-Healthcare goods and services out to competive procurement (Total contract value)	X (For Novel or Contentious issues escalated by F!R Committee)			X From £5,000,000 with Novel or Contentious Procurement route decisions to be escalated to the Board												From threshold up to Up to £5,000,000	From threshold up to Up to £3,000,000	From threshold up to Up to £3,000,000	From threshold up to £1,000,000				
K3	Approval of Quotations for Non-Healthcare expenditure (total value)		£20,000 to procurement thresholds specified in the Procurement Act 2023 (PA23) (currently £215k including VAT) in line with delegated limits for expenditure type. Minimum of three written quotes required																					
K4	Quotation Waiver Approval for Non-Healthcare goods and services (Total Contract Value) – see detailed financial policy on tendering when permissible)		£20,000 to procurement thresholds (currently Non Healthcare £214k) in line with delegated limits for expenditure type																					
K5	Procurement for Non-Healthcare goods and services through approved national / local framework agreement (in line with call off rules) (Total Contract Value)		From £20k to delegated budgeted limit for expenditure type (with approval from procurement team) Above delegated budgeted limits, subject to Finance, Investment & Resources Committee Approval																					
K6	Tender Waiver Approval for Non-Healthcare goods and services	In line with limits for procurement route decisions N.B. Reporting of all Tender Waiver Approval to Audit Committee																						
K7	Opening of Tender Documentation (where not received electronically) (at least 2 people from list)																x	x	x	x	x			
L	**VIREMENT**	Relating to a transfer of funds from an unspent or underspent budget to another; within virement rules to allow greater financial flexibility in using available resources All Transfers must be: • affordable within budget; and • agreed by both budget holders Virements may not be used to create new budgets																						
L1	Within Existing Approved Pay or Non-Pay Budgets																Over £1,000,000	Up to £1,000,000		Up to £500,000		~~Up to £250,000~~ Up to £50,000	~~Up to £250,000~~ Up to £50,000	
L2	With regards to transfers from reserves (including distribution of new in-year resource / capital allocations)																	Up to £70,000,000		Up to £25,000,000				
M	**DISPOSALS AND CONDEMNATION** All assets disposed at market value.	Over £50,000															Up to £50,000	Up to £10,000		Up to £5,000				
N	**CHARITABLE FUNDS** (Not applicable to ICB)																							
O	**HUMAN RESOURCES**																							
O1	Approve HR Decisions Not Covered By ICB HR Policies or Is Exceptional To Policies (e.g. additional compassionate leave or exceptional carry forward of leave days)																x	x		x	x	x	x	

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O2	Decisions As Set Out Within HR Policies (where there is some management discretion e.g. study leave authorisation)																x	x			x	x	x	
O3	Approval of Operational Structure (re staffing and departments), and in accordance with organisation change policy																x							
O4	Approval of Appointment to Posts Below Executive Directors (following approval at Vacancy Panel)																	x		x	x	x	x	x
O5	Approval of the below arrangements as required by the ICB: - Approval of the arrangements for discharging the ICB statutory duties as an employer - Approve human resources policies for ICB employees and for other persons working on behalf of the ICB - Approve any other terms and conditions of services for ICB AFC employees - Approve disciplinary arrangements for ICB employees - Approve arrangements for staff appointments (excluding matters detailed within the Constitution) - Approve the ICBs organisational development plans				x (following endorsement of the People Committee)																			
P	**EXTERNAL COMMUNICATIONS & REPORTING**																							
P1	Approve Complaints Responses and Letters to Politicians and Media Responses																x					x (Assistant Chief Executive)		x (Associate Director of Corporate Affairs & Governance)
P2	Approve Public Consultation Material																x					x (Assistant Chief Executive)		
P3	Approve Public & Staff Engagement Material inc Website																x					x (Assistant Chief Executive)		
P4	Approve FOI Responses and Subject Access Requests																					x (Assistant Chief Executive)		x (Associate Director of Corporate Affairs & Governance)
P5	Approve Annual Engagement & Communication Plan	x																						
Q	**FINANCE** Approval of Operational Policies as required by the organisation				x																			
R	**INDIVIDUAL PACKAGES OF CARE**																							
R1	Approval of Individual AACC Packages of Care (Annual Value)															Annual value cost of over £104,000							~~Annual value cost up to £260,000~~ Annual value cost up to £104,000	As delegated by Chief Executive / DoF at the limits outlined within the Authorised Signatory List
R2	Approval of Mental Health and Learning Disability Packages of Care (complex and S117)															Where proposed cost (new or existing) is or takes the total cost to over £500 per week							Cost per week (new or existing cases) is less than £500 per week	As delegated by Chief Executive / DoF at the limits outlined within the Authorised Signatory List
S	**INFORMATION GOVERNANCE**																							
S1	Approve Digital and Data programmes Data Protection Impact Assessments (DPIA), Information / Data Sharing agreements and Data Processing Agreements																				x (SIRO and Caldicott Guardian)			x (ICB Data Protection Officer, SIRO and Caldicott Guardian, or their deputies)
S2	Approve Confidentiality Advisory Group (CAG) Applications																				x (SIRO and Caldicott Guardian)			x (ICB Data Protection Officer, Deputy SIRO and Deputy Caldicott Guardian)
S3	Approve NHS Digital Data Access Requests (DARs) – Data Sharing Agreements, Data Sharing Framework Contracts																				x (SIRO)			
S4	Data Security and Protection Toolkit submissions approval																				x (SIRO)			x (Deputy SIRO)
S5	Privacy Notices																				x (SIRO and Caldicott Guardian)			x (ICB Data Protection Officer, Deputy SIRO or Deputy Caldicott Guardian)

Model Integrated Care Board – Blueprint v1.0

Introduction

On 1 April, we wrote to Integrated Care Board (ICB) and provider leaders outlining how we will work together in 2025/26 to deliver our core priorities and lay the foundations for reform. The letter set out the critical role ICBs will play in the future as strategic commissioners, and in realising the ambitions that will be set out in the 10 Year Health Plan. As ICBs need to develop plans to reduce their costs by the end of May, we committed to clarifying the role of ICBs by co-producing a Model ICB Blueprint and sharing the functional output of this work.

This Model ICB Blueprint has been developed by a group of ICB leaders from across the country, representing all regions and from systems of varying size, demographics, maturity and performance. It is a joint leadership product, developed and written by ICBs in partnership with NHS England. The group has worked together at pace to develop a shared vision of the future with a view to providing clarity on the direction of travel and a consistent understanding of the future role and functions of ICBs.

The delivery of the 10 Year Health Plan will require a leaner and simpler way of working, where every part of the NHS is clear on its purpose, what it is accountable for, and to whom. We expect the 10 Year Health Plan to set out more detail on the wider system architecture and clarify the role and accountabilities of trusts, systems, and the centre of the NHS.

We are sharing this blueprint with you today without the corresponding picture of what the future of neighbourhood health will look like or the role of the centre or regional teams.

We are also sharing this now without the benefit of the wide engagement with staff and stakeholders that will be required to get the detail and implementation right. Given the pace at which this work has been developed over recent weeks, our initial focus has been system-led design. We are now sharing it more widely for discussion and refinement and will be setting up engagement discussions over the coming weeks.

This blueprint document marks the first step in a joint programme of work to reshape the focus, role and functions of ICBs, with a view to laying the foundations for delivery of the 10 Year Health Plan. It is clear that moving forwards, ICBs have a critical role to play as strategic commissioners working to improve population health, reduce inequalities and improve access to more consistently high-quality care and we look forward to shaping the next steps on this together.

1. Context

In July 2022, Integrated Care Boards (ICB) were established with the statutory functions of planning and arranging health services for their population, holding responsibility for the performance and oversight of NHS services within their footprint. Alongside these system leadership and commissioning roles, they were also set up with a range of delivery functions, including emergency planning, safeguarding and NHS Continuing Healthcare assessment and provision.

As the Darzi review noted[1], since 2022, there have been differing interpretations of the role of ICBs, with some leaning towards tackling the social determinants of health, some focused on working at a local level to encourage services to work more effectively together, and some focused on supporting their providers to improve (in particular) financial and operational performance. The wider context, including performance measures focused on hospitals and the requirement for ICBs to ensure their Integrated Care System (ICS) delivers financial balance, mean that ICBs have found it hard to use their powers to commission services in line with the four ICS objectives. This has largely resulted in the status quo with increasing resources directed to acute providers, when the four objectives should have instead led to the opposite outcome.

As the Darzi review concludes, the roles and responsibilities of ICBs need to be clarified to provide more consistency and better enable the strategic objectives of redistributing resource out of hospital and integrating care. Crucial to this is a rebuilding of strategic commissioning capabilities, requiring "*as strong a focus on strategy as much as performance*" and a parallel investment in the skills required to "*commission care wisely as much as to provide it well*".

The 10 Year Health Plan will reinforce the criticality of this role and the Secretary of State is clear about his desire – and the need – to deliver the three shifts. The NHS needs to deliver better value for its customers – the population of England. This means increasingly focusing on prevention and reducing inequalities, delivering more services in a community/ neighbourhood based setting – and ensuring all services are delivered as efficiently and effectively as possible, in particular through the use of technology.

Across the NHS, these three strategic shifts form the foundation of the Model ICB's approach to transformation and redesign:

- **treatment to prevention:** A stronger emphasis on preventative health and wellbeing, addressing the causes of ill health before they require costly medical intervention and

[1] https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england

reducing inequalities in health. This involves proactive community and public health initiatives, working closely with local authorities, to keep people healthy.

- **hospital to community:** Moving care closer to home by building more joined-up, person-centred care in local neighbourhoods, reducing reliance on acute care.
- **analogue to digital:** Harnessing technology and data to transform care delivery and decision-making. From digital health services for patients, to advanced analytics (population health management, predictive modelling) for planners, the focus is on smarter, more efficient, and more personalised care.

These shifts set the direction for how ICBs need to operate going forward. The NHS needs strong commissioners who can better understand the health and care needs of their local populations, who can work with users and wider communities to develop strategies to improve health and tackle inequalities and who can contract with providers to ensure consistently high-quality and efficient care, in line with best practice.

This document, developed by a working group consisting of ICB leaders from across the country, sets out a blueprint for how ICBs can operate within a changing NHS landscape. It covers the following areas:

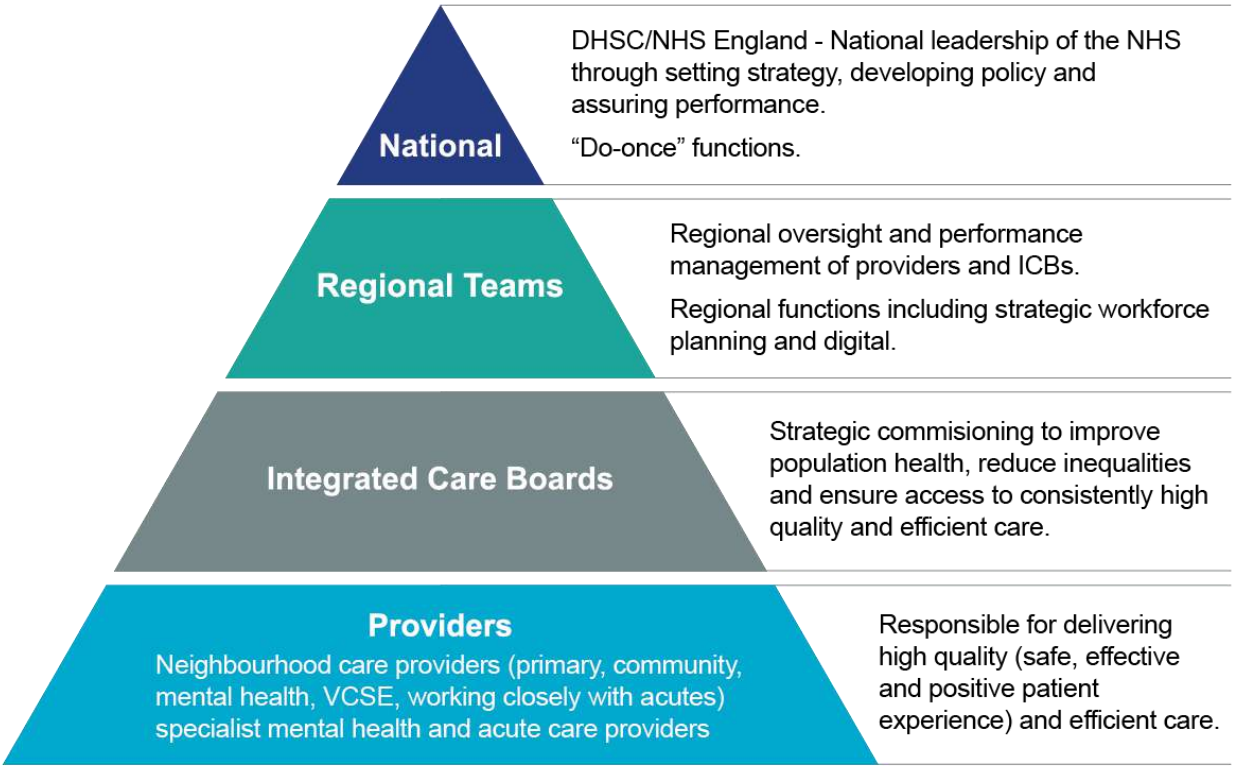
- **purpose** – why ICBs exist
- **core functions** – what they do
- **enablers and capabilities** – what needs to be in place to ensure success
- **managing transition** – supporting ICBs to manage this transition locally and the support and guidance that will be available.

2. Purpose and role: why ICBs exist

ICBs exist to improve their population's health and ensure access to consistently high-quality services. They hold the accountability for ensuring the best use of their population's health budget to improve health and healthcare, both now and in the future.

ICBs provide system leadership for population health, setting evidence based and long-term population health strategy and working as healthcare payers to deliver this, maximising the value that can be created from the available resources. This involves investing in, purchasing and evaluating the range of services and pathways required to ensure access to high quality care, and in order to improve outcomes and reduce inequalities within their footprint. ICBs not only commission services but also align funding and resources strategically with long-term population health outcomes and manage clinical and financial risks.

The refreshed role of ICBs has been developed through a set of assumptions about a refreshed system landscape, along the lines set out below:



3. Core functions: What ICBs do

To deliver their purpose, ICBs focus on the following core functions:

The following table summarises the activities that make up these core functions.

Model ICB core functions and activities	
Activity	**Detail**
1. Understanding local context: assessing population needs now and in the future, identifying underserved communities and assessing quality, performance and productivity of existing provision	
Population data and intelligence	• Using data and intelligence (including user feedback, partner insight, outcomes data, public health insight) to develop a deep and dynamic understanding of their local population and their needs and how these are likely to change over time • Leveraging real-time data and predictive modelling to identify risk, understand variation, and direct resources where they will have the greatest impact (allocative efficiency) • Segmenting their population and stratifying health risks • Dis-aggregating population health data to surface inequalities, generate actionable insights, inform service design and deployment and scrutinise progress towards equity
Forecasting and modelling	• Developing long-term population health plans using epidemiological, actuarial, and economic analysis • Forecasting and scenario modelling demand and service pressures • Understanding current and future costs to ensure clinical and financial sustainability • Convening people, communities and partners to challenge, critique and inform population health plans, demand modelling and cost forecasts
Reviewing provision	• Reviewing current provision using data and input from stakeholders, people and communities • Building a deep understanding of operational performance, quality of care (safety, effectiveness, user experience) and productivity/unit cost across all providers
2. Developing long term population health strategy: Long-term population health planning and strategy and care pathway redesign to maximise value based on evidence	
Developing strategy with options for testing and engagement	• Drawing on a variety of inputs (analysis of population health needs, evidence base on what works, national and international examples, user priorities, innovation and horizon scanning, bottom-up costing, principles of healthcare value, impact/feasibility analysis) to develop strategic options for testing and engagement with partners, people and communities • Developing and agreeing best practice care pathways with partners, people and communities, using national guidance and working closely with local clinical leaders to inform this

	• Aligning funding with need and impact using locally adapted actuarial models and bottom-up costing ("should cost" principles) • Ensuring efficiency and equity using value-based approaches to prioritisation, underpinned by public health principles
Setting strategy	• Setting overall system strategy to inform allocation of resources to maximise improved health and access to high quality care (safety, effectiveness, user experience), shifting focus from institutions to population outcomes, and targeting health inequalities by improving equity of access, experience and outcomes • Determining where change is required, the priority outcomes for improvement and population metrics to track • Co-producing strategy with communities, reflecting unmet needs and targeting inequalities • Designing new care models and investment programmes and co-ordinating major transformation programmes • Collaborating with local authorities, place-based partnerships, provider collaboratives, academia, think tanks, and analytics partners to develop and refine strategy
3. Delivering the strategy through payer functions and resource allocation: oversight and assurance of what is purchased and whether it delivers outcomes required	
Strategic purchasing	• Aligning funding to needs using data-driven models • Defining outcome-linked service specifications • Setting strategic priorities for quality assurance and oversight, developing policies and frameworks for quality improvement • Prioritising interventions to address health inequalities
Market shaping and management	• Understanding the different costs and outcomes of a range of providers • Building robust "should cost" and "should deliver" models to test against • Introducing and encouraging new providers where gaps exist in the market, for example, frailty models • Working with providers to understand factors necessary for sustainability, for example, the link between elective orthopaedics and trauma • Exploring a range of payment mechanisms
Contracting	• Negotiating and managing outcome-based contracts • Monitoring provider performance and benchmarking services with continuous review of impact, access and quality • Using performance frameworks, invoice validation • Establishing procurement governance, value-for-money checks

Payment mechanisms	• Designing incentives (blended payments, gainshare, shared savings) to improve equity, efficiency and productivity • Implementing risk mitigation strategies (for example, collaborative risk-pools) • Using financial stewardship tools (cost-effectiveness thresholds, return on investment) • Deploying payment models to improve equity (for example, blended payments linked to reducing inequalities)
4. Evaluating impact: day-to-day oversight of healthcare utilisation, user feedback and evaluation to ensure optimal, value-based resource use and improved outcomes	
Utilisation management	• Day-to-day oversight of service usage using real-time dashboards (admissions, urgent and emergency care attendances, prescribing, coding etc.) • Identifying unwarranted care variations utilising benchmarking tools and clinical audits and unwarranted over treatment, for example cataracts • Convening clinical reviews and managing complex cases • Optimising care pathways with providers
Evaluating outcomes	• Evaluating the outcomes from commissioned services • Rigorous monitoring of priority metrics, identifying unwarranted variation and clear feedback loops to inform commissioning adjustments and understand the return on investment • Establishing feedback loops for adaptive planning • Embedding feedback from people and communities, staff and partners into evaluation approaches
User feedback, co-design and engagement	• Evaluation, co-design and deliberative dialogue with people and communities, using design thinking methodologies • Ensuring user feedback mechanisms are embedded in how resource is allocated and evaluated
Governance and Core Statutory Functions: Ensures the ICB is compliant, accountable, and safe	
Ensuring the ICB is compliant, accountable and safe	• Establishing robust governance structures and processes to ensure legal compliance, transparency and public accountability • Fulfilling statutory duties (for example, equality, public involvement) and monitoring of equity outcomes alongside access, quality, and efficiency • Implementing strong clinical and information governance and effective financial and risk management systems • Maintaining business continuity and emergency planning • Overseeing delegated functions with proportionate assurance

ICB functional changes

To support the development of the future state, ICBs should consider the following assumptions about some of the functional changes that could happen. We are sharing this to provide an indication of the future state, however the detail and implementation will depend on multiple factors, including engagement and refinement with partners, the parallel development of provider and regional models, readiness to transfer and receive across different parts of the system and, in some cases, legislative change.

ICBs will need to work closely with their staff to ensure they are supported, to retain talent and to safely manage delivery across the wider system and public sector, including when functions move to different parts of the landscape.

Given the implications of these functional changes on different parts of the system, next steps will need to be developed by working closely with partners nationally and within local systems over the coming months. In light of this, no specific timeframes are provided at this stage.

ICB functional changes		
Change to manage	**Functions in scope**	**Guiding notes**
Grow: functions for ICBs to grow / invest in over time to deliver against the purpose and objectives	Population health management – data and analytics, predictive modelling, risk stratification, understanding inequalities	• Essential for core role and activities • Can be delivered within existing legislation • Will require investment in new capabilities over time
	Epidemiological capability to understand the causes, management and prevention of illness	
	Strategy and strategic planning including care pathway redesign	
	Health inequalities and inclusion expertise – capacity and capability to routinely dis-aggregate population and performance data to surface health inequalities, generate actionable insights, drive	

	evidence informed interventions and build intelligence to guide future commissioning and resource allocation decisions	
	Commissioning neighbourhood health	
	Commissioning of clinical risk management and intervention programmes (working with neighbourhood health teams to ensure proactive case finding)	
	Commissioning end-to-end pathways (including those delegated by NHS E: specialised services; primary medical, pharmacy, ophthalmic and dental services (POD); general practice, and further services that will be delegated by NHS England to ICBs over time) *Vaccinations and screening will be delegated by NHS England to ICBs in April 2026* *All remaining NHS England direct commissioning functions will be reviewed during 2025/26*	
	Core payer functions – strategic purchasing, contracting, payment mechanisms, resource allocation, market shaping and management, utilisation management	
	Evaluation methodologies and evidence synthesis using qualitative and quantitative data, feedback and insights	

	User involvement, user led design, deliberative dialogue methodologies	
	Strategic partnerships to improve population health (public health, local partners, VCSE, academia, innovation)	
Selectively retain and adapt: functions for ICBs to retain and adapt including by delivering at scale	Quality management – understanding drivers of improved health, range of health outcome measures, elements of high-quality care (safety, effectiveness, user experience); child death reviews	• Embed in commissioning cycle, monitoring of contracts • Avoid duplication with providers, regions and CQC • Use automated data sources and single version of the truth
	Board governance	• Look to streamline Boards to deliver core role as set out • Headcount should be reduced at Board level with the right roles and profiles to deliver core Model ICB functions
	Clinical governance	• Strengthen focus on embedding management of population clinical risk, best practice care pathways in commissioning approach
	Corporate governance (including data protection, information governance, legal services)	• Maintain good governance practice; look to deliver some functions at scale across ICBs
	Core organisational operations (HR, communications, internal finance, internal audit, procurement, complaints, PALs)	• Look to streamline and deliver some functions at scale
	Existing commissioning functions, including clinical policy and effectiveness – local funding decisions (individual funding	• Will be built into new commissioning/payer functions operating at ICB and pan-ICB level

	requests; clinical policy implementation)	
Review for transfer: functions and activities for ICBs to transfer over time, enabled by flexibilities under the 2022 Act for ICBs to transfer their statutory duties	Oversight of provider performance under the NHS performance assessment framework (finance, quality, operational performance)	• Performance management, regulatory oversight and management of failure to transfer to regions through the NHS Performance and Assessment Framework • Market management and contract management functions to be retained and grown in ICBs
	Emergency Preparedness, Resilience and Response (EPRR) and system coordination centre	• Transfer to regions over time
	High level strategic workforce planning, development, education and training	• Transfer to regions or national over time, retain limited strategic commissioning overview as part of strategy function
	Local workforce development and training including recruitment and retention	• Transfer to providers over time
	Research development and innovation	• Transfer to regions over time, with ICBs retaining and building strategic partnerships to support population health strategy
	Green plan and sustainability	• Transfer to providers over time
	Digital and technology leadership and transformation	• Transfer digital leadership to providers over time enabled by a national data and digital infrastructure
	Data collection, management and processing	• Transfer to national over time
	Infection prevention and control	• Test and explore options to streamline and transfer some activities out of ICBs

	Safeguarding	• Test and explore options to streamline and transfer some activities out of ICBs (accountability changes will require legislative changes)
	SEND	• Test and explore options to streamline and transfer some activities out of ICBs (accountability changes will require legislative changes)
	Development of neighbourhood and place-based partnerships	• Transfer to neighbourhood health providers over time
	Primary care operations and transformation (including primary care, medicines management, estates and workforce support)	• Transfer to neighbourhood health providers over time
	Medicines optimisation	• Transfer delivery to providers over time, retain strategic commissioning overview as part of strategy function
	Pathway and service development programmes	• Transfer to providers, retain strategic commissioning overview as part of strategy function
	NHS Continuing Healthcare	• Test and explore options to streamline and transfer some activities out of ICBs (accountability changes will require legislative changes)
	Estates and infrastructure strategy	• Transfer to providers over time, retain limited strategic commissioning overview as part of strategy function
	General Practice IT	• Explore options to transfer out of ICBs ensuring consistent offer

4. Enablers and capabilities: what ICBs need to ensure success

For an ICB to effectively perform the core functions set out in section 3, several key enablers need to be in place. A high-level summary of these is set out below:

- **Healthcare data and analytics –** to enable ICB decisions to be guided by population health data and insights, ICBs will need to develop strong population health management approaches underpinned by robust data capability. This will need to include developing the capabilities to segment the population and stratify risk and build a person-level, longitudinal, linked dataset integrating local and national data sources alongside public and patient feedback. There will need to be appropriate data-sharing and governance agreements to track individuals' journeys across health and care (to understand needs and outcomes holistically); and deploy predictive modelling to foresee future demand, cost and impact of interventions. ICBs will need to cultivate teams with the ability to analyse and interpret complex data (health economists and data-scientists) and deploy data-driven techniques (such as modelling the return on investment for preventative interventions). Data can be integrated reliably between services to provide real-time, accurate data enabling better decision-making and interoperability – the NHS Federated Data Platform (FDP) will be crucial to enable this work, and should be used as the default tool by ICBs.

- **Strategy –** ICBs will need to develop effective strategy capability, comprised of individuals with good problem solving and analytical skills. They will need to foster a greater understanding of value-based healthcare alongside the ability to synthesise a range of information (qualitative and quantitative) and develop actionable insights to support prioritisation. ICBs will need strategic leaders who can diplomatically and collaboratively work with a range of partners including by facilitating multi-agency forums and collaborative decision-making. They will also need the ability to navigate and synthesise complexity so that people and communities, staff and partners can understand the full picture, and be able to draw people together around the shared goal of improving population health.

- **Intelligent healthcare payer –** for ICBs to develop into sophisticated and intelligent healthcare payers, they will need to invest in their understanding of costs ('should cost' analysis) and wider finance functions, developing capabilities in strategic purchasing, contracting, design and oversight of payment mechanisms, utilisation management and resource allocation. This will need to include commercial skills for innovative contracting and managing new provider relationships. ICB staff will need to learn how to proactively manage and develop the provider market, using procurement and contracting levers to incentivise quality improvement and innovation. This should involve techniques that ensure effective use of public resources so that investment decisions are guided by

relative value, not just demand or precedent. This calls for deliberate use of tools such as programme budgeting and decommissioning frameworks to support allocative efficiency.

- **User involvement and co-design –** for services to truly meet communities' needs, people must be involved from the very start of planning through to implementation and review. Each ICB should have a systematic approach to co-production – meaningfully involving patients, service users, carers, and community groups in designing solutions. This goes beyond formal consultation and means working with people as partners. ICBs will need to ensure that focused effort and resources are deployed to reach seldom heard and underserved people and communities, working with trusted community partners to achieve this. Ultimately, this enabler is about shifting the relationship with the public from passive recipient to active shaper of health and care, with a particular focus on underserved communities.

- **Clinical leadership and governance –** ICBs will need effective clinical leadership embedded in how they work, ensuring they have a solid understanding of population clinical risk and of the best practice care pathways required to meet population needs and improve outcomes. Clinical governance and oversight will be crucial in ensuring that the decisions that ICBs make are robust, particularly regarding the prioritisation of resources. Contract management of commissioned services will need to include effective quality assurance processes.

- **System leadership for population health –** effective system leadership will be essential to driving improvements in population health. ICB leaders and staff need to be adept at system thinking, analytics, and collaboration. They will need to work diplomatically and be comfortable driving change and influencing without direct authority. ICBs should develop and foster strategic partnerships across their footprints with a range of partners (including academia, VCSE, innovation), alongside working together with providers and local government as they develop and implement their strategies.

- **Partnership working with local government –** recognising the critical and statutory role of local authorities in ICSs and as partner members of ICBs, engagement and co-design with local government will be critical to the next phase of this work. Linked to this, is the need for ICBs to continue to foster strong relationships with the places within their footprint, building a shared understanding of their population and working together to support improved outcomes, tackle inequalities and develop neighbourhood health. We will be working jointly with the Local Government Association to take this development work forwards.

- **Supporting ICB competency and capability development – national support offer and maturity assessment –** it is proposed that a national programme of work, including

a new commissioning framework, is developed to ensure ICBs have the necessary capabilities and competencies to discharge their functions effectively. This should be developed by learning from successful international models and World Class Commissioning and form the basis of future assessments of ICB maturity.

5. Managing the transition

The ask on ICBs is significant this year as they work to maintain effective oversight of the delivery of 2025/26 plans, build the foundation for neighbourhood health and manage the local changes involved with ICB redesign, including supporting their staff through engagement and consultation.

To support with this, the following sections set out some high-level principles around:

- delivering ICB cost reductions plans and realising the savings
- managing the impact on staff
- designing leadership structures of ICBs
- managing risk during transition through safe governance
- expectations for safe transition of transferred functions

Delivering ICB cost reductions plans and realising the savings

ICBs will need to use this guidance to create bottom-up plans which are affordable within the revised running cost envelope of £18.76 per head of population. More details on this are set out below:

- the calculations to derive the £18.76 operating cost envelope include all ICB running costs and programme pay (only excluding POD and specialised commissioning delegation)
- the reduction in ICB costs to meet this target must be delivered by the end of Q3 2025/26 and recurrently into 2026/27
- ICBs are encouraged to expedite these changes as any in-year savings can be used on a non-recurrent basis to address in-year transition pressures or risks to delivery in wider system operational plans and potentially sooner to mitigate and de-risk financial plans
- there will be flexibility at an ICB-level, as some inter-ICB variation may be warranted and will need to be managed within a region to account for hosted services, however we expect delivery of the target at an aggregate regional level
- generating savings cannot be a cost shift to a provider unless overall there is the saving, for example, a provider takes on an ICB operated service and therefore requires circa 50% less cost in line with the £18.76 running cost envelope

We recognise that not all functional changes to reach the Model ICB can be done this year as some changes will require legislation and any transfer arrangements will need to be

carefully managed to ensure safe transition. Recognising this, we anticipate that most savings will come from streamlining approaches, identifying efficiency opportunities – through benchmarking, AI and other technological opportunities and from at scale opportunities afforded through greater collaboration, clustering and where appropriate, eventual merger of ICBs. Principles to apply to footprints, clustering and mergers will be communicated and coordinated by regional teams.

NHS England is providing a planning template to facilitate the May 2025 plan returns. This will be issued in the week commencing 6 May 2025. Plans should be submitted to your regional lead by 5pm on **30 May 2025**. Plans will set out how each ICB intends to achieve the £18.76 operating cost envelope and will then go through a national moderation process (involving a confirm and challenge process) to support consistency of approach and sharing of opportunities. These plans should be informed at a high level by the vision set out in this blueprint.

Support for managing the impact on staff

A national support offer will be available to ensure fair and supportive treatment of staff affected by the transition. This includes advice on voluntary redundancy and Mutually Agreed Resignation Schemes (MARS), along with guidance on redeployment and retention where appropriate. Funding mechanisms to support these options will be clarified centrally ensuring local systems can manage workforce changes consistently. Emphasis will be placed on transparent, compassionate communication and engagement to retain talent and maintain morale through the change process. We will work in partnership with trade union colleagues to implement the change for staff.

Advice on leadership structures of ICBs

ICBs are expected to maintain clear, accountable leadership with effective governance during the transition and beyond. ICBs should look to streamline Boards and reduce headcount at Board level to deliver core purpose and role as described. Leadership structures and executive portfolios should also reflect the functions as set out above, including skills in population health data and insights, strategic commissioning (including strategy, partnerships and user involvement), finance and contracting and clinical leadership and governance. At Board level, a strong non-executive presence is encouraged to support both oversight and the delivery of transition priorities.

Managing risk during transition through safe governance

To ensure a safe and coherent transition, each ICB should establish a dedicated Transition Committee, including both executive and non-executive members. These committees will take responsibility for managing local risks, tracking progress, and overseeing the development of organisational design and implementation of change processes.

To support this work, a central NHS England programme team — under the leadership of an Executive SRO — will be set up to provide coordination, support and a check and challenge process on ICB plans. This will seek to ensure appropriate support guidance is developed to facilitate the transition, share best practices, and facilitate consistency across systems to deliver the vision set out here. This central support will also help ICBs navigate legal, operational, and workforce challenges while ensuring focus remains on delivery of statutory duties throughout the transition.

Expectations for safe transition of transferred functions

Safe transition of functions is critical to the success of the new Model ICB design and the future system landscape. To manage this transition effectively, an assessment of readiness is necessary for both the sender and the receiver. Implementing a gateway process will help verify readiness before transferring staff and functions underpinned by clear governance frameworks, outcome metrics, financial risk arrangements, and escalation protocols to ensure safe and effective delivery.

NHS England is currently developing the operating model for the Model Region. We will continue to work with ICBs as we develop the regional approach to ensure alignment with the Model ICB design and implementation. We have been clear that performance management of providers against the NHS Performance and Assessment Framework (NPAF) will transfer to Regions under the new design. It will be important to be clear on responsibilities as these functions transfer. Once transferred ICBs will oversee providers through their contracting arrangements but will not be responsible for leading the regulatory oversight of providers against the NPAF.

Frequently asked questions

FAQs covering all aspects of transition is being developed to support ICBs as they manage these elements locally.

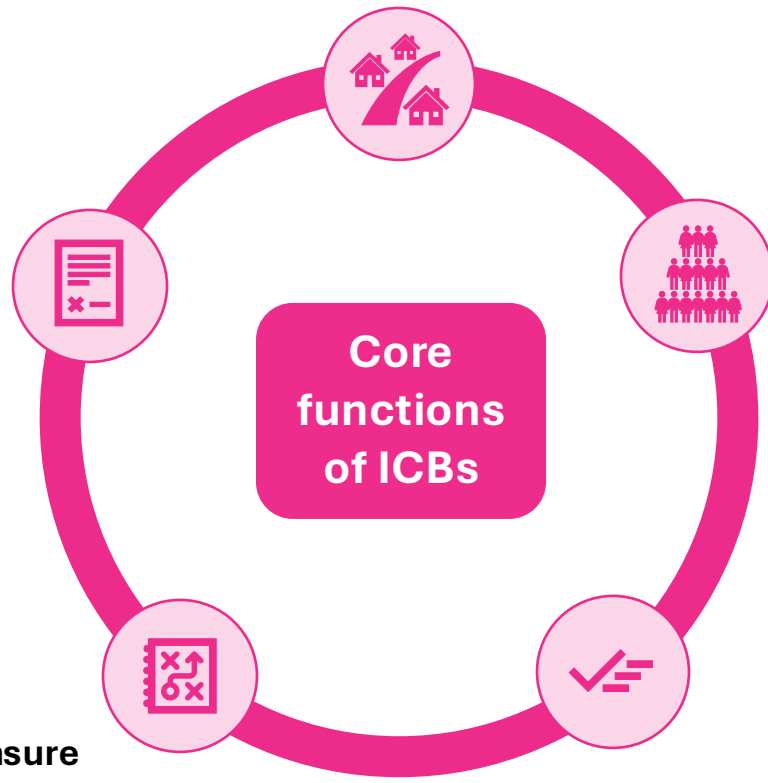
Please direct any questions to england.Model-ICB@nhs.net and we will use these to inform future sets of FAQs.

An overview of the NHS Model Integrated Care Board Blueprint

Experts in health

As part of the ongoing reforms to the structures within the NHS, a **new Blueprint for a Model ICB** has been issued to **clarify the future role of ICBs** and their purpose: **to improve their population's health**, ensure **access to high-quality services**, and **ensure the best of the population's health budget.**

1 **Understanding local context** through
- Population data and intelligence
- Forecasting and modelling
- Reviewing care provision and understanding performance



2 **Developing long-term population health strategy**
- Developing strategic options for testing and engagement
- Setting strategy for the system, co-designed with local people,

3 **Delivering the strategy through payer functions and resource allocation**
- Strategic purchasing
- Market shaping and engagement
- Contracting
- Payment mechanisms to improve equity, mitigate risk, and incentivize productivity

4 **Evaluating impact to ensure optimal, value-based resource use and improved outcomes**
- Utilisation management
- Evaluating outcomes
- User feedback, co-design and engagement

5 **Governance and core statutory functions,** ensuring the ICB is compliant, accountable and safe
- Establishing robust governance structures
- Fulfilling statutory duties and monitoring equity of outcomes

Enablers and capabilities required to ensure success

Health care data and analytics, including population segmentation, predictive modelling, with FDP as the default

Strategy capability, with strategic leaders able to work collaboratively

Intelligent healthcare payer through "should-cost" analysis and proactive management of provider markets

User involvement and co-design with local people meaningfully involved as active shapers of health and care

Clinical leadership and governance embedded in ways of working

System leadership for population health, with leaders and staff adept in system thinking

Partnership working with local government, building a shared understanding and collaborating

National programme of work to support ICB competency and capability development

Changes required

ICBs are expected to **create bottom-up plans** within an envelope of **£18.76 per capita**,to be **delivered by the end of Q3** 2025/26, with savings to come from **streamlining, efficiencies** and **at-scale opportunities** through collaboration, clustering and eventual merging

ICBs should **streamline Boards** and **reduce headcount**, with a **strong non-executive** presence encouraged to support oversight and delivery of transition priorities

Source: https://www.hsj.co.uk/integrated-care/cut-board-headcount-icbs-told/7039238.article

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Operational Model Reconfiguration and Transition Task and Finish Group

Terms of Reference

DOCUMENT CONTROL SHEET

Name of Document:	C&M ICB Operational Model Reconfiguration and Transition Task and Finish Group Terms of Reference
Version:	1.2
Date Of This Version:	02 May 2025
Produced By:	Matthew Cunningham, Associate Director of Corporate Affairs and Governance
Reviewed By:	C&M ICB Operational Model Reconfiguration and Transition Task and Finish Group
Ratified By (Committee):	C&M ICB Operational Model Reconfiguration and Transition Task and Finish Group
Date Ratified:	06.05.25
Distribute To:	Task and Finish Group Members
Date Due For Review:	01.11.25

Table 1 - document control, including author, version detail and approval

Revision History

Revision Date	Summary of changes	Author(s)	Version Number
02.05.25	Initial Draft	Matthew Cunningham	1.0
03.05.25	Inclusion of COI statement and additions to responsibilities	Cathy Elliott	1.1
06.05.25	Revision of purpose and tasks	Raj Jain	1.2

Table 2 - summary of revisions made to previous versions

NHS Cheshire and Merseyside Operational Model Reconfiguration and Transition Task and Finish Group

Terms of Reference

1. Purpose

The Cheshire and Merseyside ICB Operational Model Reconfiguration and Transition Task and Finish Group (the "Group") is established to support C&M ICB in determining the most effective organisational structure to deliver its strategic objectives within the budget allocated.

The Group's main purpose is to:

- recommend to Board an affordable Operating Model aimed at delivering C&M's Joint Forward Plan and Annual Plans
- oversee the development of the delivery plan so that the Operating Model is able togo live at an agreed date. This will include:
    - due regard to NHSE guidance
    - due regard to ICB constitution, statutory and regulatory requirements
    - detailed description of capabilities the transformed organisation must have and how these capabilities will be secured.
    - Governance (new) Plan
    - Financial Plan
    - Workforce Change Plan
    - Comms and Engagement Plan
    - ensure delivery of QIA and EIA
    - planning for the transition of functions/staff to provider and NHSE
    - risks and issues control and mitigation
- ensure reporting requirements of Board and NHS England are met.

The group will be time-limited to oversee the implementation of the above. The Chief Executive will identify a core team who will undertake the work required by the T&F Group and ensure timely delivery of the asks.

The Group will make recommendations to the Board of NHS Cheshire and Merseyside and provide assurance on matters determined by the Board and Group.

The Group has no executive powers, other than those delegated to the members of the Group in line with the ICB Scheme of Reservation and Delegation (SoRD) and Operational SoRD. For the avoidance of doubt, in the event of any conflict, NHS Cheshire and Merseyside Standing Orders, Standing Financial Instructions and the SoRD will prevail over these terms of reference other than the committee being permitted to meet in private.

For the avoidance of doubt, the Group **will not** undertake any of the responsibilities of the Remuneration Committee.

2. Membership and attendance

Membership

The Group members shall be appointed by the Chair of NHS Cheshire and Merseyside.

The formal membership of Group will be:

- NHS Cheshire and Merseyside Chair (Chair)
- at least x2 C&M ICB Non-Executive Members
- Chief Executive
- Medical Director
- Executive Director of Nursing
- Executive Director Finance.

Chair
The Group will be Chaired by the ICB Chair. The Chair will be responsible for agreeing the agenda, ensuring that the business discussed is line with the responsibilities of the Group. The Chair will ensure that the matters discussed meet the objectives as set out in these terms of reference.

Attendees
Only members have the right to attend Group meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Group. Meetings may also be attended by the following individuals who are not members of the Group for all or part of a meeting as and when appropriate. These include, but not limited to:

- Assistant Chief Executive
- Chief People Officer
- other senior officer as requested by the Chair of the Group
- Board Secretary or Secretariat.

Conflicts of Interest
The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters, managing conflicts of interest. Conflicts of interest will be proactively managed for the work of the Task and Finish Group, including at each meeting, in line with the Board's overall practice.

3. Meeting Arrangements

The Group will meet at least fortnightly (or as needed) to enable it to carry out its functions. Meetings will be held in private either in person or virtually.

The meetings will:

- have an agreed agenda (distributed at least 2 days prior to meet)
- use Programme Management methods to structure and document its work
- be noted (actions, issues and risks)
- have a risk log
- provide a summary report to Board as determined by Chair.

As this is a Task and Finish Group with no decision-making authority, there will be no formal requirements for quorum and voting etc. Decisions on recommendations should be reached by consensus, however the Chair will have final say.

4. Accountability and Reporting

The Group shall provide any relevant updates and reports to the ICB Board via a Chair's report. Reports may be redacted in some instances where appropriate.

5. Secretariat and Administration

The Group shall be supported with a Programme Management and Secretariat function, which will include ensuring that:

- the agenda and papers are prepared and distributed having been agreed by the Chair;
- key notes and action points are taken to ensure there is a record of these, with action points and issues to be carried forward are kept.
- the Chair / Chief Executive is supported to prepare and deliver reports to the Group.

6. Review

These terms of reference will be reviewed at least quarterly and earlier if required.

Date of approval: 06.05.25

Date of review: 01.11.25

NHS
Cheshire and Merseyside

Meeting of the ICB Board
NHS Cheshire and Merseyside

29 May 2025

Cheshire and Merseyside Integrated Care System Finance Report pre-audit Month 12 (2024/25)

Agenda Item No: ICB/05/25/06

Responsible Director: Mark Bakewell, Executive Director of Finance (Interim)

NHS
Cheshire and Merseyside

Cheshire and Merseyside System Finance Report pre-audit Month 12

1. Purpose of the Report

1.1 This report provides an update to the Board of NHS Cheshire and Merseyside on the financial performance of the Cheshire and Merseyside ICS ("the ICS") at Month 12 2024/25, in terms of relative position against its financial plan, and alongside other measures of financial and operational performance (e.g. efficiency, productivity and workforce).

1.2 The Board is asked to note the contents of this report in respect of the final 2024/25 ICS financial position for both revenue and capital allocations.

2. Executive Summary

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

2.2 On 2nd May 2024 the System 'ICS' plan submitted was a combined £215.8m deficit, consisting of £40.9m surplus on the commissioning side (ICB) partially offsetting an aggregate NHS Provider deficit position of £256.7m. This plan was not approved by NHS England (NHSE), and subsequently a revised plan of £150m deficit (£62.3m surplus for the ICB and £212.3m for providers) was agreed and submitted on 12th June 2024.

2.3 NHSE issued an allocation of £150m 'revenue deficit support' to the ICB in month 6 to cover the deficit to allow the financial system plan to be modified to a balanced breakeven position. The funding was distributed to providers and in turn collective provider plans have improved. The revenue deficit support is deemed repayable to NHSE, phased from 2026/27.

2.4 At month 11 systems were given the opportunity to formally declare a variation to the plan. The ICS adjusted the forecast deficit from a breakeven position (in line with plan) to a **£45.9m** deficit. NHSE expected no variation from this position within month 12 reporting.

2.5 The ICS reports a final deficit of **£51.3m** for the 2024/25 financial year against a breakeven financial plan. This is c£5.5m adverse from the revised Month 11 FOT due to a technical PFI adjustment within the Mersey and West Lancashire Hospitals NHS Trust's position agreed with NHSE. After adjusting for this issue then the Month 11 is consistent in aggregate with the revised forecast that was reported to NHSE at month 11.

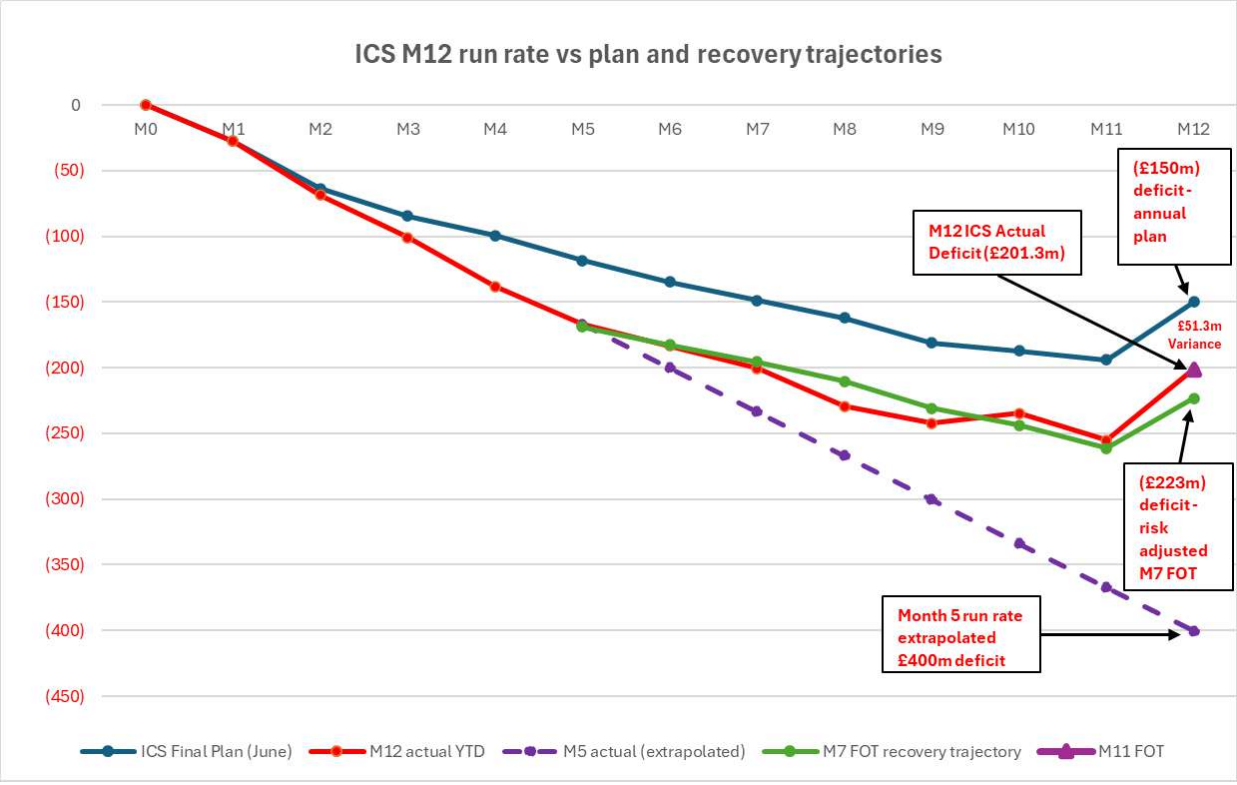
2.6 The final ICS financial position for 2024/25 as reported to NHS England is set out in **Table 1**. As this is the final financial position for the year, the system does not report a level of risk at month 12.

Table 1 – Financial Performance Month 12 - ICS

	Month 12 Actual				Month 11 FOT	Difference M12 Act to Mth 11 FOT
	Plan £m	Actual £m	Variance £m	Variance %	£m	£m
ICB	62.3	25.4	(36.9)	-0.5%	28.6	(3.2)
Total Providers	(62.3)	(76.7)	(14.4)	0.2%	(74.4)	(2.2)
Total System	**0.0**	**(51.3)**	**(51.3)**	**-0.6%**	**(45.9)**	**(5.5)**
Total Providers (exc. £150m rev support)	(212.3)	(226.7)	(14.4)	0.2%	(224.4)	(2.2)
Total System (exc. £150m rev support)	**(150.0)**	**(201.3)**	**(51.3)**	**-0.6%**	**(195.9)**	**(5.5)**

2.7 Chart 1 below shows the profile of the ICS I&E position and recent revised recovery trajectories against the actual M12 position. It excludes the £150m revenue deficit support to evidence the comparable run rate position month to month.

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



2.8 The Month 11 all organisations formally re-forecast the FY 24/25 financial positions, taking into account the £23m surge funding deployed to providers and other mitigations deployed at M11. The M11 re-forecast of £45.9m deficit reported to NHSE has been discussed and agreed in advance of formal reporting via the regular NHSE assurance and intervention meetings. There are five organisations that have not delivered original plans that are required to submit additional governance documentation reviewed and signed off by the respective individual boards.

2.9 The final M12 position against the original plan and the Month 11 FOT, excluding the £150m deficit support, is set out in **Table 2**

Table 2 – Financial Performance Month 12 – by organisation

Org	Month 12 Actual (including deficit funding)			Deficit Funding			Month 12 Actual (excluding deficit funding)			M11 FOT	M12 Variance to M11 FOT
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance		
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Alder Hey Children's	3.4	3.4	(0.0)	-	-	-	3.4	3.4	(0.0)	3.4	(0.0)
Bridgewater Community	2.1	(1.2)	(3.3)	-	-	-	2.1	(1.2)	(3.3)	(1.2)	0.0
Cheshire & Wirral Partnership	1.5	1.7	0.2	-	-	-	1.5	1.7	0.2	1.7	(0.0)
Countess of Chester Hospitals	(9.6)	(9.6)	0.0	14.0	14.0	0.0	(23.6)	(23.6)	0.0	(23.6)	0.0
East Cheshire Trust	(5.9)	(4.9)	1.0	8.5	8.5	0.0	(14.4)	(13.4)	1.0	(13.4)	0.0
Liverpool Heart & Chest	14.1	14.2	0.0	-	-	-	14.1	14.2	0.0	14.1	0.0
Liverpool University Hospitals	(32.8)	(38.3)	(5.5)	47.7	47.7	0.0	(80.5)	(86.0)	(5.5)	(88.7)	2.7
Liverpool Women's	(11.6)	(11.5)	0.1	16.9	16.9	0.0	(28.5)	(28.4)	0.1	(28.5)	0.1
Mersey Care	7.1	10.3	3.2	-	-	-	7.1	10.3	3.2	10.3	0.1
Mid Cheshire Hospitals	(14.5)	(13.3)	1.2	21.1	21.1	0.0	(35.6)	(34.4)	1.2	(34.5)	0.1
Mersey & West Lancs	(10.9)	(14.7)	(3.9)	15.8	15.8	0.0	(26.7)	(30.5)	(3.9)	(25.1)	(5.5)
The Clatterbridge Centre	0.9	0.9	0.0	-	-	-	0.9	0.9	0.0	0.9	0.0
The Walton Centre	5.3	6.4	1.0	-	-	-	5.3	6.4	1.0	6.3	0.0
Warrington & Halton Hospitals	(11.3)	(16.8)	(5.5)	16.5	16.5	0.0	(27.8)	(33.3)	(5.5)	(33.3)	0.1
Wirral Community	6.5	6.5	0.0	-	-	-	6.5	6.5	0.0	6.5	0.0
Wirral University Hospitals	(6.7)	(9.7)	(3.1)	9.7	9.7	0.0	(16.3)	(19.4)	(3.1)	(19.4)	(0.0)
TOTAL (C&M Providers)	**(62.3)**	**(76.7)**	**(14.4)**	**150.0**	**150.0**	**0.0**	**(212.3)**	**(226.7)**	**(14.4)**	**(224.4)**	**(2.2)**
C&M ICB	62.3	25.4	(36.9)				62.3	25.4	(36.9)	28.6	(3.2)
TOTAL C&M ICS	**0.0**	**(51.3)**	**(51.3)**	**150.0**	**150.0**	**0.0**	**(150.0)**	**(201.3)**	**(51.3)**	**(195.9)**	**(5.5)**

2.10 The key movements in the actual Month 12 position compared to the Month 11 FOT are:

2.10.1.1 A £5.5m adverse movement at Mersey and West Lancashire Hospital NHS Trust due to a technical accounting issue with the PFI asset and the impact of accounting changes on a IFRS16 and UK GAAP basis. This was discussed and agreed with NHSE ahead of final reporting.

2.10.1.2 £2.7m favourable movement at Liverpool University Hospitals NHS FT driven by improvement in M12 expenditure run rate compared to forecast.

2.10.1.3 £3.2m adverse movement within Cheshire and Merseyside ICB position chiefly due to increased prescribing costs, continued pressures within mental health packages of care and an increase in ADHD activity over and above previous forecasts.

2.11 As per the NHS business rules the £201.3m remains repayable by the system from 2026/27 (capped at 0.5% of core allocations). This is in addition to the existing payable overspends from 2023/24 and historic CCG deficits (pre-2020).

3. Financial Performance Month 12

ICS financial performance – M12

3.1 As of 31st March 2025 (Month 12), the ICS reports a final deficit of £51.3m against a breakeven system plan, which is £5.5m adverse against the forecast presented to NHSE at month 11. The ICB reports a surplus of £25.4m (against a £62.3m surplus plan) and collectively providers report a deficit of £76.7m (against a deficit plan of £62.3m). Overall, the system has overspent against it plan by £51.3m for the 2024/25 financial year.

3.2 The £5.5m adverse position from the revised Month 11 FOT is due to a technical PFI adjustment within the Mersey and West Lancashire Hospitals NHS Trust's position agreed with NHSE. After adjusting for this issue then the Month 11 is consistent in aggregate with the revised forecast that was reported to NHSE at month 11. The delivery of this position has been possible through the receipt of £23m additional surge funding from NHSE. The funds were distributed to support pay award pressures, impact of industrial action and the WUTH cyber-attack over Winter.

3.3 ICB overspending has been consistent throughout the year, specifically within Continuing Health Care (CHC) budgets, mental health packages of care and prescribing. All places within the ICB have experienced significant financial pressure across these budgets throughout the year. Underspending within Acute, community and primary care budgets has partially offset the pressure.

3.4 **Table 3** sets out the financial performance surplus/(deficit) at Month 12 at organisation level.

Table 3 – ICS Financial Performance M12 Actual by organisation

Org	Month 12 Actual (including deficit funding)			Deficit Funding			Month 12 Actual (excluding deficit funding)			M11 FOT	M12 Variance to M11 FOT
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance		
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Alder Hey Children's	3.4	3.4	(0.0)	-	-	-	3.4	3.4	(0.0)	3.4	(0.0)
Bridgewater Community	2.1	(1.2)	(3.3)	-	-	-	2.1	(1.2)	(3.3)	(1.2)	0.0
Cheshire & Wirral Partnership	1.5	1.7	0.2	-	-	-	1.5	1.7	0.2	1.7	(0.0)
Countess of Chester Hospitals	(9.6)	(9.6)	0.0	14.0	14.0	0.0	(23.6)	(23.6)	0.0	(23.6)	0.0
East Cheshire Trust	(5.9)	(4.9)	1.0	8.5	8.5	0.0	(14.4)	(13.4)	1.0	(13.4)	0.0
Liverpool Heart & Chest	14.1	14.2	0.0	-	-	-	14.1	14.2	0.0	14.1	0.0
Liverpool University Hospitals	(32.8)	(38.3)	(5.5)	47.7	47.7	0.0	(80.5)	(86.0)	(5.5)	(88.7)	2.7
Liverpool Women's	(11.6)	(11.5)	0.1	16.9	16.9	0.0	(28.5)	(28.4)	0.1	(28.5)	0.1
Mersey Care	7.1	10.3	3.2	-	-	-	7.1	10.3	3.2	10.3	0.1
Mid Cheshire Hospitals	(14.5)	(13.3)	1.2	21.1	21.1	0.0	(35.6)	(34.4)	1.2	(34.5)	0.1
Mersey & West Lancs	(10.9)	(14.7)	(3.9)	15.8	15.8	0.0	(26.7)	(30.5)	(3.9)	(25.1)	(5.5)
The Clatterbridge Centre	0.9	0.9	0.0	-	-	-	0.9	0.9	0.0	0.9	0.0
The Walton Centre	5.3	6.4	1.0	-	-	-	5.3	6.4	1.0	6.3	0.0
Warrington & Halton Hospitals	(11.3)	(16.8)	(5.5)	16.5	16.5	0.0	(27.8)	(33.3)	(5.5)	(33.3)	0.1
Wirral Community	6.5	6.5	0.0	-	-	-	6.5	6.5	0.0	6.5	0.0
Wirral University Hospitals	(6.7)	(9.7)	(3.1)	9.7	9.7	0.0	(16.3)	(19.4)	(3.1)	(19.4)	(0.0)
TOTAL (C&M Providers)	**(62.3)**	**(76.7)**	**(14.4)**	**150.0**	**150.0**	**0.0**	**(212.3)**	**(226.7)**	**(14.4)**	**(224.4)**	**(2.2)**
C&M ICB	62.3	25.4	(36.9)				62.3	25.4	(36.9)	28.6	(3.2)
TOTAL C&M ICS	**0.0**	**(51.3)**	**(51.3)**	**150.0**	**150.0**	**0.0**	**(150.0)**	**(201.3)**	**(51.3)**	**(195.9)**	**(5.5)**

ICB Financial Performance – M12

3.5 The ICB has reported a final surplus of £24.5m compared to a planned surplus of £62.3m resulting in an adverse variance to plan of £36.9m for 2024/25 as per **Table 4** below.

Table 4 – ICB Financial Performance M12

	M12 YTD			
	Plan £m	Actual £m	Variance £m	Variance %
ICB Net Expenditure				
Acute Services	3,781.2	3,767.4	13.8	0.4%
Mental Health Services	716.5	746.1	(29.6)	(4.1%)
Community Health Services	712.5	706.4	6.1	0.9%
Continuing Care Services	403.6	435.4	(31.8)	(7.9%)
Primary Care Services	649.1	667.3	(18.2)	(2.8%)
Of which Prescribing *	535.5	564.0	(28.6)	(5.3%)
Other Commissioned Services	15.4	14.2	1.2	8.0%
Other Programme Services	72.2	65.8	6.4	8.9%
Reserves / Contingencies	(0.2)	0.0	(0.2)	100.0%
Delegated Specialised Commissioning	628.8	618.0	10.7	1.7%
Delegated Primary Care Commissioning	865.7	861.6	4.1	0.5%
Primary Medical Services	566.3	565.2	1.1	0.2%
Dental Services	192.8	192.7	0.0	0.0%
Ophthalmic Services	27.0	26.9	0.1	0.2%
Pharmacy Services	79.7	76.7	3.0	3.8%
ICB Running Costs	48.6	48.1	0.5	1.0%
Total ICB Net Expenditure	**7,893.3**	**7,930.1**	**(36.9)**	**(0.5%)**
Allocation adjustment for reimbursable items	0.0	0.0	0.0	0
TOTAL ICB Surplus/(Deficit)	**62.3**	**25.4**	**(36.9)**	**(0.5%)**

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

3.6 The key areas of variance from budget are as follows:

a) Continuing Healthcare – continued pressures linked to the cost and volume of eligible CHC clients which has significantly exceeded planning assumptions throughout the year. An adverse variance of £31.7m is reported at Month 12 which is an adverse movement of £0.6m compared to the forecast at month 11.

b) Mental Health Services – overspend of £29.6m reported for the year of which £26.1m relates to packages of care. The variance from plan worsened by £5m during the month linked to both packages of care and ADHD activity.

Appendix 1 contains details of the CHC and MH packages of care budgetary performance by place and shows the key drivers for the pressure.

c) A pressure of £28.6m is reported on the prescribing based on January-25 prescribing data which was £4.2m greater than forecast in month 11. The increase in expenditure is due to the cost per prescribing day remaining high in recent months, and the impact of the prescribing waste management campaign yet to make significant savings.

Further analysis on the cost per prescribing day is included in chart 2 within paragraph 3.8.

d) Reserves – All required reserves have been deployed at month 12 leaving the balance of available or uncommitted reserves as a surplus at the end of the year.

e) Specialised Commissioning – The surplus of £10.7m on specialised commissioning budgets is in line with month 11 forecasts.

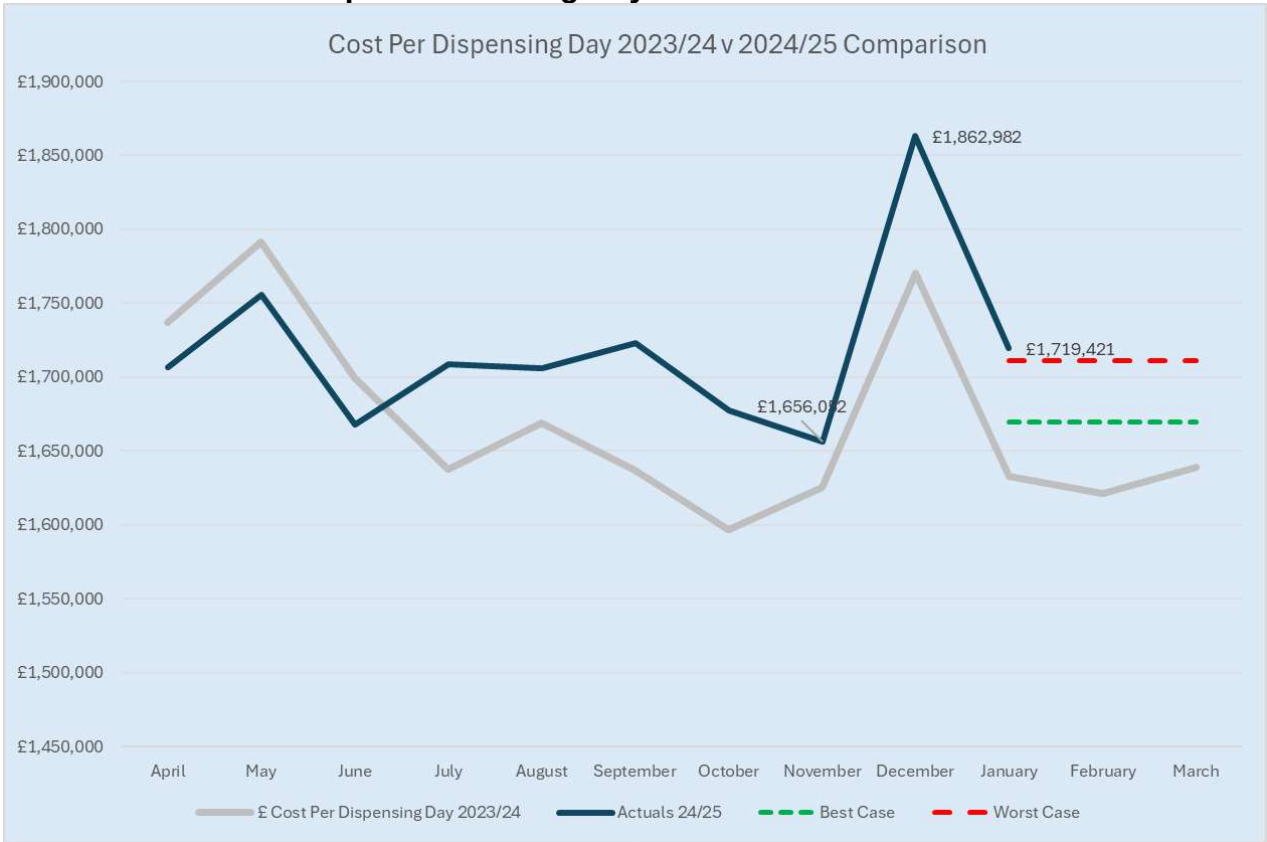
f) Primary Care – Aside from prescribing, there have been some key underspends on primary care budgets, specifically within primary care transformation funding and primary care IT. As per NHSE guidance, surplus primary care dental ringfenced funding has been clawed back this month as expected.

g) Running costs - Costs remain within the running cost allowance following the reduction in allocation this year.

h) Efficiency – The ICB reports full achievement of its efficiency savings plan for the year. Key areas of slippage within pathway transformation, MH placements and medicines efficiency were offset through additional savings secured in other areas. All reported ICB savings are recurrent in nature.

3.7 For prescribing **Chart 2** shows that the cost per prescribing day was marginally lower in the first quarter compared to Q1 of the previous year, however costs have been consistently higher than last year from July onwards. Overall prescribing costs are 2.3% greater than the same period in 2023/24 with the most marked increase being in the two most recent months for which data is available (Dec-24 and Jan-25)

Chart 2 – Cost per Prescribing Day



3.8 Details of ICB performance split by place is shown below, and more detail is provided in **Appendix 2. Table 5** sets out in summary place performance for the year:

Table 5 – Place M12 – Financial Performance

	M12 YTD Plan £000's	M12 YTD Actual £000's	M12 YTD Variance £000's
Cheshire - East	(52,033)	(62,554)	(10,521)
Cheshire - West	(42,642)	(46,662)	(4,020)
Halton	(9,379)	(12,519)	(3,140)
Knowsley	11,863	11,668	(195)
Liverpool	10,610	(5,459)	(16,069)
Sefton	(10,514)	(21,716)	(11,202)
St Helens	(11,139)	(14,722)	(3,583)
Warrington	(4,611)	(4,978)	(367)
Wirral	(20,721)	(37,411)	(16,690)
ICB	190,856	219,758	28,902
Total ICB	**62,290**	**25,405**	(36,885)

Provider Financial Performance – M12

3.9 **Table 3 above** sets out the ICS Month 12 financial position, split by individual provider alongside ICB position.

3.10 There are 5 Trusts reporting a material year end adverse variance to plan. An explanation of the key drivers of the YTD and FOT variances are set out below:

- **Bridgewater Community NHS Foundation Trust**
  £3.3m adverse to plan, M12 consistent with M11 FOT.
  Key drivers of the £3.3m year end variance are operational issues linked with premium paediatric locum spend and other demand led pay pressures £2.0m; an adverse YTD CIP variance of £2.0m; which is partially offset by £0.7m non recurrent items relating to prior year. The adverse CIP plan position is due to under-achievement of integration savings with Warrington. The position has been escalated at CEO/DOF level and also seeking to be address in 2025/26 through the phase 2 intervention process supported by PwC.

- **Liverpool University Hospitals NHS Foundation Trust**
  £5.5m adverse to plan, M12 £2.7m favourable to Month 11 FOT
  £5.5m of the YTD variance is attributable to; £15.1m undelivered CIP largely linked to non-delivery of scheme associated to releasing capacity no criteria to reside patients.; offset by c£10m expected ERF overperformance, non-recurrent technical items and balance sheet release. The trust was able to improve upon its Month 11 FOT by £2.7m due to further non recurrent efficiencies and technical items at year.
  The year end M12 and underlying position has been escalated at CEO/DOF level and also seeking to be address in 2025/26 through the phase 2 intervention process supported by PwC.

- **Mersey and West Lancashire Teaching Hospitals NHS Trust**
  £3.9m adverse to plan, M12 £5.5m adverse to Month 11 FOT
  At Month 11 the Trust forecasted to be c£1.6m favourable against its original plan due to receipt of additional surge funding in Month 11 to support operational pressures, industrial action and pay award. At Month 12, after agreement with NHSE, the trust deteriorated its Month 11 FOT position by £5.5m (£3.9m adverse against plan) due to a technical accounting issue with the PFI asset and the impact of accounting changes on a IFRS16 and UK GAAP basis.
  The recurrent impact of the PFI accounting change into 2025/26 is still being worked through collectively with the trust, NHSE and ICB.

- **Warrington and Halton Teaching Hospitals NHS Foundation Trust**
  £5.5m adverse to plan, M12 consistent with M11 FOT.
  The £5.5m adverse variance to date relates to; £0.9m shortfall on YTD CIP; and other £4.5m operational pressures linked to unfunded escalation capacity and specialling. This is a net adverse variance after the distribution of funding via NHSE for industrial action and pay award uplifts. This has

been escalated at CEO/DOF level and also seeking to be addressed through the phase 2 intervention process supported by PwC.

- **Wirral University Teaching Hospitals NHS Foundation Trust £3.1m adverse to plan, M12 consistent with M11 FOT.** Key drivers of the £3.1m YTD variance are; c£16m elective underperformance across surgical specialties T&O and Urology driven by under-utilisation of C&M Surgical Centre by system partners, consultant vacancies and CSSD downtime; £3.0m acute pay overspend within ED medical and ED nursing driven primarily by corridor care, with work on-going to review rotas and how to reduce shifts subject to escalated rates of pay. The above has been mitigated to an extent by c.£5m of underspends and vacancies elsewhere across the Trust, c.£7m balance sheet release; and c£4m of non-recurrent income benefit.

  Those Providers with an adverse variance to plan must provide additional governance information to NHSE, setting out the reasons for deterioration and Board awareness.

3.11 **Table 6** sets out the provider year end position compared to annual plan by income, pay, non-pay and non-operating items. This shows that the aggregate YTD pay position is £119.2m (2.7%) adverse to plan, which is explained by; the net cost of medical cover during the industrial action in June and July of c£5.5m (0.1%); undelivered pay efficiencies YTD of £68m (1.4%); YTD pay award pressure £12m (0.3%); and selected operational pay pressures and underspends across several providers as set out in section 3.11 above (0.9%). NHS Providers are also reporting additional non pay inflation across drugs and consumables above those assumed in the plan and is a key contributor to the 7.9% year end adverse variance on non-pay expenditure. A full breakdown of the expenditure variance by provider can be found in **Appendix 3.**

Table 6 – Provider Income and Expenditure vs YTD Plan

	Month 12			
	Plan	Actual	Variance	
	£m	£m	£m	%
Total Income	**6,880.4**	**7,148.6**	**268.2**	**3.9%**
Pay	**(4,712.8)**	**(4,842.0)**	**(129.2)**	**-2.7%**
Non Pay	**(2,133.5)**	**(2,302.9)**	**(169.3)**	**-7.9%**
Non Operating Items (excl gains on disposal)	**(96.4)**	**(80.4)**	**15.9**	**16.5%**
Total Provider Surplus/(Deficit)	**(62.3)**	**(76.7)**	**(14.4)**	**-0.2%**

NHS Provider Agency Expenditure

3.12 ICS NHS Providers set a 2025/26 plan for agency spend of £92.0m, compared to actual spend in 2023/24 of £128.5m. The System is required to manage

agency costs within a ceiling and to demonstrate reduced reliance on agency staffing year on year. The ICS agency ceiling for 2024/25 is £120.6m.

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

3.14 At Month 12, agency spend is £98.5m (£6.5m above plan), equating to 2.0% of total pay. Nine Trusts are reporting a year-to-date adverse variance to plan. Trust level information on agency spend can be found in **Appendix 4**.

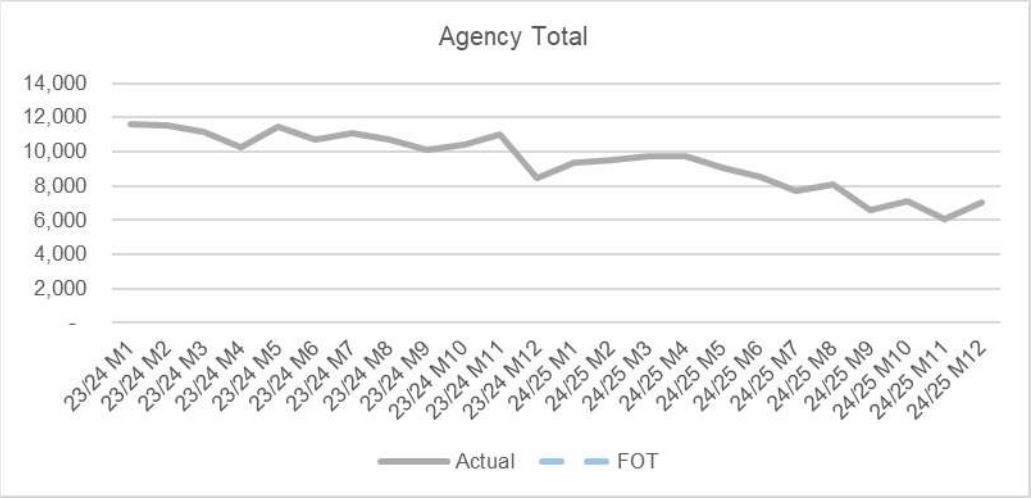
3.15 **Table 7** below sets out the aggregate agency performance as a system. This indicates providers reported a £6.5m adverse variance to plan however remain within the national agency cap by £22.1m. **Chart 3** below sets out the agency expenditure monthly run rate from 23/24 to Month 12 indicating a downward trajectory throughout the year. Further work is ongoing in this area with providers and forms a key part of provider CIP plans and reductions in variable pay over 2025/26.

Table 7 – Provider Agency Expenditure

Agency Costs Year End	Year End Plan £m	Year End Actual £m	Variance £m	Actual agency as a % of pay costs %
All ProvidersAgency Spend	**(92.0)**	**(98.5)**	**(6.5)**	**2.0%**

C&M Annual Agency Ceiling	**(120.6)**
Forecast Variance to Ceiling	**22.1**

Chart 3 – Agency Expenditure Run Rate

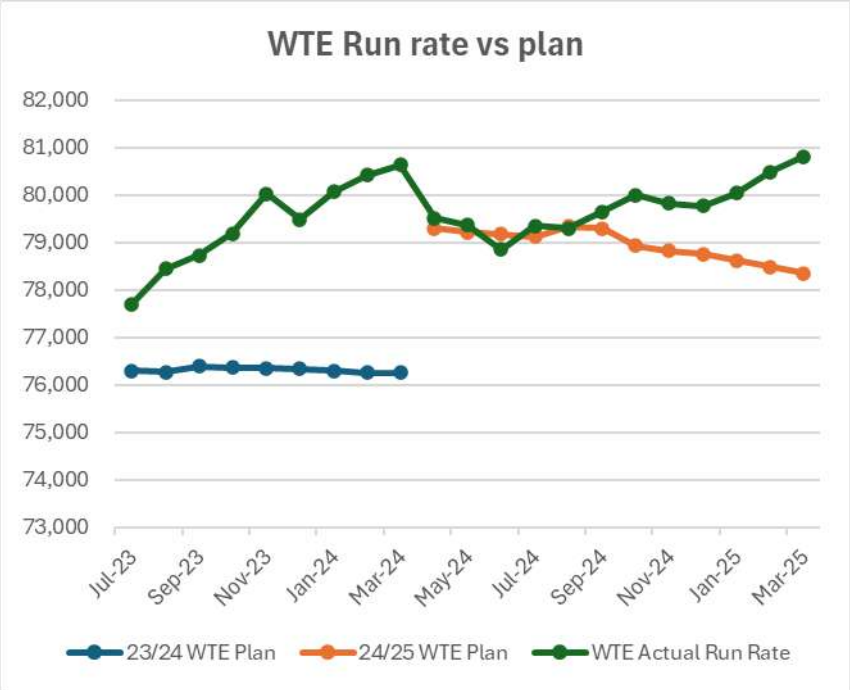


Workforce

3.16 Workforce and its triangulation with finance, performance and productivity will continue to be key focus across the system. **Chart 4** sets out the provider

WTEs run rate across 23/24 to Month 12 24/25 and the planned aggregate planned reductions forecast to the end of the year. **Appendix 5** sets out in more detail the movements at provider level.

Chart 4 – Workforce (WTE) Run Rate 23/24 and 24/25



3.17 **Table 8** below sets out the workforce run rate per month and the actuals against M12 plan by sector:

Table 8 – M12 Workforce movements vs M12 23/24 and M12 24/25 Plan

	2023/24	2024/25													M12 Variance	
Workforce (WTEs) - source PWRs / mitigation plan submission	M12 Actuals	M1 Actual	M2 Actual	M3 Actual	M4 Actual	M5 Actual	M6 Actual	M7 Actual	M8 Actual	M9 Actual	M10 Actual	M11 Actual	M12 Actual	M1 to M12 Trend	M12 Variance from plan trajectory favourable / (adverse)	
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	%
C&M Providers Total	**80,465**	**79,516**	**79,361**	**78,849**	**79,352**	**79,303**	**79,645**	**80,002**	**79,822**	**79,773**	**80,046**	**80,492**	**80,808**		**(2,454)**	**-3.1%**
by Sector																
Acute	**50,353**	49,719	49,687	49,296	49,704	49,604	49,616	49,868	49,637	49,668	49,731	49,918	50,108		(1,420)	-2.3%
Specialist	**11,423**	11,353	11,386	11,431	11,382	11,436	11,495	11,628	11,645	11,559	11,645	11,768	11,821		(437)	-3.2%
Community / MH	**18,689**	18,444	18,289	18,123	18,265	18,263	18,534	18,506	18,539	18,546	18,669	18,806	18,879		(598)	-2.9%
TOTAL Providers	**80,465**	**79,516**	**79,361**	**78,849**	**79,352**	**79,303**	**79,645**	**80,002**	**79,822**	**79,773**	**80,046**	**80,492**	**80,808**		**(2,454)**	**-3.1%**

3.18 The Month 12 provider workforce data indicate there is a 2,454 WTE adverse position against the YTD plan (3.1%), and this remains a significant departure from the revised workforce trajectories submitted in July as part of recovery plans. The system in March 2025 is utilising more staffing resources compared to the same point in March 2024. As part of the investigation and intervention

Phase 2 work the workforce trajectories and pay controls have been reported and reviewed on a weekly basis for all providers up to December and also covered in the Balance Scorecard CEO meetings from January. Triangulation of the workforce plans with finance and performance has been a critical key component of the 2025/26 planning process, and extended provider and system vacancy controls have been established in April 2024.

System Efficiencies

3.19 For 2024/25 providers and ICB are planning delivery of £368m and £72m efficiencies respectively. The aggregate system efficiency plan of £440m represents 6.1% of ICB Allocations / Provider Expenditure.

3.20 **Table 9** shows at Month 12 organisations reported a shortfall on planned CIP delivery of £22.8m against the ICS plan, with £23.0m attributable against providers (adverse) and £1.0m against the ICB (favourable). The £417.1m efficiencies delivered represent **5.5%** of ICS YTD expenditure/allocation against the annual plan of 6.1%.

3.21 Furthermore 70% of the system efficiencies plan have been delivered recurrently as at Month 12. The non recurrent CIP delivery of £109.2m represents a significant pressure as the ICS exits 2024/25 and this is subject to ongoing work by providers to evidence the full year effect of CIP schemes delivered part way through 2024/25 and whilst also recovering the remaining recurrent shortfall as part of 2025/26 planning review process.

Table 9 – ICS M12 Efficiency Delivery

Org	CIP delivery					CIP Recurrent / Non Recurent YTD		
	M12 YTD Plan £,000	M12 YTD Actual £,000	M12 YTD Variance £,000	M12 YTD % Variance %	M12 CIP actual as a % of Op Ex %	M12 YTD Actual Recurrent £,000	M12 YTD Actual Non Recurrent £,000	M12 Actual Recurrent as a % of YTD plan %
Alder Hey Children's	19,950	19,953	2	0.0%	4.4%	13,600	6,353	68%
Bridgewater Community	6,939	5,000	(1,939)	-27.9%	4.4%	1,760	3,240	25%
Cheshire & Wirral Partnership	13,913	13,913	0	0.0%	4.7%	11,086	2,827	80%
Countess of Chester Hospitals	19,822	11,906	(7,916)	-39.9%	2.9%	11,906	0	60%
East Cheshire Trust	11,225	11,229	4	0.0%	4.6%	5,537	5,692	49%
Liverpool Heart & Chest	10,644	9,891	(753)	-7.1%	3.8%	7,163	2,729	67%
Liverpool University Hospitals	114,600	99,495	(15,105)	-13.2%	6.3%	64,059	35,436	56%
Liverpool Women's	5,904	5,904	0	0.0%	3.0%	2,412	3,492	41%
Mersey Care	25,967	25,967	0	0.0%	3.1%	24,137	1,830	93%
Mid Cheshire Hospitals	22,437	22,404	(33)	-0.1%	4.8%	12,443	9,961	55%
Mersey & West Lancs	45,165	47,965	2,800	6.2%	4.7%	35,380	12,585	78%
The Clatterbridge Centre	10,000	10,000	(0)	0.0%	3.1%	2,762	7,238	28%
The Walton Centre	8,558	8,558	0	0.0%	4.1%	7,974	584	93%
Warrington & Halton Hospitals	19,433	18,495	(938)	-4.8%	4.5%	12,568	5,927	65%
Wirral Community	6,275	6,278	3	0.0%	5.7%	2,279	3,999	36%
Wirral University Hospitals	26,878	26,878	0	0.0%	4.8%	19,584	7,294	73%
TOTAL Providers	**367,710**	**343,836**	**(23,874)**	**-6.5%**	**5.2%**	**234,649**	**109,187**	**64%**
C&M ICB	72,236	73,269	1,033	1.4%	0.9%	73,269	0	101%
TOTAL ICS System	**439,946**	**417,105**	**(22,841)**	**-5.2%**	**5.5%**	**307,918**	**109,187**	**70%**

Productivity

3.22 The 2024/25 planning guidance set out an expectation for all providers, with a focus on the acute sector, to improve towards pre-pandemic levels (recognising potential adjustments for case mix change, structural factors and uncaptured activity). 'Implied Productivity Growth' of acute and specialist trusts is calculated by NHSE by comparing output growth (activity) to input growth (based on expenditure costs) against a baseline period. The measure examines the current year's YTD activity and costs with the same period in 19/20 and more recently, with 23/24. A negative value implies decreased productivity whilst positive implies productivity growth.

3.23 The most recently available comparative productivity data is from M10 24/25, and **Table 10** below sets out the aggregate position across all C&M acute and specialist providers compared to the national average. **Appendices 7A** sets out the position at a provider level.

Table 10 - Implied Productivity Growth M10

*Productivity Measure	C&M %	North West %	National Average %
Implied Productivity Growth M5 24/25 vs 19/20	-18.8%	-20.2%	-14.3%
Implied Productivity Growth M5 24/25 vs 23/24	0.2%	0.4%	1.6%
Implied Productivity Growth M6 24/25 vs 19/20	-18.9%	-20.2%	-14.3%
Implied Productivity Growth M6 24/25 vs 23/24	0.0%	0.5%	1.8%
Implied Productivity Growth M9 24/25 vs 19/20	-17.3%	-18.2%	-12.9%
Implied Productivity Growth M9 24/25 vs 23/24	0.1%	0.5%	2.2%
Implied Productivity Growth M10 24/25 vs 19/20	-18.6%	-19.6%	-14.0%
Implied Productivity Growth M10 24/25 vs 23/24	-0.7%	-0.1%	1.5%

*acute providers only

3.24 Furthermore, the ICB has undertaken a series on provider CEO/CFO meetings that has reviewed a range of metrics under a Balanced Scorecard taking into account finance, WTE, balance sheet and productivity metrics. This scorecard focused on delivery of the year-end financial position, and the improvements required for 25/26. A paper was shared at the January FIRC with the detailed productivity metrics per organisation, with a summary of the key Model Hospital, productivity reported in **Appendix 7A** based on Month 10**.** NHSE have issued a set of national and organisation specific productivity packs to support the 25/26 planning process to support this agenda and development of 25/26 productivity and efficiency improvements.

Cash

3.25 The Providers' cash position at Month 12 was £476.2m, with the detail set out in **Appendix 8** by organisation. Year-end cash balances are £44.4m lower than at

the end of 2023/24 whilst also including £102.9m of external NHSE cash support received during the year supporting several acute organisations. Acute organisations with a planned deficit have also received £150m deficit support funding.

3.26 There are seven organisations that have formally received external cash support from NHSE up to Month 12 of 2024/25 to support their I&E deficit plans – Mersey and West Lancs Teaching NHS Trust, Mid Cheshire Hospitals NHST, Warrington & Halton Teaching Hospitals FT, Liverpool Women's NHS FT, Liverpool University Hospitals NHS FT, Countess of Chester Hospital NHS FT and Wirral Teaching Hospitals NHS FT.

3.27 **Table 11** below set out the aggregate provider cash balance at Month 12, the level of distress cash requests received by NHSE to date and the Month 12 average Better Payment Practice Code (BPPC) position across providers. The aggregate provider BPPC performance has deteriorated from an average number of 92.3% of bills paid within the 95% target at M12 2023/24 to an average number of 90.4% at Month 12 2024/25. Further detail of BPPC performance by provider is set put in **Appendix 9.**

Table 11 – Provider Cash and BPPC Performance – Month 12

Org	Cash Balance			Operating Days Cash	External Cash Support*	BPPC % of bills paid in target	
	2023/24 M12 Closing Cash Balance £m	2024/25 M12 Closing Cash Balance £m	Movement £m	24/25 M12 Days	Received as at M12 £m	2024/25 M12 By number %	2024/25 M12 By Value %
Alder Hey Children's	78.3	53.7	(24.6)	34	0.0	93.2%	91.5%
Bridgewater Community	17.3	8.2	(9.2)	20	0.0	98.4%	98.4%
Cheshire & Wirral Partnership	28.1	28.5	0.4	28	0.0	96.2%	93.9%
Countess of Chester Hospitals	12.3	28.2	15.8	17	13.6	95.0%	95.4%
East Cheshire Trust	17.9	14.0	(3.9)	15	0.0	93.8%	92.4%
Liverpool Heart & Chest	43.2	49.4	6.2	58	0.0	97.4%	98.2%
Liverpool University Hospitals	40.6	30.4	(10.2)	6	30.0	76.6%	90.9%
Liverpool Women's	2.0	3.8	1.8	6	7.0	93.4%	94.7%
Mersey Care	72.9	53.8	(19.1)	17	0.0	95.5%	96.0%
Mid Cheshire Hospitals	16.4	36.3	19.8	21	19.7	94.7%	94.4%
Mersey & West Lancs	24.7	10.2	(14.5)	3	17.0	85.7%	92.6%
The Clatterbridge Centre	74.3	73.2	(1.1)	63	0.0	97.7%	98.9%
The Walton Centre	51.6	62.4	10.8	83	0.0	88.8%	90.7%
Warrington & Halton Hospitals	17.6	16.3	(1.3)	11	12.1	87.3%	92.9%
Wirral Community	12.7	7.8	(4.9)	19	0.0	92.3%	95.8%
Wirral University Hospitals	10.6	0.1	(10.5)	0	3.5	60.2%	76.0%
TOTAL Providers	**520.6**	**476.2**	**(44.4)**	**11**	**102.9**	**90.4%**	**93.3%**

3.28 The BPPC of WUTH is of particular system concern. WUTH have been in conversations with the national team regarding their cash requirements and have been in the position where they have had to delay PDC and PAYE payments in order to protect the timeliness of payroll payments.

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

3.30 The ICB has supported WUTH where possible but is constrained by our own levels of cash available. Cash can be transferred between NHS Providers, but this would be a PDC transfer and requires Board approval. This is an area for further development in 2025/26.

ICB Recovery Update

3.31 For the ICB the recovery programme targets consist of 3 main areas:

- efficiency plans agreed as part of the plan.
- stretch targets for Mental Health Pressures in A&E/Out of Area Placements, S117 Packages and Workforce agreed as part of the plan.
- additional stretch targets identified for each programme.

3.32 The savings against the combined recovery programme targets is £91.6m of which £73.3m relates to the efficiency plans agreed as part of the plan and £18.3m are additional savings identified by the programmes to contribute towards to recovery plan. **Table 12** sets out the final position by programme.

Table 12 – ICB Recovery Programme Performance – Month 12

Programme Name	YTD			Forecast		
	Plan £000's	Actual £000's	Variance £000's	Plan £000's	Actual £000's	Variance £000's
All Age Continuing Health Care/Complex Care	36,465	34,626	(1,839)	36,465	34,626	(1,839)
Cheshire Urgent Care Improvement	4,965	4,005	(960)	4,965	4,005	(960)
Medicines Management	30,700	28,552	(2,148)	30,700	28,552	(2,148)
Mental Health System Flow	10,953	0	(10,953)	10,953	0	(10,953)
Optimising Patient Choice Independent Sector Value	1,800	2,625	825	1,800	2,625	825
Unwarranted Variation	520	825	305	520	825	305
Workforce Optimisation	10,924	10,924	0	10,924	10,924	0
Other	8,750	10,026	1,276	8,750	10,026	1,276
TOTAL	**105,077**	**91,583**	**(13,494)**	**105,077**	**91,583**	**(13,494)**

Provider and Primary Care Capital

3.33 The ‘Charge against Capital Allocation’ represents the System’s performance against its operational capital allocation, which is wholly managed at the System’s discretion. For 2024/25 the System’s Secondary Care Core allocation in 2023/24 is £258.4m, a Primary Care allocation of £4.7m, and a provider IFRS16 Operating Leases allocation of £40.0m. The plan submitted in June set out an overprogramming position against allocation of c£12m with plans to spend £315.0m with an expectation that the overprogramming position would be managed in year.

3.34 As reported at Month 7 the previous £12m overprogramming position at plan stage had been managed to £nil due to a review of capital lease expenditure and slippage of three contractually committed schemes into 2025/26 across,

therefore the system forecasted a compliant capital position for 2024/25 from this point.

3.35 **Tables 13 & 14** sets out the actual Month 12 position capital expenditure against plan at a system level but also the ICB's primary care capital position. At Month 12 there is a £16.7m overspend against the original plan, which largely relates to additional spend at the Mid-Cheshire Leighton site to address the ongoing RAAC programme and nationally approved revenue to capital schemes. The ICS has been provided with additional allocation by the national team to continue with the RAAC works. A reconciliation of the agreed changes from Plan to actual Month 12 spend are set out in **Table 15** below.

3.36 In summary the ICS overspent against its ICS allocation by £4k which represents 0.001% of its annual capital allocation and allowable by NHSE.

Table 13 - System (Provider & ICB) - Charge against Capital Allocation M12

	Plan YTD £'000	Actual YTD £'000	Variance YTD £'000	Plan Year Ending £'000	Actual Year Ending £'000	Variance Year Ending £'000	%
System charge against allocation	315,026	331,706	(16,680)	315,026	331,706	(16,680)	-5.3%
Capital allocation					331,702		
Variance to allocation					(4)		
Allocation met					Yes		

Table 14 – ICB - Charge against allocation M12

	Plan YTD £'000	Actual YTD £'000	Variance YTD £'000	Plan Year Ending £'000	Actual Year Ending £'000	Variance Year Ending £'000	%
Cheshire And Merseyside ICB	4,698	4,677	21	4,698	4,677	21	0.4%
Capital allocation					4,698		
Variance to allocation					21		
Allocation met					Yes		

Table 15 – Reconciliation from ICS Capital Plan to ICS Capital M12 actual

	£,000	Comment
Capital Plan (submitted June 2024)	**315,026**	
Additions funded nationally		
Mid Cheshire RAAC	*24,682*	Funded by NHSE - priority
Wirral RAAC	*1,953*	Funded by NHSE - priority
Countess of Chester RAAC	*550*	Funded by NHSE - priority
Liverpool University RAAC	*2,100*	Funded by NHSE - priority
Mid Cheshire Digital	*3,000*	Bespoke - Rev to Cap M10
Wirral Sterlile Services	*2,000*	Bespoke - Rev to Cap M10
Countess of Chester RAAC reprofile to 25/26	*(5,600)*	Agreed with NHSE 25/26
Subtotal Additional funded schemes	***28,685***	
Reductions supporting £12m local overprogramming		
Review of IFRS16 leases	*(6,909)*	various trusts
Mersey Care - L2 scheme slippage	*(2,000)*	contractual spend now in 25/26
CWP - Mother & Baby Unit slippage	*(1,500)*	contractual spend now in 25/26
Alder Hey - various schemes slippage	*(1,500)*	contractual spend now in 25/26
Minor schemes	*(96)*	minor adjustments
Subtotal reductions	***(12,005)***	
Actual Capital Spend M12	**331,706**	

3.37 **Appendix 10** sets out the detailed M12 capital position by provider.

4. Ask of the Board and Recommendations

4.1 The Board is asked to note the final reported financial position and metrics for 2024/25, which are subject now subject to audit processes.

5. Officer contact details for more information

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Appendices

Appendix 1:	**Continuing Care and Complex Care Forecast Outturn by Place M12**
Appendix 2:	**ICB Place Performance split by Programme Area M12**
Appendix 3:	**Provider Income and Expenditure vs YTD Plan**
Appendix 4:	**Agency Expenditure M12 by provider**
Appendix 5:	**Workforce Analysis M12 vs trend and M12 Plan by Provider**
Appendix 6:	**System Efficiencies: Current Performance M12**
Appendix 7:	**NHSE Model Hospital Reference Cost Index and Implied Productivity**
Appendix 8:	**Provider Cash at Month 12**
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Appendix 10:	**ICS Capital Expenditure vs ICS Allocation at Month 12**

Appendix 1

Continuing Care and Complex Care Forecast Outturn by Place as at 31st March 2025

Continuing Care M12 Forecast Variance (£'000)	Total	ICB Central	Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
FYE of Packages 23/24	-3,868		1,329	5,810	-697	1,985	550	-6,379	-1,779	-234	-4,453
Prior Year Impact (relating to 23/24)	7,053		1,355	1,963	105	26	1,383	434	-340	787	1,339
Prior Year Impact (Budget Change)	-5,047		-1,156	-1,677	-405	322	1,178	-2,159	340	-401	-1,090
Volume above 4.3% (24/25)	-2,466		-2,513	-2,458	-351	-223	4,354	-2,962	4,438	-304	-2,447
Price/Inflation above 1.9% (24/25)	-8,018		-3,138	1,646	958	855	-7,430	1,351	-2,879	-419	1,037
QIPP Delivered YTD (inherent in Price/Volume)	-9,159		-970	-700	-1,239	-977	-651	307	197	-1,645	-3,481
Non Package Driven	-3,481		-668	-356	134	417	-1,534	-2,477	-366	79	1,290
Other Planning Adjustments	820		63	178	15	0	290	41	17	20	196
QIPP Underdelivery	-3,016		-1,010	-935	342	0	960	0	-2,363	110	-119
In Year Budget Changes	-3,791		391	263	-139	-313	-2,738	-1,431	17	278	-118
Other	-4		-0	-4	-0	0	-0	0	0	-0	-0
Grand Total	**-30,977**	**0**	**-6,318**	**3,731**	**-1,278**	**2,093**	**-3,638**	**-13,275**	**-2,718**	**-1,730**	**-7,845**

Complex Care (Packages) M12 Forecast Variance (£'000)	Total	ICB Central	Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
FYE of Packages 23/24	-9,558		-1,332	367	-427	15	-5,255	-1,714	-1,427	268	-54
Prior Year Impact (relating to 23/24)	10,949		1,792	1,175	447	-159	2,904	2,512	557	397	1,324
Prior Year Impact (Budget Change)	-11,686		-1,669	-825	-483	159	-2,957	-2,259	-557	-367	-2,729
Volume above 4.3% (24/25)	-7,579		241	-1,099	-220	-563	-882	-1,590	-1,890	121	-1,696
Price/Inflation above 1.9% (24/25)	-7,909		-912	-3,822	-936	-739	-2,722	1,789	600	157	-1,324
QIPP Delivered YTD (cannot be split price/volum	-4,117		0	-14	-577	0	-1,188	-791	0	-504	-1,043
Non Package Driven	2,843		369	718	-9	117	558	-52	-33	1,144	31
Other Planning Adjustments	955		0	0	-0	81	-2	-3	-1	898	-18
QIPP Underdelivery	-473		312	-0	106	0	-817	0	0	-73	0
In Year Budget Changes	496		-182	136	65	28	1,552	20	50	-1,153	-20
Other	-0		0	-0	-0	0	-0	0	0	-0	0
Grand Total	**-26,080**	**0**	**-1,381**	**-3,365**	**-2,035**	**-1,061**	**-8,810**	**-2,088**	**-2,700**	**888**	**-5,529**

Appendix 2

ICB Place Performance split by Programme Area as at 31st March 2025

ICB CENTRAL	C&M ICB Default - Month 12 Position		
	Budget £'m	Actual £'m	Variance £'m
Acute	565	561	4
Community	25	24	0
CHC	(7)	(7)	(1)
Mental Health - Packages of Care	0	0	(0)
Mental Health - Contracts	61	61	0
Other Commissioned Services	2	1	0
Other Programme	45	43	2
Reserves	4	0	4
Primary Care - Delegated GP	1	0	0
Primary Care - Delegated Other	301	297	4
Prescribing	15	15	(0)
Primary Care - Other	5	0	4
Specialised Commissioning	629	618	11
Sub Total - Programme Expenditure	**1,642**	**1,614**	**28**
Running Costs	49	48	0
TOTAL EXPENDITURE	**1,691**	**1,662**	**29**
Surplus / (Deficit) Plan	*191*	*0*	*191*
Sub Total - Net Surplus / (Deficit) Reported	***1,882***	***1,662***	***220***

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CHESHIRE EAST	Cheshire East Place - Month 12 Position		
	Budget £'m	Actual £'m	Variance £'m
Acute	422	421	0
Community	92	90	2
CHC	78	84	(6)
Mental Health - Packages of Care	22	24	(1)
Mental Health - Contracts	57	58	(0)
Other Commissioned Services	2	2	0
Other Programme	2	1	0
Reserves	(3)	0	(3)
Primary Care - Delegated GP	82	82	(0)
Primary Care - Delegated Other	0	0	(0)
Prescribing	72	75	(3)
Primary Care - Other	18	17	1
Specialised Commissioning	0	0	(0)
Sub Total - Programme Expenditure	**844**	**854**	**(11)**
Running Costs	0	0	(0)
TOTAL EXPENDITURE	**844**	**854**	**(11)**
Surplus / (Deficit) Plan	*(52)*	*0*	*(52)*
Sub Total - Net Surplus / (Deficit) Reported	***792***	***854***	***(63)***

CHESHIRE WEST	Cheshire West Place - Month 12 Position		
	Budget £'m	Actual £'m	Variance £'m
Acute	431	430	1
Community	68	69	(1)
CHC	65	61	4
Mental Health - Packages of Care	23	27	(3)
Mental Health - Contracts	61	62	(1)
Other Commissioned Services	2	2	0
Other Programme	1	1	0
Reserves	(3)	0	(3)
Primary Care - Delegated GP	78	77	1
Primary Care - Delegated Other	0	0	(0)
Prescribing	70	72	(2)
Primary Care - Other	17	16	1
Specialised Commissioning	0	0	(0)
Sub Total - Programme Expenditure	**814**	**818**	**(4)**
Running Costs	0	0	(0)
TOTAL EXPENDITURE	**814**	**818**	**(4)**
Surplus / (Deficit) Plan	*(43)*	*0*	*(43)*
Sub Total - Net Surplus / (Deficit) Reported	***771***	***818***	***(47)***

HALTON	Halton Place - Month 12 Position		
	Budget £'m	Actual £'m	Variance £'m
Acute	169	168	0
Community	39	40	(0)
CHC	18	19	(1)
Mental Health - Packages of Care	9	11	(2)
Mental Health - Contracts	25	25	0
Other Commissioned Services	1	1	(0)
Other Programme	1	1	1
Reserves	0	0	0
Primary Care - Delegated GP	28	28	0
Primary Care - Delegated Other	0	0	(0)
Prescribing	28	29	(2)
Primary Care - Other	4	4	0
Specialised Commissioning	0	0	(0)
Sub Total - Programme Expenditure	**322**	**325**	**(3)**
Running Costs	0	0	(0)
TOTAL EXPENDITURE	**322**	**325**	**(3)**
Surplus / (Deficit) Plan	*(9)*	*0*	*(9)*
Sub Total - Net Surplus / (Deficit) Reported	***313***	***325***	***(13)***

KNOWSLEY	Knowsley Place - Month 12 Position		
	Budget £'m	Actual £'m	Variance £'m
Acute	216	216	1
Community	62	63	(1)
CHC	16	14	2
Mental Health - Packages of Care	7	9	(1)
Mental Health - Contracts	36	36	0
Other Commissioned Services	1	1	0
Other Programme	4	3	1
Reserves	0	0	0
Primary Care - Delegated GP	44	44	0
Primary Care - Delegated Other	0	0	(0)
Prescribing	36	39	(3)
Primary Care - Other	3	3	0
Specialised Commissioning	0	0	(0)
Sub Total - Programme Expenditure	**427**	**428**	**(0)**
Running Costs	0	0	(0)
TOTAL EXPENDITURE	**427**	**428**	**(0)**
Surplus / (Deficit) Plan	*12*	*0*	*12*
Sub Total - Net Surplus / (Deficit) Reported	***439***	***428***	***12***

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LIVERPOOL	Liverpool Place - Month 12 Position		
	Budget £'m	Actual £'m	Variance £'m
Acute	701	699	2
Community	139	139	(0)
CHC	66	70	(4)
Mental Health - Packages of Care	31	39	(9)
Mental Health - Contracts	114	116	(2)
Other Commissioned Services	4	3	0
Other Programme	10	9	1
Reserves	0	0	0
Primary Care - Delegated GP	118	118	0
Primary Care - Delegated Other	0	0	(0)
Prescribing	103	109	(6)
Primary Care - Other	30	28	2
Specialised Commissioning	0	0	(0)
Sub Total - Programme Expenditure	**1,315**	**1,331**	**(16)**
Running Costs	0	0	(0)
TOTAL EXPENDITURE	**1,315**	**1,331**	**(16)**
Surplus / (Deficit) Plan	*11*	*0*	*11*
Sub Total - Net Surplus / (Deficit) Reported	***1,326***	***1,331***	***(5)***

SEFTON	Sefton Place - Month 12 Position		
	Budget £'m	Actual £'m	Variance £'m
Acute	362	359	3
Community	95	93	2
CHC	42	55	(13)
Mental Health - Packages of Care	20	22	(2)
Mental Health - Contracts	55	56	(0)
Other Commissioned Services	1	1	0
Other Programme	3	2	1
Reserves	0	0	0
Primary Care - Delegated GP	55	55	(0)
Primary Care - Delegated Other	0	0	(0)
Prescribing	59	61	(2)
Primary Care - Other	13	12	0
Specialised Commissioning	0	0	(0)
Sub Total - Programme Expenditure	**705**	**717**	**(11)**
Running Costs	0	0	(0)
TOTAL EXPENDITURE	**705**	**717**	**(11)**
Surplus / (Deficit) Plan	*(11)*	*0*	*(11)*
Sub Total - Net Surplus / (Deficit) Reported	***695***	***717***	***(22)***

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ST HELENS	St. Helens Place - Month 12 Position		
	Budget £'m	Actual £'m	Variance £'m
Acute	245	245	1
Community	57	54	2
CHC	27	29	(3)
Mental Health - Packages of Care	21	24	(3)
Mental Health - Contracts	35	35	0
Other Commissioned Services	1	1	0
Other Programme	4	4	(0)
Reserves	1	0	1
Primary Care - Delegated GP	44	44	0
Primary Care - Delegated Other	0	0	(0)
Prescribing	42	45	(3)
Primary Care - Other	6	5	1
Specialised Commissioning	0	0	(0)
Sub Total - Programme Expenditure	**482**	**486**	**(4)**
Running Costs	0	0	(0)
TOTAL EXPENDITURE	**482**	**486**	**(4)**
Surplus / (Deficit) Plan	*(11)*	*0*	*(11)*
Sub Total - Net Surplus / (Deficit) Reported	***471***	***486***	***(15)***

WARRINGTON	Warrington Place - Month 12 Position		
	Budget £'m	Actual £'m	Variance £'m
Acute	246	245	1
Community	44	44	(0)
CHC	31	33	(2)
Mental Health - Packages of Care	12	12	1
Mental Health - Contracts	35	35	0
Other Commissioned Services	1	1	0
Other Programme	2	2	0
Reserves	1	0	1
Primary Care - Delegated GP	42	42	0
Primary Care - Delegated Other	0	0	(0)
Prescribing	38	41	(3)
Primary Care - Other	6	6	0
Specialised Commissioning	0	0	(0)
Sub Total - Programme Expenditure	**461**	**461**	**(0)**
Running Costs	0	0	(0)
TOTAL EXPENDITURE	**461**	**461**	**(0)**
Surplus / (Deficit) Plan	*(5)*	*0*	*(5)*
Sub Total - Net Surplus / (Deficit) Reported	***456***	***461***	***(5)***

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Cheshire and Merseyside

WIRRAL	Wirral Place - Month 12 Position		
	Budget £'m	Actual £'m	Variance £'m
Acute	425	423	2
Community	91	89	2
CHC	68	76	(8)
Mental Health - Packages of Care	25	31	(6)
Mental Health - Contracts	64	66	(1)
Other Commissioned Services	1	1	0
Other Programme	0	0	0
Reserves	(1)	0	(1)
Primary Care - Delegated GP	72	74	(1)
Primary Care - Delegated Other	0	0	(0)
Prescribing	73	79	(6)
Primary Care - Other	12	11	1
Specialised Commissioning	0	0	(0)
Sub Total - Programme Expenditure	**832**	**848**	**(17)**
Running Costs	0	0	(0)
TOTAL EXPENDITURE	**832**	**848**	**(17)**
Surplus / (Deficit) Plan	*(21)*	*0*	*(21)*
Sub Total - Net Surplus / (Deficit) Reported	***811***	***848***	***(37)***

Appendix 3: Provider Income and Expenditure vs Annual Plan

	Income - Month 12			Total Pay - Month 12			Non Pay - Month 12			Other Operating Items			Income YTD Variance	Pay YTD Variance	Non Pay YTD Variance	Other Operating YTD Var	TOTAL YTD variance to plan
	YTD Plan £,000	YTD Actual £,000	YTD Variance £,000	YTD Plan £,000	YTD Actual £,000	YTD Variance £,000	YTD Plan £,000	YTD Actual £,000	YTD Variance £,000	YTD Plan £,000	YTD Actual £,000	YTD Variance £,000	%	%	%	%	%
Alder Hey Children's	434,012	451,414	**17,402**	(287,757)	(285,652)	**2,105**	(135,512)	(154,457)	**(18,945)**	(7,360)	(7,924)	**(564)**	4.0%	0.7%	-12.3%	-7.1%	-0.3%
Bridgewater Community	103,893	107,586	**3,693**	(72,577)	(77,584)	**(5,007)**	(29,358)	(31,132)	**(1,774)**	180	(26)	**(206)**	3.6%	-6.5%	-5.7%	-792.3%	-2.8%
Cheshire & Wirral Partnership	296,421	296,547	**126**	(237,336)	(233,824)	**3,512**	(55,790)	(60,437)	**(4,647)**	(1,800)	(550)	**1,250**	0.0%	1.5%	-7.7%	227.3%	0.0%
Countess of Chester Hospitals	379,173	408,257	**29,084**	(284,148)	(294,520)	**(10,372)**	(102,212)	(121,589)	**(19,377)**	(2,420)	(1,749)	**671**	7.7%	-3.5%	-15.9%	38.3%	-3.0%
East Cheshire Trust	223,439	235,611	**12,172**	(155,024)	(164,163)	**(9,139)**	(71,966)	(75,099)	**(3,133)**	(2,312)	(1,262)	**1,050**	5.4%	-5.6%	-4.2%	83.2%	-0.2%
Liverpool Heart & Chest	249,739	268,265	**18,526**	(120,823)	(125,624)	**(4,801)**	(113,903)	(127,965)	**(14,062)**	(872)	(492)	**380**	7.4%	-3.8%	-11.0%	77.2%	-0.3%
Liverpool University Hospitals	1,305,061	1,375,407	**70,346**	(892,093)	(942,759)	**(50,666)**	(421,553)	(453,003)	**(31,450)**	(24,236)	(17,939)	**6,297**	5.4%	-5.4%	-6.9%	35.1%	-1.0%
Liverpool Women's	176,907	176,706	**(201)**	(117,482)	(115,778)	**1,704**	(68,725)	(70,867)	**(2,143)**	(2,334)	(1,609)	**725**	-0.1%	1.5%	-3.0%	45.1%	0.9%
Mersey Care	763,860	802,122	**38,262**	(596,259)	(616,475)	**(20,216)**	(155,337)	(172,636)	**(17,299)**	(5,136)	(2,666)	**2,470**	5.0%	-3.3%	-10.0%	92.6%	0.0%
Mid Cheshire Hospitals	439,299	447,428	**8,129**	(318,371)	(319,903)	**(1,532)**	(129,803)	(136,030)	**(6,227)**	(5,627)	(4,817)	**810**	1.9%	-0.5%	-4.6%	16.8%	-0.4%
Mersey & West Lancs	985,978	999,854	**13,876**	(668,531)	(670,132)	**(1,601)**	(297,694)	(313,279)	**(15,585)**	(30,631)	(31,171)	**(540)**	1.4%	-0.2%	-5.0%	-1.7%	0.5%
The Clatterbridge Centre	298,399	320,611	**22,212**	(118,566)	(122,196)	**(3,630)**	(176,092)	(196,149)	**(20,057)**	(2,865)	(1,388)	**1,477**	7.4%	-3.0%	-10.2%	106.4%	0.0%
The Walton Centre	196,507	212,035	**15,528**	(103,833)	(106,638)	**(2,805)**	(86,945)	(99,319)	**(12,374)**	(382)	290	**672**	7.9%	-2.6%	-12.5%	-231.6%	0.4%
Warrington & Halton Hospitals	381,748	391,915	**10,167**	(280,480)	(293,840)	**(13,360)**	(108,015)	(110,882)	**(2,868)**	(4,588)	(4,022)	**566**	2.7%	-4.5%	-2.6%	14.1%	-0.5%
Wirral Community	113,413	115,453	**2,040**	(81,671)	(83,747)	**(2,076)**	(24,529)	(24,572)	**(44)**	(714)	(586)	**128**	1.8%	-2.5%	-0.2%	21.8%	0.0%
Wirral University Hospitals	532,595	539,431	**6,836**	(377,895)	(389,191)	**(11,296)**	(156,078)	(155,439)	**639**	(5,279)	(4,530)	**749**	1.3%	-2.9%	0.4%	16.5%	-2.4%
TOTAL Providers	**6,880,444**	**7,148,642**	**268,198**	**(4,712,847)**	**(4,842,026)**	**(129,179)**	**(2,133,511)**	**(2,302,857)**	**(169,346)**	**(96,376)**	**(80,441)**	**15,935**	**3.9%**	**-2.7%**	**-7.9%**	**16.5%**	**-0.2%**

Appendix 4 – Agency Expenditure M12 by provider

Agency Costs Year End	Year End Plan	Year End Actual	Variance	Actual agency as a % of pay costs
	£m	£m	£m	%
Alder Hey Children's	(0.6)	(1.3)	(0.7)	0.5%
Bridgewater Community	(1.5)	(1.8)	(0.3)	2.3%
Cheshire & Wirral Partnership	(8.3)	(7.3)	1.0	3.1%
Countess of Chester Hospitals	(4.9)	(4.2)	0.8	1.4%
East Cheshire Trust	(7.3)	(6.0)	1.3	3.7%
Liverpool Heart & Chest	(0.9)	(0.5)	0.4	0.4%
Liverpool University Hospitals	(10.0)	(11.2)	(1.1)	1.2%
Liverpool Women's	(1.4)	(0.8)	0.6	0.7%
Mersey Care	(18.0)	(15.3)	2.8	2.5%
Mid Cheshire Hospitals	(8.5)	(12.3)	(3.8)	3.9%
Mersey & West Lancs	(17.9)	(22.0)	(4.0)	3.3%
The Clatterbridge Centre	(0.7)	(1.4)	(0.6)	1.1%
The Walton Centre	0.0	(0.6)	(0.6)	0.6%
Warrington & Halton Hospitals	(7.3)	(3.7)	3.6	1.3%
Wirral Community	(0.5)	(0.7)	(0.2)	0.8%
Wirral University Hospitals	(4.2)	(9.5)	(5.3)	2.4%
All ProvidersAgency Spend	**(92.0)**	**(98.5)**	**(6.5)**	**2.0%**

C&M Annual Agency Ceiling	**(120.6)**
Forecast Variance to Ceiling	**22.1**

Appendix 5 – Workforce Analysis M12 vs trend and M12 Trajectory Plan by Provider

	2023/24	2024/25													M12 Variance	
Workforce (WTEs) - source PWRs / mitigation plan submission	M12 Actuals	M1 Actual	M2 Actual	M3 Actual	M4 Actual	M5 Actual	M6 Actual	M7 Actual	M8 Actual	M9 Actual	M10 Actual	M11 Actual	M12 Actual	M1 to M12 Trend	M12 Variance from plan trajectory favourable / (adverse)	
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	%
Alder Hey Children's	**4,368**	4,333	4,347	4,326	4,334	4,292	4,310	4,400	4,418	4,383	4,426	4,480	4,464		(190)	-4.5%
Bridgewater Community	**1,434**	1,453	1,462	1,447	1,454	1,445	1,459	1,476	1,471	1,458	1,444	1,436	1,422		57	3.9%
Cheshire & Wirral Partnership	**4,072**	4,061	4,024	4,017	4,000	3,967	4,032	4,041	4,014	4,042	4,050	4,095	4,152		(124)	-3.1%
Countess of Chester Hospitals	**4,886**	4,849	4,783	4,809	4,829	4,829	4,848	4,841	4,842	4,826	4,864	4,870	4,920		(156)	-3.3%
East Cheshire Trust	**2,675**	2,691	2,633	2,633	2,656	2,697	2,660	2,668	2,641	2,625	2,672	2,663	2,707		(82)	-3.1%
Liverpool Heart & Chest	**1,912**	1,874	1,880	1,898	1,886	1,889	1,887	1,915	1,904	1,899	1,912	1,934	1,939		(59)	-3.1%
Liverpool University Hospitals	**15,448**	15,261	15,163	15,041	15,228	15,170	15,128	15,153	15,119	15,136	15,104	15,249	15,232		(631)	-4.3%
Liverpool Women's	**1,687**	1,703	1,718	1,717	1,715	1,748	1,760	1,783	1,784	1,767	1,772	1,803	1,842		(77)	-4.4%
Mersey Care	**11,623**	11,344	11,224	11,091	11,244	11,286	11,475	11,419	11,474	11,478	11,616	11,714	11,758		(495)	-4.4%
Mid Cheshire Hospitals	**5,687**	5,445	5,425	5,398	5,429	5,428	5,380	5,455	5,455	5,441	5,529	5,538	5,577		(228)	-4.3%
Mersey & West Lancs	**10,614**	10,458	10,538	10,478	10,556	10,551	10,547	10,694	10,621	10,642	10,575	10,632	10,638		(74)	-0.7%
The Clatterbridge Centre	**1,893**	1,890	1,919	1,920	1,896	1,906	1,930	1,921	1,926	1,922	1,931	1,942	1,957		(50)	-2.6%
The Walton Centre	**1,562**	1,554	1,522	1,570	1,552	1,600	1,608	1,608	1,614	1,588	1,604	1,608	1,619		(61)	-3.9%
Warrington & Halton Hospitals	**4,786**	4,626	4,646	4,637	4,657	4,615	4,707	4,699	4,658	4,639	4,653	4,658	4,692		(133)	-2.9%
Wirral Community	**1,560**	1,587	1,579	1,567	1,566	1,564	1,568	1,570	1,581	1,568	1,560	1,561	1,547		(35)	-2.3%
Wirral University Hospitals	**6,258**	6,389	6,499	6,300	6,350	6,315	6,344	6,358	6,301	6,360	6,336	6,308	6,343		(116)	-1.9%
C&M Providers Total	**80,465**	**79,516**	**79,361**	**78,849**	**79,352**	**79,303**	**79,645**	**80,002**	**79,822**	**79,773**	**80,046**	**80,492**	**80,808**		**(2,454)**	**-3.1%**
by Sector																
Acute	**50,353**	49,719	49,687	49,296	49,704	49,604	49,616	49,868	49,637	49,668	49,731	49,918	50,108		(1,420)	-2.3%
Specialist	**11,423**	11,353	11,386	11,431	11,382	11,436	11,495	11,628	11,645	11,559	11,645	11,768	11,821		(437)	-3.2%
Community / MH	**18,689**	18,444	18,289	18,123	18,265	18,263	18,534	18,506	18,539	18,546	18,669	18,806	18,879		(598)	-2.9%
TOTAL Providers	**80,465**	**79,516**	**79,361**	**78,849**	**79,352**	**79,303**	**79,645**	**80,002**	**79,822**	**79,773**	**80,046**	**80,492**	**80,808**		**(2,454)**	**-3.1%**

Appendix 6 - System Efficiencies: Current Performance M12

Org	CIP delivery					CIP Recurrent / Non Recurent YTD		
	M12 YTD Plan	M12 YTD Actual	M12 YTD Variance	M12 YTD % Variance	M12 CIP actual as a % of Op Ex	M12 YTD Actual Recurrent	M12 YTD Actual Non Recurrent	M12 Actual Recurrent as a % of YTD plan
	£,000	£,000	£,000	%	%	£,000	£,000	%
Alder Hey Children's	19,950	19,953	2	0.0%	4.4%	13,600	6,353	68%
Bridgewater Community	6,939	5,000	(1,939)	-27.9%	4.4%	1,760	3,240	25%
Cheshire & Wirral Partnership	13,913	13,913	0	0.0%	4.7%	11,086	2,827	80%
Countess of Chester Hospitals	19,822	11,906	(7,916)	-39.9%	2.9%	11,906	0	60%
East Cheshire Trust	11,225	11,229	4	0.0%	4.6%	5,537	5,692	49%
Liverpool Heart & Chest	10,644	9,891	(753)	-7.1%	3.8%	7,163	2,729	67%
Liverpool University Hospitals	114,600	99,495	(15,105)	-13.2%	6.3%	64,059	35,436	56%
Liverpool Women's	5,904	5,904	0	0.0%	3.0%	2,412	3,492	41%
Mersey Care	25,967	25,967	0	0.0%	3.1%	24,137	1,830	93%
Mid Cheshire Hospitals	22,437	22,404	(33)	-0.1%	4.8%	12,443	9,961	55%
Mersey & West Lancs	45,165	47,965	2,800	6.2%	4.7%	35,380	12,585	78%
The Clatterbridge Centre	10,000	10,000	(0)	0.0%	3.1%	2,762	7,238	28%
The Walton Centre	8,558	8,558	0	0.0%	4.1%	7,974	584	93%
Warrington & Halton Hospitals	19,433	18,495	(938)	-4.8%	4.5%	12,568	5,927	65%
Wirral Community	6,275	6,278	3	0.0%	5.7%	2,279	3,999	36%
Wirral University Hospitals	26,878	26,878	0	0.0%	4.8%	19,584	7,294	73%
TOTAL Providers	**367,710**	**343,836**	**(23,874)**	**-6.5%**	**5.2%**	**234,649**	**109,187**	**64%**
C&M ICB	72,236	73,269	1,033	1.4%	0.9%	73,269	0	101%
TOTAL ICS System	**439,946**	**417,105**	**(22,841)**	**-5.2%**	**5.5%**	**307,918**	**109,187**	**70%**

Appendix 7 - Productivity Data – NHSE Implied Productivity and Model Hospital Metrics

Implied Productivity 2024/25 M10 vs 2019/20 M10

	YTD Real Term Cost Growth	YTD Cost Weighted Activity Growth	YTD Implied Productivity Growth	
Org Name	YTD Real Terms Cost Growth at M10	YTD CWA Growth at M10	YTD Implied Productivity Growth at M10	*Change from previous month*
ENGLAND	**22.5%**	**5.3%**	**(14.0%)**	**(0.6%)**
Countess of Chester Hospital NHS Foundation Trust	22.7%	5.3%	(14.2%)	*0.9%*
East Cheshire NHS Trust	11.2%	(12.9%)	(21.7%)	*(0.2%)*
Liverpool University Hospitals NHS Foundation Trust	16.7%	(13.2%)	(25.6%)	*(3.0%)*
Mid Cheshire Hospitals NHS Foundation Trust	32.6%	9.5%	(17.4%)	*0.8%*
St Helens And Knowsley Teaching Hospitals NHS Trust	24.5%	6.4%	(14.6%)	*(0.2%)*
Warrington and Halton Teaching Hospitals NHS Foundation Trust	18.7%	(17.9%)	(30.9%)	*0.1%*
Wirral University Teaching Hospital NHS Foundation Trust	10.1%	3.4%	(6.1%)	*0.8%*
Alder Hey Children's NHS Foundation Trust	30.7%	8.2%	(17.2%)	*0.5%*
Liverpool Heart and Chest Hospital NHS Foundation Trust	39.4%	14.4%	(18.0%)	*(0.2%)*
Liverpool Women's NHS Foundation Trust	29.2%	(7.2%)	(28.2%)	*(0.5%)*
The Clatterbridge Cancer Centre NHS Foundation Trust	45.9%	63.8%	12.3%	*0.7%*
The Walton Centre NHS Foundation Trust	28.3%	29.3%	0.8%	*(0.2%)*
Cheshire and Merseyside ICB/ICS	**22.7%**	**(0.1%)**	**(18.6%)**	**(0.4%)**
North West	**22.3%**	**(1.6%)**	**(19.6%)**	**(0.9%)**

Implied Productivity 2024/25 M10 vs 2023/24 M10

	YTD Real Term Cost Growth (please note	YTD Cost Weighted Activity Growth	YTD Implied Productivity Growth	
MARSID	**YTD Real Terms Cost Growth at M10**	**YTD CWA Growth at M10**	**YTD Implied Productivity Growth at M10**	***Change from previous month***
England	**3.4%**	**4.9%**	**1.5%**	**(0.7%)**
CHESTER	2.0%	4.9%	2.8%	*0.3%*
EASTCHESHIRE	4.0%	5.1%	1.0%	*(0.4%)*
AINTREE	3.4%	(0.8%)	(4.0%)	*(4.6%)*
MIDCHESHIRE	2.0%	7.1%	5.0%	*0.7%*
STHELENS	6.7%	2.1%	(4.3%)	*(0.1%)*
WARRINGTON	2.5%	(4.3%)	(6.6%)	*0.3%*
WIRRAL	(0.7%)	3.5%	4.2%	*0.4%*
ALDERHEY	4.5%	7.0%	2.4%	*0.7%*
LIVERPOOLHEART	4.4%	5.3%	0.9%	*(1.1%)*
LIVERPOOLWOMEN	5.4%	12.3%	6.6%	*(0.1%)*
CLATTERBRIDGE	1.0%	9.6%	8.5%	*0.9%*
CHESHIRE_ICB	**3.3%**	**2.6%**	**(0.7%)**	**(0.8%)**
North West	**3.3%**	**3.2%**	**(0.1%)**	**(0.6%)**

NHS
Cheshire and Merseyside

NHSE Model Hospital – key productivity measures

	Info from Model System / Model Hospital (Not checked for data quality) Trust with biggest potential scope for improvement highlighted (worst performing Quartile)									
Org Name	Updated: Capped theatre utilisation - weekly (reported on 11 Aug 24)	Updated: Additional capacity (%) inc. 5% on the day cancellation rate - weekly (reported on 28 Jan 24)	ALOS for elective admissions (days) - rolling 6 months (reported on Mar-24)	Updated: ALOS for emergency admissions (days) - rolling 6 months (reported on Mar-24)	Updated: % of elective admissions with the length of stay > 6 days (reported on Mar-24)	Updated: % of emergency admissions with the length of stay > 6 days (reported on Mar-24)	Day case rates for BADCS procedures (3mths to month end) (reported on Apr-24)	Day case conversion to inpatient for BADCS procedures (3mths to month end) (reported on Apr-24)	Updated: % outpatient DNAs (reported on Jun-24)	Updated: % of OP appts performed virtually (SUS) - Weekly (reported on Jun-24)
ENGLAND	**79%**	**11%**	**3.0**	**10.3**	**9.2%**	**20.10%**	**81.3%**	**9.0%**	**6.9%**	**25%**
Countess of Chester Hospital NHS Foundation Trust	76.4%	0.0%	2.6	12.0	9.5%	20.4%	86.0%	8.0%	9.2%	17.6%
East Cheshire NHS Trust	80%	5%	3.2	11.0	8.2%	27.0%	88.3%	7.0%	4.2%	12.7%
Liverpool University Hospitals NHS Foundation Trust	76%	12%	3.9	12.4	18.0%	20.7%	78.2%	10.0%	10.5%	15.5%
Mid Cheshire Hospitals NHS Foundation Trust	71%	12%	2.5	10.2	10.2%	17.6%	85.5%	7.0%	6.0%	14.8%
St Helens And Knowsley Teaching Hospitals NHS Trust	75%	14%	3.0	11.3	7.2%	16.6%	79.1%	12.0%	8.2%	12.7%
Warrington and Halton Teaching Hospitals NHS Foundation Trust	73%	29%	2.7	11.5	7.9%	28.3%	74.8%	17.0%	8.5%	16.1%
Wirral University Teaching Hospital NHS Foundation Trust	82%	9%	3.1	10.7	9.5%	22.4%	84.9%	8.0%	7.5%	14.7%
Alder Hey Children's NHS Foundation Trust	75%	0%	4.3	7.1	12.1%	8.1%	91.9%	3.0%	9.7%	17.6%
Liverpool Heart and Chest Hospital NHS Foundation Trust	85%	0%	4.8	8.7	25.1%	24.4%	83.2%	7.0%	9.6%	30.4%
Liverpool Women's NHS Foundation Trust	0%	30%	1.6	4.4	2.4%	6.9%	77.1%	9.0%	9.2%	24.6%
The Clatterbridge Cancer Centre NHS Foundation Trust	0.0%	0.0%	12.4	14.1	35.6%	59.3%	92.7%	0.0%	2.8%	25.5%
The Walton Centre NHS Foundation Trust	82%	10%	3.6	22.6	16.6%	51.5%	78.1%	7.0%	6.8%	32.5%

Appendix 8: Provider Cash at Month 12

Org	Cash Balance			Operating Days Cash - Trend												External Cash Support*	BPPC % of bills paid in target	
	2023/24 M12 Closing Cash Balance	2024/25 M12 Closing Cash Balance	Movement	2023/24 M12	24/25 M3	24/25 M4	24/25 M5	24/25 M6	24/25 M7	24/25 M8	24/25 M9	24/25 M10	24/25 M11	24/25 M12	Trend	Received as at M12	2024/25 M12 By number	2024/25 M12 By Value
	£m	£m	£m	Days	Days	Days	Days	Days	Days	Days	Days	Days	Days	Days		£m	%	%
Alder Hey Children's	78.3	53.7	(24.6)	63	52	47	52	50	43	46	53	53	46	34		0.0	93.2%	91.5%
Bridgewater Community	17.3	8.2	(9.2)	51	53	52	50	38	31	33	33	29	33	20		0.0	98.4%	98.4%
Cheshire & Wirral Partnership	28.1	28.5	0.4	27	32	33	31	39	41	40	42	44	41	28		0.0	96.2%	93.9%
Countess of Chester Hospitals	12.3	28.2	15.8	8	4	2	10	7	14	10	6	4	29	17		13.6	95.0%	95.4%
East Cheshire Trust	17.9	14.0	(3.9)	21	18	18	13	14	24	24	22	20	32	15		0.0	93.8%	92.4%
Liverpool Heart & Chest	43.2	49.4	6.2	59	63	65	68	71	58	66	65	62	66	58		0.0	97.4%	98.2%
Liverpool University Hospitals	40.6	30.4	(10.2)	9	10	5	1	4	9	6	5	2	8	6		30.0	76.6%	90.9%
Liverpool Women's	2.0	3.8	1.8	3	7	4	2	6	27	28	16	15	13	6		7.0	93.4%	94.7%
Mersey Care	72.9	53.8	(19.1)	29	27	26	36	38	28	32	30	29	27	17		0.0	95.5%	96.0%
Mid Cheshire Hospitals	16.4	36.3	19.8	11	13	13	18	25	31	27	31	34	41	21		19.7	94.7%	94.4%
Mersey & West Lancs	24.7	10.2	(14.5)	8	1	2	2	2	13	1	2	1	3	3		17.0	85.7%	92.6%
The Clatterbridge Centre	74.3	73.2	(1.1)	130	93	81	90	91	85	91	89	85	82	63		0.0	97.7%	98.9%
The Walton Centre	51.6	62.4	10.8	69	119	108	113	105	100	99	106	111	103	83		0.0	88.8%	90.7%
Warrington & Halton Hospitals	17.6	16.3	(1.3)	12	6	10	5	6	20	15	15	14	11	11		12.1	87.3%	92.9%
Wirral Community	12.7	7.8	(4.9)	33	45	41	49	55	28	31	37	37	37	19		0.0	92.3%	95.8%
Wirral University Hospitals	10.6	0.1	(10.5)	6	3	3	3	1	5	2	2	3	3	0		3.5	60.2%	76.0%
TOTAL Providers	**520.6**	**476.2**	**(44.4)**	N/A	N/A	N/A	N/A	N/A	N/A	**16**	**16**	**16**	**17**	**11**		**102.9**	**90.4%**	**93.3%**

Appendix 9: Provider BPPC at Month 12

Better Payment Pratice Code (BPPC)	BPPC % of bills paid within 95% target – By Number												BPPC % of bills paid within 95% target – By Value											
	2023/24 M12	24/25 M3	24/25 M4	24/25 M5	24/25 M6	24/25 M7	24/25 M8	24/25 M9	24/25 M10	24/25 M11	24/25 M12	Trend	2023/24 M12	24/25 M3	24/25 M4	24/25 M5	24/25 M6	24/25 M7	24/25 M8	24/25 M9	24/25 M10	24/25 M11	24/25 M12	Trend
	%	%	%	%	%	%	%	%	%	%	%		%	%	%	%	%	%	%	%	%	%	%	
Alder Hey Children's	94.0%	92.6%	93.0%	93.4%	93.0%	93.3%	93.4%	93.6%	93.3%	93.3%	93.2%		92.9%	91.4%	91.0%	91.3%	91.4%	91.9%	92.0%	92.2%	91.8%	91.8%	91.5%	
Bridgewater Community	96.2%	96.6%	97.2%	97.5%	97.8%	98.0%	98.1%	98.2%	98.2%	98.3%	98.4%		96.8%	97.3%	97.7%	98.0%	98.3%	98.3%	98.4%	98.5%	98.2%	98.5%	98.4%	
Cheshire & Wirral Partnership	97.7%	94.6%	95.4%	95.7%	96.0%	95.9%	95.9%	96.0%	95.8%	95.9%	96.2%		97.1%	93.2%	93.5%	94.1%	94.2%	92.3%	92.9%	93.3%	93.0%	93.3%	93.9%	
Countess of Chester Hospitals	86.3%	95.7%	95.8%	95.6%	95.3%	95.2%	95.1%	95.1%	95.2%	95.1%	95.0%		89.1%	95.7%	95.9%	95.5%	95.6%	95.4%	95.7%	95.1%	95.2%	95.2%	95.4%	
East Cheshire Trust	94.9%	94.0%	94.6%	92.1%	91.7%	93.1%	93.3%	93.6%	93.3%	93.6%	93.8%		95.4%	93.3%	93.9%	92.8%	92.8%	92.0%	92.0%	91.0%	91.3%	91.8%	92.4%	
Liverpool Heart & Chest	96.4%	97.0%	96.9%	97.1%	97.2%	97.1%	97.2%	97.3%	97.2%	97.3%	97.4%		97.0%	97.1%	97.2%	97.4%	97.6%	97.8%	98.0%	98.0%	98.1%	98.1%	98.2%	
Liverpool University Hospitals	82.1%	76.6%	76.1%	76.9%	75.6%	76.3%	76.0%	76.8%	76.8%	76.9%	76.6%		92.8%	91.3%	91.4%	91.8%	91.7%	91.6%	91.5%	91.4%	91.3%	91.2%	90.9%	
Liverpool Women's	91.1%	92.2%	92.5%	92.9%	92.8%	93.5%	93.7%	93.7%	93.5%	93.1%	93.4%		93.6%	95.1%	95.1%	93.9%	94.7%	94.9%	95.3%	95.0%	95.2%	94.9%	94.7%	
Mersey Care	95.2%	95.2%	95.3%	95.3%	95.2%	95.3%	95.5%	95.4%	95.4%	95.5%	95.5%		93.0%	96.3%	96.1%	96.2%	96.1%	96.1%	96.1%	96.0%	96.1%	96.0%	96.0%	
Mid Cheshire Hospitals	88.6%	93.2%	93.4%	93.9%	94.1%	94.4%	94.3%	94.5%	94.5%	94.6%	94.7%		92.8%	93.2%	93.7%	94.1%	94.1%	94.4%	94.6%	94.4%	94.4%	94.5%	94.4%	
Mersey & West Lancs	90.2%	83.8%	82.6%	82.5%	82.4%	83.2%	83.8%	84.0%	84.3%	85.0%	85.7%		92.6%	92.4%	93.2%	92.6%	92.1%	92.4%	91.8%	91.8%	92.0%	92.3%	92.6%	
The Clatterbridge Centre	97.6%	97.8%	98.0%	97.8%	97.9%	97.8%	97.9%	97.9%	97.9%	97.9%	97.7%		99.3%	98.9%	99.1%	99.1%	99.3%	99.2%	99.1%	99.0%	98.9%	98.9%	98.9%	
The Walton Centre	90.4%	93.5%	93.9%	93.8%	93.5%	93.4%	93.2%	93.1%	93.1%	93.0%	88.8%		92.5%	94.9%	94.8%	94.2%	94.2%	94.1%	94.3%	94.0%	93.4%	92.9%	90.7%	
Warrington & Halton Hospitals	91.5%	91.8%	87.4%	86.8%	88.0%	87.7%	86.7%	86.6%	87.0%	87.0%	87.3%		91.4%	91.2%	89.2%	90.3%	90.7%	90.0%	91.3%	92.3%	92.9%	93.3%	92.9%	
Wirral Community	91.6%	92.4%	92.1%	92.1%	92.5%	92.6%	92.3%	92.2%	91.9%	91.9%	92.3%		93.4%	93.4%	94.1%	94.2%	94.0%	94.8%	95.2%	95.0%	95.2%	95.5%	95.8%	
Wirral University Hospitals	92.3%	74.2%	60.3%	52.3%	47.1%	48.6%	52.6%	54.8%	57.8%	61.3%	60.2%		95.1%	87.0%	81.9%	76.7%	74.5%	71.8%	73.1%	73.6%	74.6%	76.0%	76.0%	
Average C&M Providers	**92.3%**	**91.3%**	**90.3%**	**89.7%**	**89.4%**	**89.7%**	**89.9%**	**90.2%**	**90.3%**	**90.6%**	**90.4%**		**94.0%**	**93.9%**	**93.6%**	**93.3%**	**93.2%**	**92.9%**	**93.2%**	**93.2%**	**93.2%**	**93.4%**	**93.3%**	

Appendix 10: Provider Capital Expenditure vs ICS Allocation at Month 12

	Plan YTD £'000	Actual YTD £'000	Variance YTD £'000	Plan Year Ending £'000	FOT Year Ending £'000	Variance Year Ending £'000	Variance Year Ending %	Spend YTD as % of FOT
Alder Hey Children'S NHS Foundation Trust	16,923	16,129	794	16,923	16,129	794	4.7%	100%
Bridgewater Community Healthcare NHS Foundation Trus	4,467	3,776	691	4,467	3,776	691	15.5%	100%
Cheshire And Wirral Partnership NHS Foundation Trust	7,866	6,651	1,215	7,866	6,651	1,215	15.4%	100%
Countess Of Chester Hospital NHS Foundation Trust	77,750	73,059	4,691	77,750	73,059	4,691	6.0%	100%
East Cheshire NHS Trust	6,222	6,079	143	6,222	6,079	143	2.3%	100%
Liverpool Heart And Chest Hospital NHS Foundation Trus	7,811	7,780	31	7,811	7,780	31	0.4%	100%
Liverpool University Hospitals NHS Foundation Trust	59,398	51,777	7,621	59,398	51,777	7,621	12.8%	100%
Liverpool Women'S NHS Foundation Trust	5,035	5,035	-	5,035	5,035	-	0.0%	100%
Mersey Care NHS Foundation Trust	36,254	34,500	1,754	36,254	34,500	1,754	4.8%	100%
Mid Cheshire Hospitals NHS Foundation Trust	13,553	41,232	(27,679)	13,553	41,232	(27,679)	-204.2%	100%
Mersey and West Lancashire Teaching Hospitals NHS Tr	28,256	29,357	(1,101)	28,256	29,357	(1,101)	-3.9%	100%
The Clatterbridge Cancer Centre NHS Foundation Trust	11,110	11,409	(299)	11,110	11,409	(299)	-2.7%	100%
The Walton Centre NHS Foundation Trust	6,890	8,409	(1,519)	6,890	8,409	(1,519)	-22.0%	100%
Warrington And Halton Teaching Hospitals NHS Foundati	9,470	9,645	(175)	9,470	9,645	(175)	-1.8%	100%
Wirral Community Health And Care NHS Foundation Trus	6,453	5,245	1,208	6,453	5,245	1,208	18.7%	100%
Wirral University Teaching Hospital NHS Foundation Trus	12,870	16,946	(4,076)	12,870	16,946	(4,076)	-31.7%	100%
Total Provider CDEL	**310,328**	**327,029**	**(16,701)**	**310,328**	**327,029**	**(16,701)**	**-5.4%**	**100%**

ICS Capital allocation	**327,004**
Variance to allocation	(25)
Allocation met	Yes

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

27 May 2025

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

Agenda Item No: ICB/05/25/07

Report approved by: Mike Burrows, ICB Non-Executive Member

NHS
Cheshire and Merseyside

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

Committee Chair	Mike Burrows
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Meeting date	15 April 2025 and 20 May 2025

Key escalation and discussion points from the Committee meeting

Alert

At its meeting on the 15 April 2025 the Committee considered and discussed the following areas:

- **Month 11 position**
  As at Month 11 the ICS is reporting a YTD deficit of £89.7m against a planned YTD deficit of £56.5m resulting in an adverse variance of £33.2m.
  At Month 11 systems were given the opportunity to formally declare a variation to the plan. C&M has taken up this opportunity and has adjusted the forecast deficit from a break-even position to a £45.9m deficit.
  Efficiencies are behind plan by £29.4m, but £101.4m of the £363.7m achieve is non-recurrent, which impacts on the overall underlying position of the system

  The cash position is very challenged in MWL, LUHFT and WUTH who are operating with less than 10 working days of cash. The distress cash regime is extremely rigid, and providers are not receiving all the cash that they request. The ICB has provided some cash advances, but they all must be repaid before 31 March 2025.

- **Month 12 tabled position**
  Early headline figures for month 12 indicate achievement of the revised deficit of £45.9m a Small overperformance in a number of Trusts, mainly £2.7m at LUHFT, has been offset within the ICB's position. NB: The pre-deficit Support funding deficit of £195m remains repayable in accordance with current NHS Business Rules.

At its meeting on the 20 May 2025 the Committee considered and discussed the following areas:

- **Month 12 position**
  The ICS has reported a final deficit of £51.3m for the 24/25, which is a £5.5m adverse variance from the revised M11 FOT. This is due to a technical PFI adjustment for Mersey & West Lancashire, which has been recognised by the national team. The overall deficit of £201.3m is repayable in future years as per NHS Business Rules.

  Cash remains challenging for LUHFT, MWL and WUTH.
  Efficiencies delivered were £22.8m behind plan, with £109.2m delivered non-recurrently – impacting on the challenge in 25/26 and beyond
  Capital plan was delivered at just £4k above the allocation given to C&M.

- **Month 1**
  Month 1 performance was a pre-deficit Support Funding (DSF) deficit of £33.3m, £165k ahead of plan. Within this, was underachievement on efficiencies of £1.6m, highlighting where financial positions have been delivered through non-recurrent means creating a risk that month 2 could deteriorate considerably unless pace is picked up on planned CIP delivery. WTEs are down, but pay is up, highlighting dependence on Bank staff. Reported that agreement has been reached on harmonising bank rates which should alleviate this pressure in subsequent months.

Advise

At its meeting on the 15 April 2025 the Committee considered and discussed the following areas:

- **2025/26 Planning**
  Plan submitted on 27th March was a **£255m** deficit for the whole system. This is **£77m** short of the expected control total of **£178m** deficit. The national team have requested a further submission on 30th April where it is expected that the ICS can meet the expected Control Total.
  Presentation also highlighted expected reduction in workforce of 3,045 (3.8%), further work required on UEC and RTT performance

- **Next steps** include development of enhanced intervention process to oversee delivery of plans with Provider Trusts and with the ICB Chief System Improvement and Delivery Officer and a formal turnaround support for those trusts assessed as high risk

- **Financial strategy**
  Work with LAASP to deliver a 3 yr plan to breakeven and the same for the Cheshire system.

At its meeting on the 20 May 2025 the Committee considered and discussed the following areas:

- **25/26 Plan**
  The ICS has submitted a £178.3m deficit plan, in line with the nationally expected control total. Within this, the ICB has submitted a **£50.3m** surplus, alongside a Provider deficit of **£228.6m**. Set out expectation of identification of schemes to address "gap" in plans with unidentified CIPs and will keep under close scrutiny.
  Total CIP for the year equates to £572.5m – 7.5% of the ICS total allocation.
  Underlying position for 25/26 totals **£327m** deficit – this does not include distance from target, which takes the underlying position to **£620m**– further work will be carried out in year to ensure this is accurately reported and understood.

- **FCOG update**
  Meetings held weekly, with system/ICB focus on alternate weeks. Dashboard in development to help transparency of schemes and delivery.
  CEO and CFO meetings in diary for May in Cheshire and Merseyside regions.

Assure
At its meeting on the 20 May 2025 the Committee considered and discussed the following areas: • **Procurement** Update given on progress made in regard to the annual procurement plan. Noted that a challenge has been received in relation to one procurement process in 24/25. Actions now taken to address this matter. • **Workplan updated** Agreed that review of discretionary procurements will be undertaken in light of revenue recovery requirements • **Strategic Estates update on progress provided.** Clarification sought that capital plan supports revenue recovery. • **Productivity** Reviewed as provides insight into potential areas of improvement work. Future meetings will retain focus on this rea of work including relationship with provider contract values.

Committee risk management

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

Achievement of the ICB Annual Delivery Plan

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

Service Programme / Focus Area	Key actions/discussion undertaken
Deliver of financial savings through productivity and reducing Waste	FCOG update
Delivery of the financial position	Month 12 and Month 1 report
Development and delivery of the Capital Plans.	Month 11, 12 and Month 1 report
Development and delivery of a Cheshire and Merseyside system-wide financial strategy for 2024/5	Month 12 headline report
Delivery of the Finance Efficiency & Value Programme	Month 11 and Month 12 finance report
Development of System Estates Plans to deliver a programme to review and rationalise our corporate estates.	Estates Strategy update

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

29 May 2025

Integrated Performance Report

Agenda Item No: ICB/05/25/08

Responsible Director: Anthony Middleton: Director of Performance and Planning

Integrated Performance Report

1. Purpose of the Report

1.1 To inform the Board of the current position of key system, provider and place level metrics against the ICB's Annual Operational Plan.

2. Executive Summary

2.1 The integrated performance report for May 2025, see Appendix One, provides an overview of key metrics drawn from the 2024/25 Operational plans, specifically covering Urgent Care, Planned Care, Diagnostics, Cancer, Mental Health, Learning Disabilities, Primary and Community Care, Health Inequalities and Improvement, Quality & Safety, Workforce and Finance.

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

3. Ask of the Board and Recommendations

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

4. Reasons for Recommendations

4.1 The report is sent for assurance.

5. Background

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

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

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

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

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

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

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

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

8. Link to meeting CQC ICS Themes and Quality Statements

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

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

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

9. Risks

9.1 The report provides a broad selection of key metrics and identifies areas where delivery is at risk. Exception reporting identifies the issues, mitigating actions and delivery against those metrics. The key risks identified are ambulance response times, ambulance handover times, long waits in ED resulting in poor patient outcomes and poor patient experience, which all correspond to Board Assurance Framework Risk P5.

9.2 Additionally, waits for cancer and elective treatment, particularly due to industrial action and winter pressures within the urgent care system could result in reduced capacity and activity leading to poor outcomes, which maps to Board Assurance Framework Risk P3.

10. Finance

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

11. Communication and Engagement

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

12. Equality, Diversity and Inclusion

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

13. Climate Change / Sustainability

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

14. Next Steps and Responsible Person to take forward

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

15. Officer contact details for more information

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

16. Appendices

Appendix One: Integrated Quality and Performance report

NHS
Cheshire and Merseyside

Integrated Performance Report

29th May 2025

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Integrated Quality & Performance Report – Guidance:

NHS Cheshire and Merseyside

Provider Acronyms:

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

Key:

Data formatting

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

C&M National Ranking against the 42 ICBs

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

C&M National Ranking against the 22 Cancer Alliances

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

Notes on interpreting the data

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

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

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

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

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

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

Integrated Quality & Performance Report – Interpreting SPC Charts:

NHS Cheshire and Merseyside

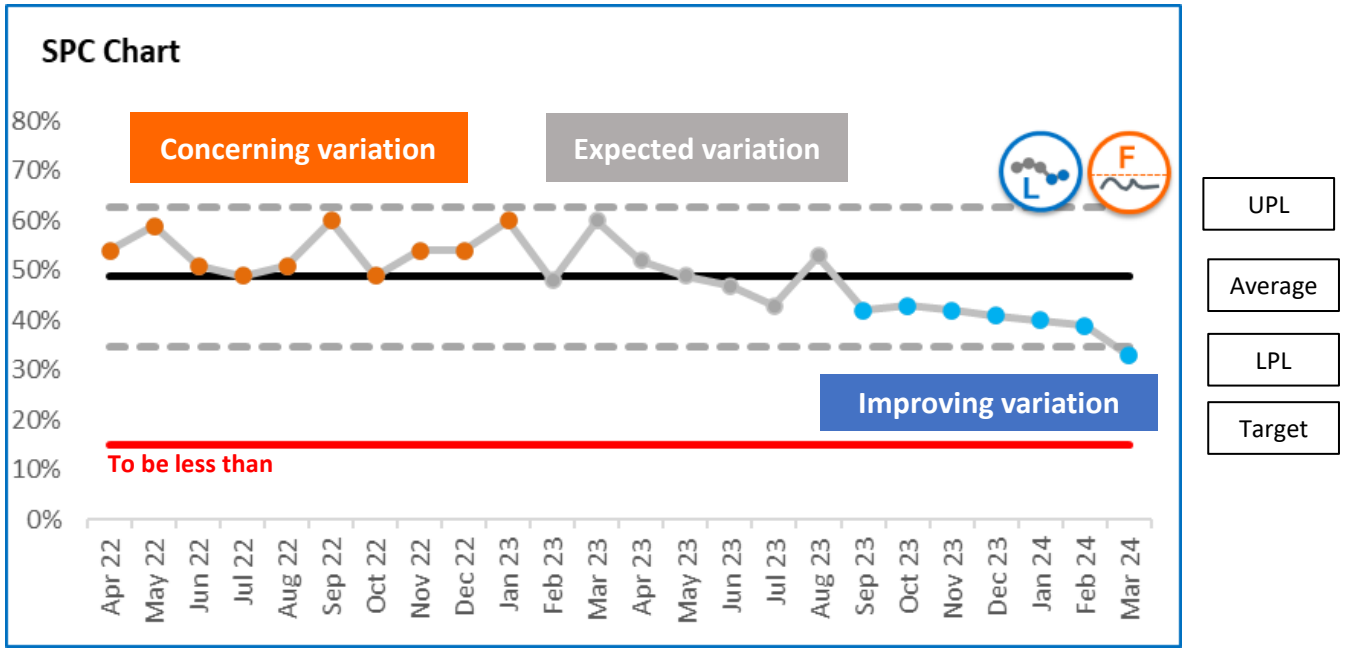
A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

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

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

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

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



UPL

Average

LPL

Target

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

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

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

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

Integrated Quality & Performance Report – Interpreting summary icons:

NHS Cheshire and Merseyside

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

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

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

1. ICB Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	Local Trajectory	National Target	Region value	National value	Latest Rank
Urgent care	4-hour A&E waiting time (% waiting less than 4 hours)	Apr-25	72.1%	71.1%	72.7%	74.4%	74.3%	72.9%	72.3%	72.4%	71.4%	72.9%	73.1%	72.6%	72.7%	72.6%	78% by Year end	72.4%	74.8%	27/42
	Ambulance category 2 mean response time	Apr-25	00:24:49	00:33:02	00:34:47	00:37:59	00:24:58	00:38:08	00:56:23	00:52:34	01:06:45	00:52:51	00:38:28	00:32:43	00:27:58	-	00:30:00	00:25:31	00:28:34	-
	Mean Ambulance Handover time (ED and Non ED) (NEW)	Apr-25	00:29:30	00:35:46	00:37:03	00:38:45	00:32:05	00:44:08	00:52:35	00:50:58	00:55:51	00:47:53	00:39:09	00:34:32	00:34:23	00:41:49	00:15:00	00:28:56	00:31:48	27/42
	A&E 12 hour waits from arrival	Apr-25	15.8%	16.8%	15.8%	15.6%	15.5%	16.6%	17.0%	15.7%	18.3%	18.3%	17.4%	16.2%	15.9%	17.0%	-	13.4%	9.9%	37/42
	Adult G&A bed occupancy	Apr-25	95.3%	95.8%	95.9%	95.5%	94.9%	95.6%	96.3%	96.5%	96.0%	97.4%	97.2%	95.9%	96.4%		92.0%	96.1%	95.8%	34/42
	Percentage of beds occupied by patients no longer meeting the criteria to reside*	Apr-25	21.6%	21.8%	21.3%	21.5%	19.9%	19.6%	20.4%	21.7%	19.5%	22.7%	21.6%	22.4%	20.3%		-	16.7%	14.4%	41/42
	Discharges - Average delay (exclude zero delay) (NEW)##	Feb-25						10.5	9.2	9.0	8.8	9.5	9.0			9.3		7.0	6.1	37/42
	Percentage of patients discharged on discharge ready date (NEW)##	Feb-25						88.1%	89.0%	87.8%	89.1%	88.2%	89.0%			85.4%		87.7%	86.2%	11/42
Planned care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Mar-25	2,324	2,331	2,285	2,098	1,972	985	1,091	1,093	1,282	1,167	1,091	659		0	-	991	7,381	-
	Number of 52+ week RTT waits, of which children under 18 years.	Mar-25	1,471	1,505	1,542	1,493	1,295	1,029	1,063	886	902	922	919	750		943	-	n/a	n/a	-
	Total incomplete Referral to Treatment (RTT) pathways	Mar-25	367,759	369,179	368,967	370,607	372,357	369,065	367,350	366,053	361,746	358,637	356,570	360,184		369,916	-	1,034,497	7,420,899	-
	The % of people waiting less than 18 weeks on the waiting list (RTT) (NEW)##	Mar-25	57.0%	57.7%	57.4%	57.1%	56.3%	56.2%	56.9%	57.4%	56.7%	56.5%	57.3%	58.0%		57.6%	92.0%	57.4%	59.8%	26/42
	The % of people waiting more than 52 weeks on the waiting list (RTT) (NEW)##	Mar-25	4.0%	4.0%	4.0%	4.0%	4.1%	3.7%	3.5%	3.4%	3.3%	3.4%	3.3%	3.0%		3.3%		3.2%	2.4%	34/42
	Patients waiting more than 6 weeks for a diagnostic test	Mar-25	10.2%	10.0%	10.1%	9.0%	10.1%	8.8%	7.2%	6.9%	10.3%	11.2%	5.9%	6.7%		5.0%	5.0%	11.4%	18.4%	1/42
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Mar-25	70.9%	71.8%	72.1%	75.9%	74.6%	73.0%	73.8%	75.9%	74.9%	71.6%	74.7%	76.4%		72.5%	85.0%	72.8%	71.3%	6/42
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Mar-25	91.8%	95.4%	94.5%	94.8%	94.3%	93.3%	94.6%	94.2%	95.5%	92.8%	95.8%	95.3%		96.0%	96.0%	94.4%	91.4%	10/42
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Mar-25	71.3%	71.4%	73.8%	74.1%	73.2%	71.4%	73.3%	75.4%	75.5%	66.8%	76.6%	76.3%		77.0%	77% by Year end	78.7%	79.0%	34/42
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028. (rolling 12 months)	Jan-25	58.0%	57.9%	57.9%	58.0%	58.4%	58.9%	59.0%	59.2%	59.5%	59.5%				70.0%	75% by 2028	58.6%	59.0%	21/42
Mental Health	Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Feb-25	20,330	20,435	20,425	20,600	20,565	20,670	20,905	21,070	21,285	21,420	21,585			21037		54680	597374	-
	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Feb-25	78%	78%	78%	76%	75%	73%	75%	76%	78%	79%	79%			60.0%	60.0%	72.0%	57.8%	16/41
	People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months	To Dec 2024		55.0%			52.0%			52.0%						-	60.0%	56.0%	59.0%	35/42
	Dementia Diagnosis Rate	Mar-25	67.0%	67.2%	67.4%	67.7%	67.6%	67.4%	67.6%	67.4%	67.3%	67.2%	67.4%	67.6%		66.7%	66.7%	70.1%	65.6%	15/42
	CYP Eating Disorders Routine	Feb-25	79.0%	79.0%	71.0%	79.0%	77.0%	79.0%	84.0%	87.0%	89.0%	88.0%	87.0%			95.0%	95.0%	81.0%	77.9%	10/41
	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact (NEW)	Feb-25	35080	35140	35220	35105	34655	34660	34730	35000	34550	34710	34550			37246	-	121315	822031	-
	Number of people accessing specialist Community PMH and MMHS services (NEW)	Feb-25	3220	3260	3280	3335	3370	3420	3480	3505	3555	3530	3555			3420	-	8850	63858	-
	Talking Therapies completing a course of treatment - % of LTP trajectory (YTD)	Feb-25	100.0%	98.6%	93.6%	93.0%	93.0%	93.1%	95.0%	94.0%	92.0%	92.0%	92.0%			100.0%	100.0%	88.0%	96.0%	23/42
	Talking Therapies Reliable Recovery	Feb-25	48.0%	46.0%	41.0%	47.0%	46.0%	46.0%	48.0%	48.0%	45.0%	47.0%	47.0%			48.0%	48.0%	46.0%	47.4%	24/42
	Talking Therapies Reliable Improvement	Feb-25	66.0%	67.0%	50.0%	66.0%	65.0%	65.0%	66.0%	66.0%	65.0%	66.0%	68.0%			67.0%	67.0%	66.0%	67.3%	19/42
Note/s	* No local plan for 2025/26 ## RAG rated against April plan as new metric																			

1. ICB Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	Local Trajectory	National Target	Region value	National value	Latest Rank
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Mar-25	95	95	100	100	95	90	85	85	85	80	80	80		60	-	250	1,805	25/42
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Feb 25 YTD	3.1%	7.3%	12.0%	17.7%	23.9%	30.2%	38.2%	46.8%	54.1%	65.1%	76.6%	92.3%		85.0%	**75%** by Year end	91.3%	90.0%	10/42
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Mar-25	84%	87%	85%	84%	86%	85%	86%	83%	85%	84%	83%	85%		70.0%	**70.0%**	89.0%	84.0%	25/42
	Virtual Wards Utilisation	Mar-25	41%	39%	70%	67%	62%	74.6%	93.2%	75.2%	69.2%	94.7%	73.5%	83.1%		80.0%	**80.0%**	66.0%	76.2%	9/42
	Community Services Waiting List (Adults)	Feb-25	48,213	53,285	49,459	54,375	54,021	54,830	48,815	48,663	50,574	50,937	41,919					86,588	767,553	-
	Community services Waiting List (CYP)	Feb-25	21,954	24,712	25,209	25,378	24,426	23,542	21,747	22,890	22,834	23,164	20,184					43,215	298,533	-
	Community Services – Adults waiting over 52 weeks	Feb-25	289	308	329	359	382	433	435	411	234	164	94			1		447	9,702	-
Primary Care	Units of dental activity delivered as a proportion of all units of dental activity contracted	Apr-25	81.0%	81.0%	80.0%	79.0%	77.0%	82.0%	86.0%	88.0%	78.0%	82.0%	94.0%	95.0%	78.0%	80.0%	**100.0%**	88.0%	91.0%	34/42
	Number of unique patients seen by an NHS Dentist – Adults (24 month)	Apr-25	926,008	926,012	926,430	928,591	928,716	929,925	932,009	932,314	933,534	934,964	936,873	937,773	939,105	940,075		2,646,836	18,119,453	-
	Number of unique patients seen by an NHS Dentist – Children (12 month)	Apr-25	322,008	323,306	323,089	325,212	325,733	327,329	329,456	330,255	331,503	332,275	332,480	333,475	332,615	334,258		1,018,037	7,119,415	-
	Appointments in General Practice & Primary Care networks (NEW)##	Mar-25	1,281,415	1,281,078	1,186,608	1,300,504	1,171,799	1,253,935	1,649,116	1,319,968	1,191,861	1,401,109	1,258,627	1,342,136		1,294,229		-	-	-
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care. (rolling 12 months)	Feb-25	7.22%	7.17%	7.12%	7.08%	7.07%	7.06%	6.94%	6.94%	6.94%	6.98%	7.02%			10.0%	**10.0%**	-	7.62% (Dec 24)	-
	Total volume of antibiotic prescribing in primary care	Feb-25	1.04	1.04	1.04	1.04	1.03	1.02	1.02	1.01	1.01	0.99	0.98			0.871	**0.871**	-	1.00	-
Integrated care - BCF metrics	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (average of place rates)***	Q3 24/25		235.7			231.5			228.6						-	-	237.7	198.9	-
	Percentage of people who are discharged from acute hospital to their usual place of residence	Mar-25	93.1%	93.4%	93.3%	93.0%	93.3%	93.3%	93.2%	93.2%	93.4%	92.8%	93.4%	91.3%		-	-	92.4%	93.0%	-
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 (average of place rates)***	Q3 24/25		535.3			526.1			542.5						-	-	346.4	351.0	-
Specialised Commissioning	Cardiac Treatment waiting list (LH&CH) #	Mar-25	396	418	425	450	407	410	414	390	401	389	386	376		419				-
	Neurosurgery waiting list (TWC) #	Mar-25	849	786	895	858	853	885	876	929	914	927	921	967		862				-
	Specialised Paediatrics waiting list (AHCH) #	Mar-25	363	365	352	350	356	287	312	265	261	256	269	248		343				-
	Vascular waiting list (LUFT) #	Mar-25	196	197	171	176	160	145	145	163	153	166	167	180		203				-
Note/s	* no national target for 2024/25 *** Awaiting clarification from NHSE re: metric criteria. Plans are no longer comparable to actuals largely due to implementation of SDEC (Type 5) in year but also revisions to National crtieria which systems need time to adopt and validate. # RAG rating based on 12 month comparison (Red = Higher, Green = Lower) ~ Wirral and Warrington reported figures less than half the previous quarter ## RAG rated against April plan as new metric																			

1. ICB Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Local Trajectory	National Target	Region value	National value	Latest Rank
Health Inequalities & Improvement	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q3 24/25	69.6%	65.8%			65.6%			65.50%						77.0%	80.0%	66.53%	67.2%	29/42
	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with lipid lowering therapies	Q3 24/25	61.9%	62.2%			62.3%			62.6%							65.0%	61.1%	62.74%	19/42
	Smoking at Time of Delivery V2	Q3 24/25	7.3%	7.3%			6.8%			6.1%							<6%	5.8%	5.50%	27/42
	Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems. (NEW METHODOLOGY - March 25)	Mar-25	13.9%	13.9%	13.8%	13.7%	13.6%	13.7%	13.7%	13.6%	13.6%	13.5%	13.5%	13.4%	15.8%	12.0%	12.0%	-	12.7%^	-
Continuing Healthcare	Standard Referrals completed within 28 days	Q3 24/25	62.40%	71.70%			64.70%			73.10%						>80%	>80%	81.3%	75.5%	29/42
	% DST's (Decision Support Tool) completed that were in Hospital	Q3 24/25	0.00%	0.00%			0.00%			0%						<15%		0.0%	0.0%	1/42
	Number eligible for Fast Track CHC per 50,000 population (snapshot at end of quarter)	Q3 24/25	25.33	28.75			29.15			27.18						<18		23.05	17.29	36/42
	Number eligible for standard CHC per 50,000 population (snapshot at end of quarter)	Q3 24/25	47.04	51.69			53.36			53.85						34.0		47.82	33.97	39/42
Maternity	HIE (Hypoxic ischemic encephalopathy) grade 2 or 3 per 1,000 live births (>=37 weeks)	Q3 24/25	1.2	0.7			1.1			0.9						2.5	2.5	0.6		
	Still birth per 1,000 (rolling 12 months)	Dec-24	2.95	2.78	2.58	2.83	2.71	2.45	2.48	2.64	2.53	2.72				-	-	-	3.8	-
Quality & Safety	Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation (Healthcare associated)	12 months to Feb 25	608	636	655	655	694	710	726	738	755	777	777	784		439	439	2205	11806	-
	Healthcare Acquired Infections: E.Coli (Healthcare associated)	12 months to Feb 25	812	816	823	810	813	813	817	829	831	821	820	815		518	518	2137	14667	-
	Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation #	Nov-24	1.001	0.998	0.993	0.999	0.991	0.992	0.988	0.989	0.984					0.887 to 1.127 *		-	1.000	-
	Never Events	Mar-25	3	4	2	2	1	1	1	0	3	0	6	1	2	0	0	-	-	-
Workforce / HR (ICS total)	Staff in post	Mar-25	73,267	73,078	73,011	72,945	72,909	73,039	73,548	73,910	74,068	74,101	74,208	74,450	74,600	71,994	-	198,623	-	-
	Bank	Mar-25	6,086	5,230	5,262	4,833	5,339	5,255	5,122	5,084	4,868	4,848	5,000	5,289	5,459	3,246	-	16,424	-	-
	Agency	Mar-25	1,279	1,209	1,088	1,072	1,104	1,009	932	1,009	886	824	838	775	749	980.8	-	4,206	-	-
	Turnover	Dec-24	11.2%	11.3%	11.2%	11.3%	11.0%	11.0%	10.9%	10.9%	10.8%	10.7%				11.4%	-	12.3%	-	-
	Sickness	Dec-24	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%				5.8%	-	5.9%	5.04%	37/42
Note/s	* National average upper and lower control limits (UCL and LCL) for SHMI across all non-specialist trusts. This gives an indication of whether the observed number of deaths in hospital, or within 30 days of discharge from hospital, for C&M was as expected when compared to the national baseline. This "rate" is different to the SHMI "banding" used for trusts on slide 8, therefore a comparison cannot be drawn between the two. ^ National figure is the latest ONS figure from 2022. local data is directly from GP systems. this has been reviewed against historic ONS data for LA's and the variation ranges from -0.9% to +5.9% # Banding changed Aug 23 to reflect SOF bandings for providers. Green = no providers higher than expected, Amber = 1-2 providers higher than expected, Red = more than 2 providers higher than expected ** -From December 2023 this metric is now available at ICB level, previously this was only reported at Cancer Alliance level. historical data has been updated																			

2. ICB Aggregate Financial Position

NHS Cheshire and Merseyside

ICB Overall Financial Position:

Category	Metric	Latest period	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Plan (£m)	Dir. Of Travel	FOT (£m) Plan	FOT (£m) Current	FOT (£m) Variance
Finance	Financial position £m (ICS) ACTUAL	Mar-25	-98.7	-	-68.8	-101.0	-138.0	-166.9	-108.5	-112.9	-129.5	-129.7	-109.7	-89.7	-45.9	0	↗	0.0	-45.9	-45.9
	Financial position £ms (ICS) VARIANCE	Mar-25	-98.7	-	-19.1	-16.5	-38.5	-48.5	-48.8	-51.4	-67.4	-61.2	-47.3	-33.2	-45.9		↘			
	Efficiencies £ms (ICS) ACTUAL	Mar-25	388.6	-	41.9	64.7	92.3	119.9	156.4	192.9	235.3	276.6	321.3	362.7	417.1	439.9	↗	439.9	417.1	-22.8
	Efficiencies £ms (ICS) VARIANCE	Mar-25	-0.1	-	-15.2	-13.1	-20.2	-26.6	-25.0	-26.7	-22.5	-20.7	-23.4	-29.4	-22.8		↗			
	Capital £ms (ICS) ACTUAL	Mar-25	267.3	-	N/A	39.5	65.6	81.8	97.1	121.7	145.0	170.0	204.1	241.0	327.0	310.3		310.3	327.0	-16.7
	Capital £ms (ICS) VARIANCE	Mar-25	1.1	-	N/A	3.9	11.3	13.6	26.8	28.3	28.2	32.1	24.6	10.9	-16.7					

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

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

3. Provider / Trust Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Providers																	
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts				Net OOA/ Other/ ICB	ICB *
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP		
Urgent care	4-hour A&E waiting time % waiting less than 4 hours)	Apr-25	60.1%	49.2%	56.7%	74.4%	68.7%	72.2%	79.5%	91.7%	-	89.1%	-	-	-	-	-	-	-	72.7%
	Mean Ambulance Handover time (ED and Non ED) (NEW)	Apr-25	00:32:31	00:32:48	00:29:31	00:33:06	00:28:30	00:39:46	00:35:09	00:23:16										00:34:23
	A&E 12 hour waits from arrival	Apr-25	25.2%	14.8%	15.7%	21.7%	20.1%	15.3%	16.6%	0.2%	-	0.0%	-	-	-	-	-	-	-	15.9%
	Adult G&A bed occupancy	Apr-25	98.3%	97.7%	93.3%	94.8%	96.6%	95.5%	98.7%	-	76.8%	64.3%	91.5%	82.4%					-	96.4%
	Percentage of beds occupied by patients no longer meeting the criteria to reside	Apr-25	20.1%	21.2%	19.4%	14.3%	21.9%	22.5%	20.6%										-	20.3%
	Discharges - Average delay (exclude zero delay) (NEW)##	Feb-25	15.2	**	**	5.9	11.0	8.0	9.7	0.0	5.1	2.3	2.8	0.0						9.0
	Percentage of patients discharged on discharge ready date (NEW)	Feb-25	89.4%	**	**	89.1%	80.5%	85.2%	92.7%	100.0%	98.4%	89.7%	97.7%	100.0%						89.0%
Planned care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Mar-25	141	2	225	34	128	32	88	0	4	0	0	0			2	-	3	659
	Number of 52+ week RTT waits, of which children under 18 years.	Mar-25	27	3	144	116	74	39	104	241	0	1	0	1						750
	Total incomplete Referral to Treatment (RTT) pathways	Mar-25	34,895	13,530	36,755	49,099	34,726	70,730	75,365	20,797	5,711	16,348	900	14,327			51	-	-	360,184
	The % of people waiting less than 18 weeks on the waiting list (RTT) (NEW)	Mar-25	48.5%	59.7%	56.8%	57.6%	58.4%	53.2%	64.6%	54.1%	69.7%	50.9%	97.1%	61.6%			90.2%			58.0%
	The % of people waiting more than 52 weeks on the waiting list (RTT) (NEW)##	Mar-25	5.5%	0.6%	3.9%	2.2%	4.0%	3.5%	2.5%	1.2%	1.0%	2.1%	0.0%	0.7%			3.5%			3.0%
	Patients waiting more than 6 weeks for a diagnostic test	Mar-25	10.7%	3.3%	5.0%	7.6%	3.3%	6.5%	6.9%	3.9%	3.9%	2.4%	0.0%	0.3%	13.2%	0.0%	-	-	-	6.7%
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Mar-25	78.2%	75.9%	69.5%	77.4%	73.1%	70.2%	85.7%		87.8%	45.7%	83.0%	100.0%	90.7%				-	76.4%
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Mar-25	94.4%	100.0%	86.6%	88.6%	98.8%	91.2%	93.2%	100.0%	100.0%	84.6%	99.7%	100.0%	88.0%				-	95.3%
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Mar-25	84.8%	79.4%	75.2%	75.2%	74.2%	75.5%	74.0%	100.0%	87.0%	75.4%	89.5%	100.0%	84.3%				-	76.3%
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	Oct-24	61.7%	63.0%	61.2%	57.4%	58.5%	68.8%	59.7%	-	58.1%	71.3%	41.8%	-	100.0%	-				59.5%
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics ** Indicates that provider did not meet to DQ criteria and is excluded from the analysis # Value supressed due to small numbers ~ No targets set for 2025/26 ## RAG rated against April plan as new metric																			

3. Provider / Trust Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Providers																	
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts				Net OOA/ Other/ ICB	ICB *
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP		
Mental Health	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Feb-25			Mental Health service providers only												76.0%	85.0%	-	79.0%
	CYP Eating Disorders Routine	Feb-25								81%							85.0%	100.0%		87.0%
	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact (NEW)	Feb-25				1665				4475					1790		9070	8560	8990	34550
	Number of people accessing specialist Community PMH and MMHS services (NEW)	Feb-25															2290	1335		3555
	Talking Therapies completing a course of treatment - % of LTP trajectory		Just number available/ no target																	92.0%
	Talking Therapies Reliable Recovery	Feb-25															46.0%			47.0%
	Talking Therapies Reliable Improvement	Feb-25															66.0%			68.0%
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Mar-25	80.0%	90.0%	-	Community Service Providers only									86.0%	89.0%	81.0%	-	76%	84.0%
	Virtual Wards Utilisation	Mar-25	110.4%	117.5%	87.5%	92.5%	75.0%	76.8%	95.8%	156.3%										83.1%
	Community Services Waiting List (Adults)	Feb-24	0	4,522	5,145	443	-	-	402	0	142	-	-	-	3,249	4,657	19,529	3,830	0	41,919
	Community services Waiting List (CYP)	Feb-24	1,137	692	1,552	5,001	-	-	881	5,441	0	-	-	-	3,812	593	820	255	0	20,184
	Community Services – Adults waiting over 52 weeks	Feb-24	0	27	2	0	-	-	0	0	0	-	-	-	33	0	0	32	0	94
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics ** Indicates that provider did not meet to DQ criteria and is excluded from the analysis # Value supressed due to small numbers																			

3. Provider / Trust Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Providers																	
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts				Net OOA/ Other/ ICB	ICB *
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP		
Health Inequalities & Improvement	Smoking at Time of Delivery (NEW) data only available at ICB/Place level																			
Maternity	HIE (Hypoxic ischemic encephalopathy) grade 2 or 3 per 1,000 live births (>=37 weeks)	24/25 Q3	0.0	1.5	0.0	1.4	1.7		0.0			0.6								0.9
	Still birth per 1,000 (rolling 12 months)	Dec-24	1.58	0.81	4.72	2.44	2.41	-	1.97	-	-	3.38	-	-						2.72
Quality & Safety	Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation (Healthcare Associated)	12 months to Mar 25	(82 vs 56)	(25 vs 6)	(47 vs 31)	(166 vs 71)	(90 vs 36)	(207 vs 133)	(114 vs 85)	(13 vs 0)	(4 vs 2)	(2 vs 0)	(13 vs 13)	(7 vs 6)						770
	Healthcare Acquired Infections: E.Coli (Healthcare associated)	12 months to Mar 25	(61 vs 35)	(32 vs 27)	(53 vs 24)	(96 vs 53)	(89 vs 54)	(257 vs 165)	(158 vs 121)	(15 vs 8)	(5 vs 6)	(4 vs 5)	(23 vs 10)	(8 vs 10)						801
	Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation #	Nov-24	0.9094	1.2041	0.9209	0.9679	1.0347	0.9536	1.0253											0.984
	Never Events (rolling 12 month total)	12 Months to Apr 25	1	0	0	0	1	2	5	3	1	2	0	4	0	0	0	0	0	19
Workforce / HR (Trust Figures)	Staff in post	Mar-25	4,543	2,414	5,020	5,915	4,273	14,081	9,696	4,315	1,863	1,724	1,909	1,516	1,393	1,496	10,579	3,865	-	74,600
	Bank	Mar-25	348	223	446	405	378	1,042	793	141	72	107	40	96	22	47	1,064	237	-	5,459
	Agency	Mar-25	29	70	112	23	40	109	149	8	5	11	8	7	7	5	116	51	-	749
	Turnover	Dec-24	11.8%	10.1%	8.9%	9.6%	10.2%	10.4%	9.8%	9.7%	11.7%	10.6%	9.8%	12.0%	10.0%	10.0%	12.9%	12.4%	-	10.7%
	Sickness (via Ops Plan Monitoring Dashboard)	Dec-24	6.0%	5.7%	5.1%	6.1%	5.8%	6.2%	4.0%	5.6%	5.2%	6.0%	4.7%	5.7%	6.2%	6.5%	7.8%	6.2%	-	5.6%
Finance	Overall Financial position **Variance** (£m)	Mar-25	0.00	0.95	1.18	-3.07	-5.49	-5.47	1.60	-0.00	0.04	0.09	0.00	1.02	-3.33	0.05	3.22	0.24	-36.90	-45.89
	Efficiencies (Variance)	Mar-25	-7.92	0.00	-0.03	0.00	-0.94	-15.10	2.80	0.00	-0.75	0.00	-0.00	0.00	-1.94	0.00	0.00	0.00	1.00	-22.87
	Capital (Variance)	Mar-25	4.70	0.10	-27.70	-4.00	-0.20	7.60	-1.10	0.80	0.00	0.00	-0.30	-1.50	0.70	1.21	1.81	1.20	0.00	-16.69
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics ** The SHMI banding gives an indication for each non-specialist trust on whether the observed number of deaths in hospital, or within 30 days of discharge from hospital, was as expected when compared to the national baseline, as the UCL and LCL vary from trusts to trust. This "banding" is different to the "rate" used for the ICB on slide 5, therefore a comparison cannot be drawn between the two. *** Independent Providers / Other providers 1 at Spire Murrayfield # Banding changed Aug 23 to reflect SOF rating by NHSE. 'As expected' rating is RAG rated Green, 'Higher than expected' is RAG rated Red.																			

4. Place Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Sub ICB Place										ICB *	Local Trajectory	National Target
			Cheshire & Wirral				Merseyside								
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton				
			East **	West **							South Sefton	S/port & Formby			
Urgent Care	4-hour A&E waiting time % waiting less than 4 hours)	Apr-25	53.8%	58.8%	28.9%	58.2%	74.7%	73.7%	76.9%	75.8%	62.7%		72.7%	72.6%	78% by Year end
	Ambulance category 2 mean response time	Apr-25	00:29:05		00:27:46	00:26:21	00:26:15	00:28:01	00:27:27	00:28:31	00:29:44		00:27:58		00:30:00
	A&E 12 hour waits from arrival	Apr-25	15.3%	21.1%	19.8%	18.6%	11.9%	20.5%	14.1%	21.6%	14.2%		15.9%	-	-
	Discharges - Average delay (exclude zero delay) (NEW)##	Feb-25	7.5	11.6	5.9	9.5	7.9	10.8	8.7	12.7	9.5		9.0	9.3	
	Percentage of patients discharged on discharge ready date (NEW)	Feb-25	91.0%	90.6%	89.2%	84.4%	85.6%	96.3%	92.9%	90.7%	85.5%		89.0%	85%	
Planned Care	Total incomplete Referral to Treatment (RTT) pathways	Mar-25	106,880		53,383	28,642	60,089	28,312	23,149	20,875	38,854		360,184	369,916	-
	The % of people waiting less than 18 weeks on the waiting list (RTT) (NEW)	Mar-25	55.8%		57.8%	59.9%	55.7%	64.9%	59.4%	60.0%	55.5%	65.5%	58.0%		
	The % of people waiting more than 52 weeks on the waiting list (RTT) (NEW)	Mar-25	3.6%		2.3%	3.4%	2.9%	2.3%	3.0%	3.5%	2.7%		3.0%	3.3%	
	Patients waiting more than 6 weeks for a diagnostic test	Mar-25	7.2%		7.5%	3.4%	5.8%	8.7%	7.7%	8.7%	6.2%		6.7%	5.0%	10%
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	Feb-25	72.1%	74.8%	78.1%	75.7%	69.8%	86.6%	83.3%	83.1%	76.7%		76.4%	72.3%	85.0%
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	Feb-25	92.4%	91.8%	94.9%	94.4%	97.2%	95.9%	96.0%	95.4%	93.9%		95.3%	96.0%	96.0%
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	Feb-25	76.8%	81.3%	74.6%	76.2%	77.1%	79.5%	78.5%	77.4%	69.7%		76.3%	77.0%	77% by Year end
Mental Health	Access to Transformed Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses	Feb-25	4,050		2,225	1,430	6,565	1,085	1,855	1,010	3,610		21585		
	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Feb-25	87.0%		88.0%	78.0%	75.0%	69.0%	60.0%	83.0%		89.0%	79.0%	60.0%	60.0%
	People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months	To Dec 2024	51.0%		50.0%	58.0%	54.0%	47.0%	57.0%	60.0%	43.0%	59.0%	52.0%	-	60.0%
	Dementia Diagnosis Rate	Mar-25	67.5%		66.5%	72.5%	68.2%	66.8%	63.3%	66.2%	68.28%		67.6%	66.7%	66.7%
	CYP Eating Disorders Routine	Feb-25	100.0%		95.0%	96.0%	71.0%	90.0%	93.0%	88.0%	80.0%	93.0%	87.0%	95.0%	95.0%
	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact (NEW)	Feb-25	6370		4755	4040	7405	4280	2565	1705	2220	1385	34550	37246	-
	Number of people accessing specialist Community PMH and MMHS services (NEW)	Feb-25	1035		410	305	700	265	270	185	240	145	3555	3420	-
	Talking Therapies completing a course of treatment - % of LTP trajectory	Feb-25	97.9%		121.2%	77.5%	87.2%	109.1%	83.2%	65.3%	66.8%	77.9%	92.0%	100.0%	100.0%
	Talking Therapies Reliable Recovery	Feb-25	49.0%		49.0%	50.0%	46.0%	45.0%	50.0%	48.0%	41.0%	39.0%	47.0%	48.0%	48.0%
	Talking Therapies Reliable Improvement	Feb-25	70.0%		72.0%	74.0%	65.0%	66.0%	65.0%	72.0%	63.0%	65.0%	68.0%	67.0%	67.0%
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics ** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT. # Potential data issue at Wirral Cummunity Health which recorded no patients seen within 4-hours ## RAG rated against ICB April plan as new metric														

4. Place Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Sub ICB Place										ICB *	Local Trajectory	National Target
			Cheshire & Wirral				Merseyside								
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton				
			East **	West **							South Sefton	S/port & Formby			
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Feb-25	20		10	5	15	5	10	10	5		80	60	-
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Mar 25 YTD	97.4%		104.1%	89.6%	89.7%	87.4%	97.1%	90.7%	75.9%		92.3%	85.0%	**75%** by Year end
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Feb-25	84.3%		89.1%	77.8%	72.1%	78.5%	89.3%	90.6%	75.6%	89.5%	85.0%	70.0%	**70.0%**
	Virtual Wards Utilisation Number only	Mar-25	72	68	37	24	50	36	9	8	14		328		
	Community Services Waiting List (Adults) - data only available at ICB/Provider level												41,919		
	Community services Waiting List (CYP) - data only available at ICB/Provider level												20,184		
	Community Services – Adults waiting over 52 weeks - data only available at ICB/Provider level												94		
Primary Care	Appointments in General Practice & Primary Care networks (NEW)@	Mar-25	206499	183297	209193	113143	266204	87905	84584	57375	133936		1342136	1294229	
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care. (rolling 12 months)	Feb-25	5.91%	7.19%	9.01%	6.13%	7.19%	5.79%	6.53%	6.12%	7.67%		7.02%	10.0%	**10.0%**
	Total volume of antibiotic prescribing in primary care	Feb-25	0.82	0.91	1.06	0.89	0.98	1.14	1.14	1.03	1.01		0.98	0.871	**0.871**
Integrated care - BCF metrics ***	Unplanned hospitalisation for chronic ambulatory care sensitive conditions ***	Q3 24/25	195.9	219.7	165.8	187.0	272.5	277.8	312.3	254.8	171.3		228.6	-	-
	Percentage of people who are discharged from acute hospital to their usual place of residence	Mar-25	86.4%	90.1%	93.6%	92.3%	94.4%	89.7%	90.3%	90.4%	92.1%		91.3%	-	-
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 ***	Q3 24/25	552.8	547.7	329.8	383.4	751.0	550.2	772.2	494.1	501.4		542.5	-	-
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics ** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT. *** Awaiting clarification from NHSE re: metric criteria. Plans are no longer comparable to actuals largely due to implementation of SDEC (Type 5) in year but also revisions to National crtieria which systems need time to adopt and validate. ~ Wirral and Warrington have reported figures less than half the previous quarter @ RAG based on last year postion, Green for greater than last year														

4. Place Aggregate Position

NHS Cheshire and Merseyside

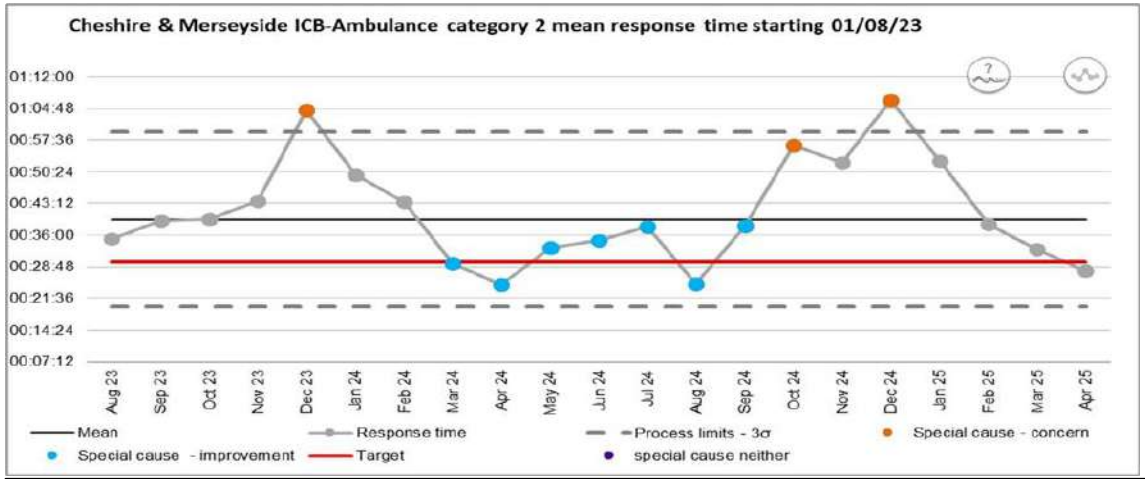
Category	Metric	Latest period	Sub ICB Place										ICB *	Local Trajectory	National Target
			Cheshire & Wirral				Merseyside								
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton				
			East **	West **							South Sefton	S/port & Formby			
Health Inequalities & Improvement	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q3 24/25	66.6%		63.5%	64.7%	66.4%	65.4%	64.5%	68.2%	63.6%		65.5%	77.0%	80.0%
	% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with lipid lowering therapies	Q3 24/25	61.8%		65.3%	61.0%	64.7%	62.0%	63.7%	62.1%	60.2%		62.6%		65%
	Smoking at Time of Delivery	Q3 24/25	4.5%		6.7%	6.3%	6.6%	7.2%	5.7%	9.8%	5.3%		6.1%		<6%
	Smoking prevalence - As per GP systems Via CIPHA.(NEW METHODOLOGY March 25)	Mar-25	13.10%		15.20%	14.40%	19.20%	16.00%	19.20%	17.40%	17.20%	13.10%	15.8%	12%	12%
Continuing Healthcare	Referrals completed within 28 days	Q3 24/25	81.3%		80.1%	90.2%	66.9%	69.7%	97.1%	80.0%	75.0%	56.9%	73.10%	>80%	>80%
	Number eligible for Fast Track CHC per 50,000 population (snapshot at end of quarter)	Q3 24/25	18.46		23.62	19.06	25.51	40.20	17.01	21.66	62.29	81.90	27.18	<18	
	Number eligible for standard CHC per 50,000 population (snapshot at end of quarter)	Q3 24/25	61.9		74.3	42.5	46.4	24.2	27.4	44.7	59.6	85.2	53.85	34	
Quality & Safety	Still birth per 1,000 - data only available at ICB/Provider level														
	Healthcare Acquired Infections: Clostridium Difficile - (Healthcare & Community associated) (NEW)	12 months to Mar 25	299		253	98	221	52	98	66	104		1191	-	-
	Healthcare Acquired Infections: E.Coli - (Healthcare & Community associated) (NEW)	12 months to Mar 25	646		282	206	468	177	225	108	218		2330		
Finance	Overall Financial position Variance (£m)	Mar-25	-10.6	-4.0	-16.7	-0.4	-16.1	-3.6	-0.2	-3.2	-11.0		28.9	0.0	0.0
	Efficiencies (Variance)	Mar-25	-0.3	-0.7	-0.2	3.2	-1.7	-0.7	0.3	1.7	-0.6		0.0	0.0	0.0
	Mental Health Investment Standard met/not met (MHIS)	Mar-25	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Yes	Yes
	BCF achievement (Places achieving expenditure target)	Mar-25	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	9/9	9/9
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics ** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT. *** Local trajectories set by Place as part of their BCF submissions to NHSE, therefore RAG rating will vary for Places with lower/higher trajectories **** In order to report performance at Place the indicator "% of CYP accessing services following a referral" has been used - this is different to the NHS Oversight Framework indicator used in the ICB table														

5. Exception Report – Urgent Care

NHS Cheshire and Merseyside

Ambulance category 2 mean response time

Latest ICB Performance (Apr-25)	00:27:58	National Ranking	n/a
ICB Trend (Apr-25)			Improved



Issue

- While performance has shown steady month-on-month improvement since December 2024, and performance across Cheshire and Merseyside (C&M) in April fell within the Category 2 (Cat 2) ambulance response time standard of 30 minutes, special cause improvement is yet to be demonstrated.

Action

- Ambitions for 25/26: Nationally communicated 'Ambulance Ambitions', have set site-specific improvement targets based on November 2024 baseline performance. All sites have submitted trajectories for improvement
- Ambulance Improvement Group (AIG) has been relaunched. The primary focus is on implementation of 45-minute rapid handover with the aim that no ambulance will be delayed longer than 45 minutes. This involves the development of site level escalation plans which dovetail to those of NWAS and the ICB. A rapid improvement event is due to take place at Aintree from 16 – 18 June to test out a series of changes using a PDSA approach ahead of go live on 1 July .
- Call Before Convey: The system continues to promote the 'Call Before Convey' initiative to maximise utilisation of alternatives to emergency department (ED) attendance, as part of the broader at-scale improvement programme.

Delivery

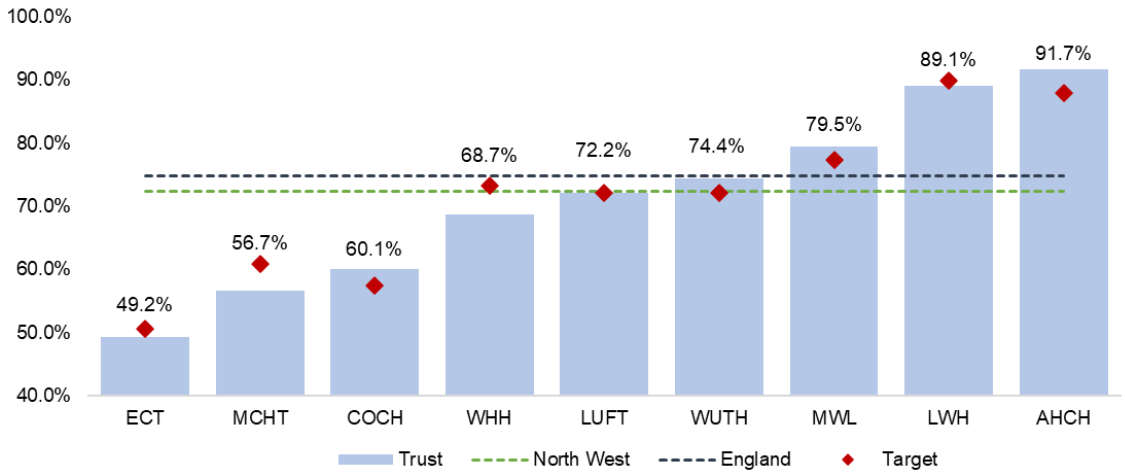
- The nationally mandated OPEL framework has been embedded into SCC's operational rhythm, supporting the implementation of revised performance parameters including average ambulance handover times from midnight as a key improvement metric. Enhanced governance through the Ambulance Improvement Group will underpin the implementation of a 45-minute rapid handover. These measures aim to contribute directly to improved Cat 2 mean response times

5. Exception Report – Urgent Care

Cheshire and Merseyside

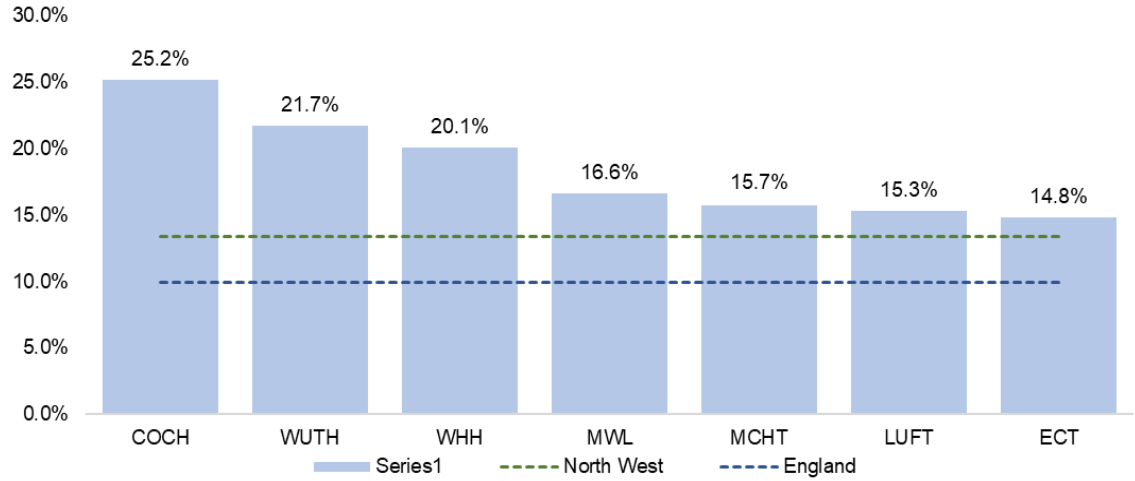
A&E 4 hour waits from arrival

Latest ICB Performance (Apr-25)	72.7%	National Ranking	27/42
Provider Breakdown (Apr-25)			Improved



A&E 12 hour waits from arrival

Latest ICB Performance (Apr-25)	15.9%	National Ranking	37/42
Provider Breakdown (Apr-25)			Improved



Issue

- Although achieving the internal trajectory in April, Cheshire and Merseyside's current performance is 5.3% below the national ambition of 78%, placing the ICB 27th out of 42 ICBs in England.
- 15.9% of patients attending emergency departments (EDs) experienced delays exceeding 12 hours. This compares unfavourably with the North West average of 13.2% and the national average of 9.7%. While some improvement has been noted over the past month, continued efforts are required to drive down patient delays and improve performance against this standard.

Action

- Although further improvement is required, there has been a significant reduction in the number of patients delayed over 72 hours in recent months. This improvement has enabled greater scrutiny and a shift in operational focus to patients delayed 24 / 36 hours. Wait times for acute physical health beds have reduced. However, significant pressures persist in accessing side rooms for infection control.
- Mental health delays also remain a considerable challenge. The ICB remains committed to reducing delays for patients requiring mental health admission.
- To address this, regular consideration of the least restrictive care options is being embedded to avoid unnecessary admissions. Mental health providers have signed up to system wide discharge principles to support flow and are engaging with the new Mental health Learning Improvement Network (LIN)
- Progress has also been made in visibility of patient delays through SHREWD Resilience. All acute providers now have full reporting visibility, reducing the need for exception-based reporting and allowing for a more action-focused approach to managing long stays in ED.
- Wirral have sustained streaming of 20% of patients arriving at ED to Urgent Treatment Centres (UTCs) and are maximising redirection of Cat 3 and 4 patients to Urgent Community Response (UCR).

Delivery

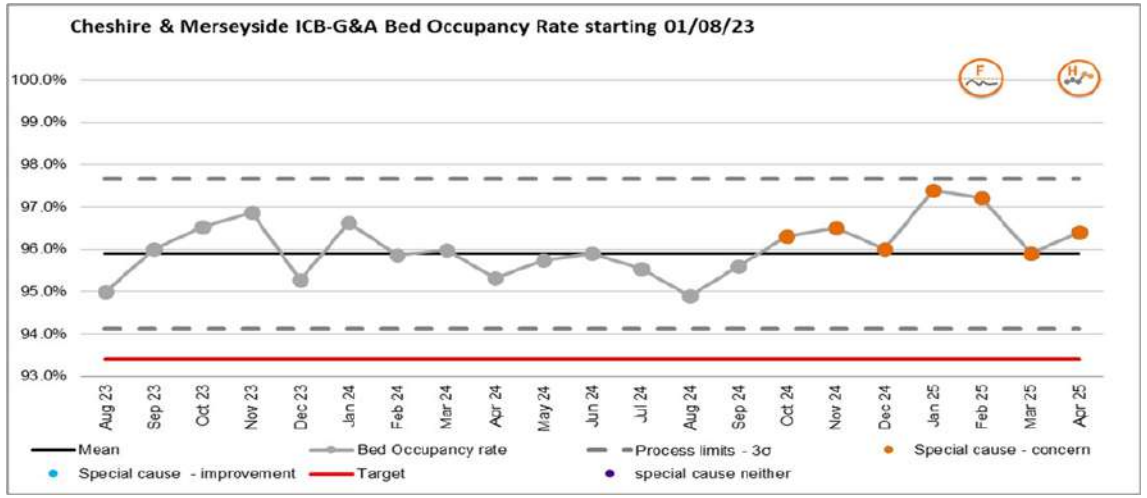
- Cheshire and Merseyside is adopting a recovery-focused approach to Urgent and Emergency Care (UEC) for 2025/26. The system remains committed to achieving the national target of 78% performance by Quarter 3 and to delivering a sustained reduction in 12-hour ED waits.

5. Exception Report – Urgent Care

NHS Cheshire and Merseyside

Adult G&A bed occupancy

Latest ICB Performance (Apr-25)	96.4%	National Ranking	34/42
ICB Trend (Apr-25)			Deteriorated



Issue

- Bed occupancy remains high across the system, with current levels at 96.4%. This continues to place significant pressure on patient flow and operational efficiency.

Action

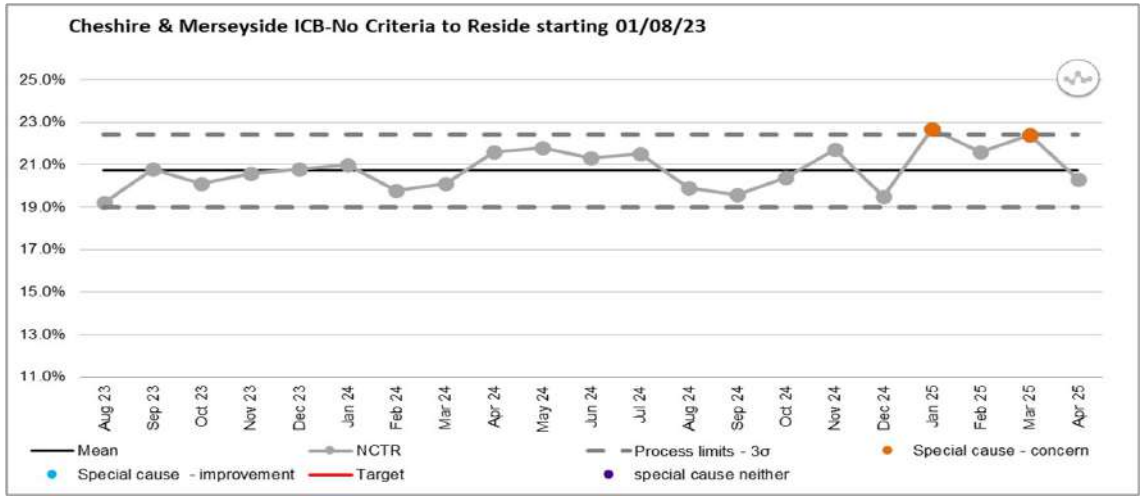
- Tier 1 Rapid Improvement Offer: Ongoing support is focused on enhancing ward-based processes to increase the volume and timeliness of patient discharges, with particular emphasis on early-day discharges.
- All acute and mental health providers implemented discharge initiatives aimed at increasing discharge rates and reducing G&A bed occupancy ahead of the bank holiday weekends.
- Discharge Monitoring has been embedded within the operational rhythm of the System Coordination Centre (SCC), with clearly defined discharge ambitions integrated into weekend planning protocols.
- East Cheshire estates work on ED and discharge lounge is due for completion in June and will provide additional cubicles and ambulatory spaces.

Delivery

- As part of the recovery-focused approach to UEC in 2025/26, the ICB remains committed to reducing bed occupancy across the system as a key performance metric.

No Criteria To Reside (NCTR)

Latest ICB Performance (Apr-25)	20.3%	National Ranking	41/42
ICB Trend (Apr-25)			Improved



Issue

- The proportion of Non-Criteria to Reside patients currently stands at 20.3%, significantly higher than the national average of 14.4% and the North West average of 16.7%. This continues to present a substantial challenge for patient flow and bed capacity management.

Action

- Enhanced joint working between HomeFirst and Domiciliary Care at Wirral has been underpinned by a trusted assessment model. A full launch of the discharge pathway filter, which has been piloted since December 2024, is planned for May to drive a shift in activity, reducing P3 and P2 discharges.
- The Learning Improvement Network (LIN) is due to launch a frailty collaborative which will involve localities working across the North West footprint to implement new nationally developed frailty care standards. The first clinical reference group is due to take place 20 May.
- MWL now have weekly LLOS meetings chaired by COO and including acute, community and local authority leads which is seeing early signs of LLOS reduction.

Delivery

- The ICB is committed to achieving a measurable reduction in long lengths of stay and NCTR levels, which are key system performance indicators.

5. Exception Report – Planned Care

NHS Cheshire and Merseyside

ICB incomplete RTT pathways of 65 weeks or more

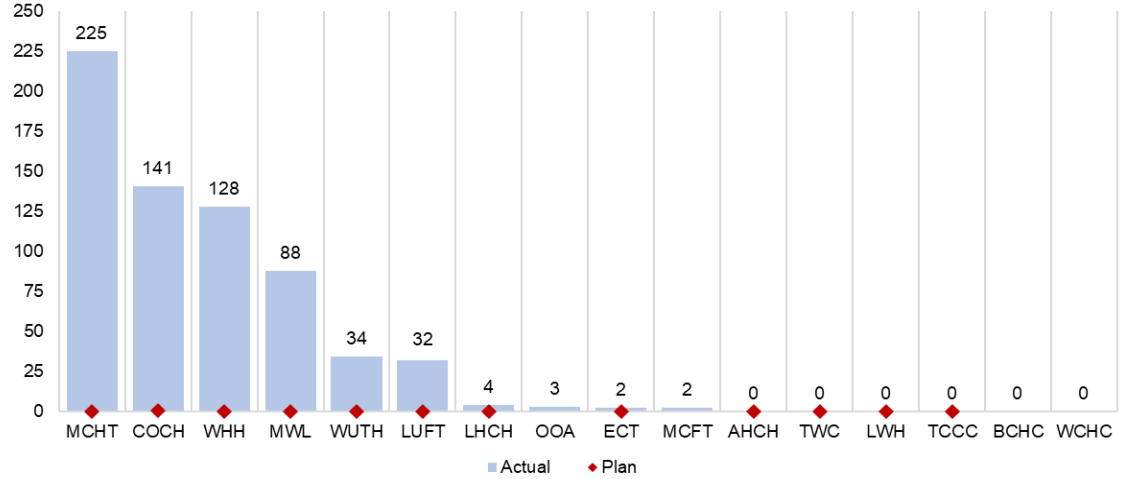
Latest ICB Performance (Mar-25)	659	National Ranking	n/a

ICB Trend (Mar-25) — Improved

Trust incomplete RTT pathways of 65 weeks or more

Latest ICB Performance (Mar-25)	659	National Ranking	n/a

Provider Breakdown (Mar-25) — Improved



Issue

- Challenges remain in clearing 65 week wait patients, excluding patient choice and complexity issues with 9 providers reporting capacity breaches at April month end.
- Local data shows 883 patients reported 65-week breaches at end of April, largely sitting within Mid Cheshire and LUFT where we have seen increase in reported position, with 611 being capacity breaches, 123 complex patients and 130 choice related delays and 19 corneal grafts.
- For May, the system is currently predicting 507 breaches with 264 being capacity breaches, 122 complex patients and 100 choice related delays and 21 corneal grafts
- The CYP 52WW ambition is currently underperforming against trajectory, there are currently 979 CYP waiting over 52 weeks. Revised trajectories to eliminate 52ww have now been requested

Action

- The elective programme is working closely with providers to ensure that mutual aid and operational tactical measures are explored and expedited. Active mutual aid is being supported for Mid Cheshire in relation to T&O and monitoring of LUFT's ENT and Oral Services remain a priority given some of their challenges.
- Validation SDF funding was allocated and utilised per Trust supported by improvement trajectories. This has shown an improvement year to date of 13.5% for 12-weeks, 22.6% for 26-weeks and 14.7% for 52-weeks. Further discussions are underway around how the national validation sprint will be implemented across C&M and how this links to the 5% improvement target for RTT by March 2026.
- At MCHT, there are significant pressures within T&O. The Trust have breaches from 2024/25 which are now being prioritised through Clatterbridge. The trust is subject to additional oversight from NHS England (via Tier 2) with daily support in place from CMAST.
- At LUHFT, ENT and Oral and Maxillofacial Surgery are the most challenged specialties. An outsourcing contract is in place; patients are being transferred and these numbers now decreasing although an increase has been submitted for end of April.

Delivery

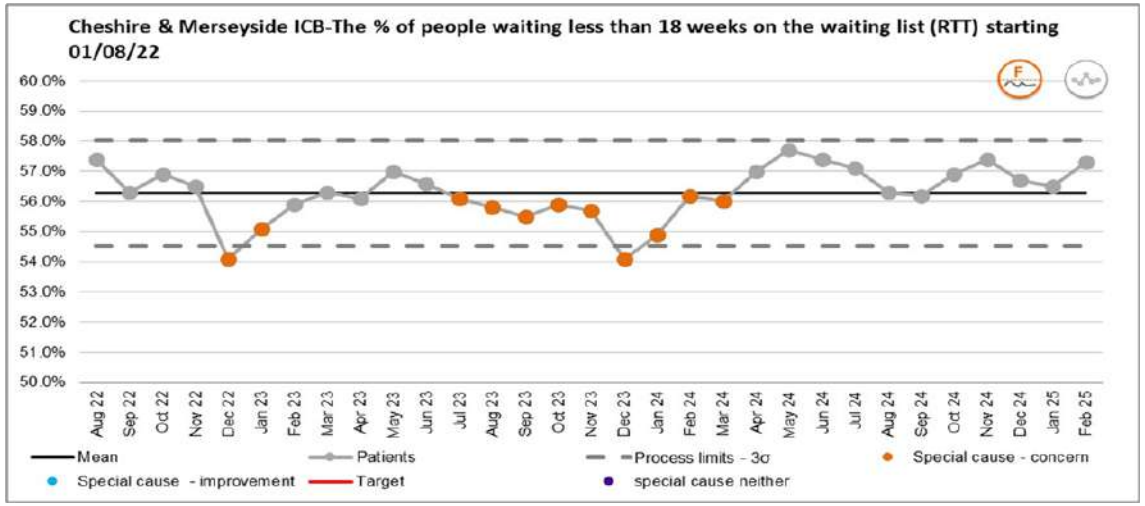
- There is a continued focus on eradicating 65 week waits and to model the delivery of 52 and 18 weeks for future planning.
- The team are currently working through improvement schemes to deliver 65% with a focus on annual planning for 2025/26 and implementation of the elective reform plan.

5. Exception Report – Planned Care & Cancer

NHS Cheshire and Merseyside

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

Latest ICB Performance (Far-25)	58.0%	National Ranking	n/a
ICB Trend (Mar-25)	Improved		



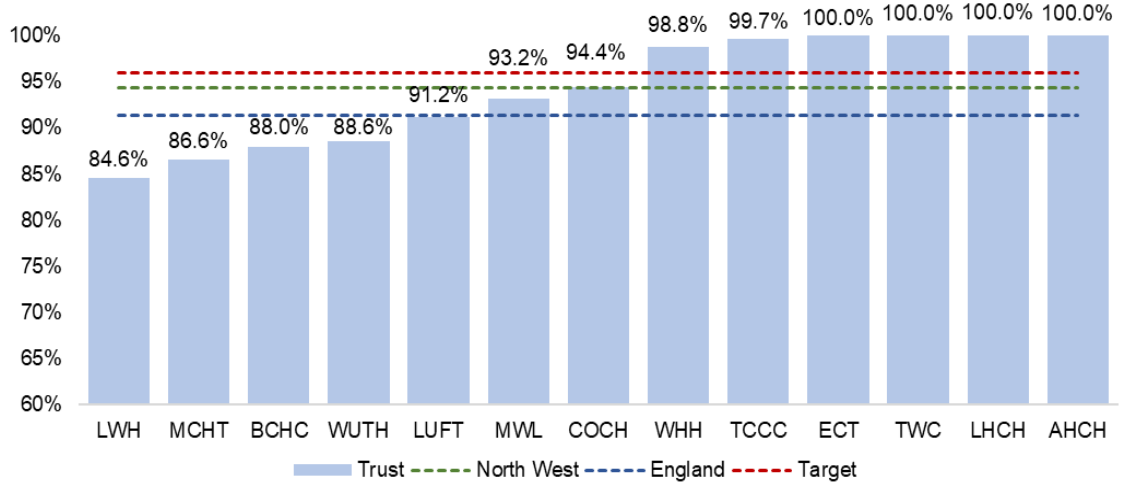
Issue
- The percentage of patients waiting less than 18 weeks across C&M is reported as 58.0%.

Action
- System wide scheme / programmes currently being initiated across C&M.
- Weekly monitoring and operational tactical meetings with organisations across C&M providing performance monitoring against key milestones and 'check & challenge'.
- Key overarching priorities remain across CMAST and providers Reducing long waits, and improving waiting list management, reducing variation between providers and Improving productivity and efficiency within the providers.

Delivery
- The system has committed to a 5% improvement in RTT by March 2026.
- The are 5 key schemes of work that will act as a vehicle for delivery, TIF & Growth, New to follow up, Theatre and Outpatient Productivity, Validation and A&G
- The Elective Recovery Programme is delivery focused, with tangible metrics and deliverables across 5 key workstreams.

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

Latest ICB Performance (Mar-25)	95.3%	National Ranking	10/42
Provider Breakdown (Mar-25)	Deteriorated		



Issue
- C&M not yet achieving the 96% 31-day combined standard required however, the figure of 95.8% is 4th amongst Cancer Alliances and 12th amongst ICBs in this latest month.

Action
- Those providers not yet achieving the 31-day standard are surgical treatment providers.
- Capacity and demand exercises for 25/26 are addressing this and short-term investment is already being made by the Cancer Alliance in key areas.
- Improvement plans for each provider are either in place or under development for 25/26 These are included in the operational improvement plan to be submitted to NHSE as part of alliance assurance. Performance has improved significantly to only 0.2% below target in this latest month.

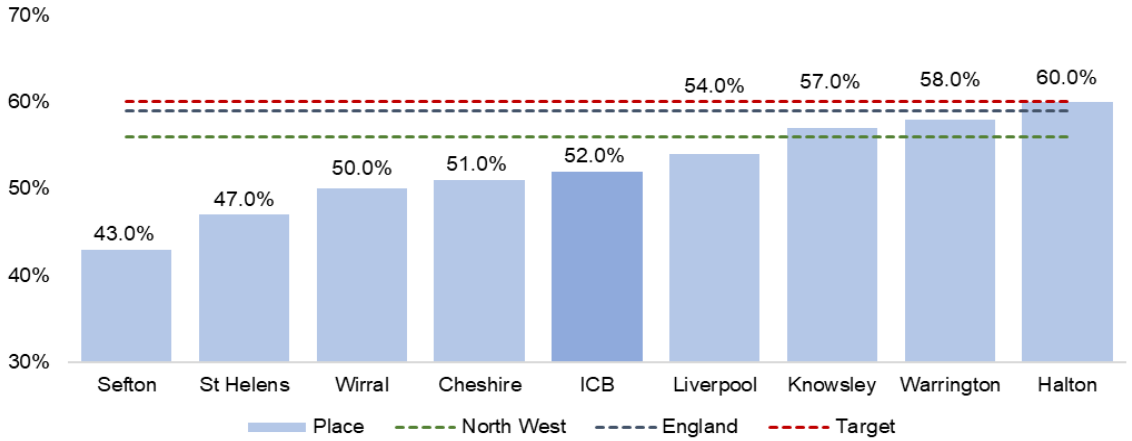
Delivery
- C&M expects to meet the 96% performance standard by the end of Q4 24/25 as the specific areas of 31-day breaches are identified and are targeted with improvement plans.

5. Exception Report – Mental Health

Cheshire and Merseyside

People with SMI receiving a full annual physical health check

Latest ICB Performance (Q3-24/25)	**52.0%**	National Ranking	**35/42**
Place Breakdown (Q3 – 24/25)			**No Change**



Issue

- C&M is not achieving the minimum 60% target for all 6 health checks. Changes to SMI health check QOF payments for GPs and GP Collective Action may have further impact
- Only Halton is currently meeting the minimum 60% national target for all 6 Health checks

Action

- The ICB Board received a deep dive into PH in SMI at the November 2024 Public Board meeting.
- All Places have access to the new BI report which allows information at GP practice level.
- Support is being offered to practices which are not meeting targets.
- All places have a local SMI steering group where performance is managed, and local improvement initiatives are developed.

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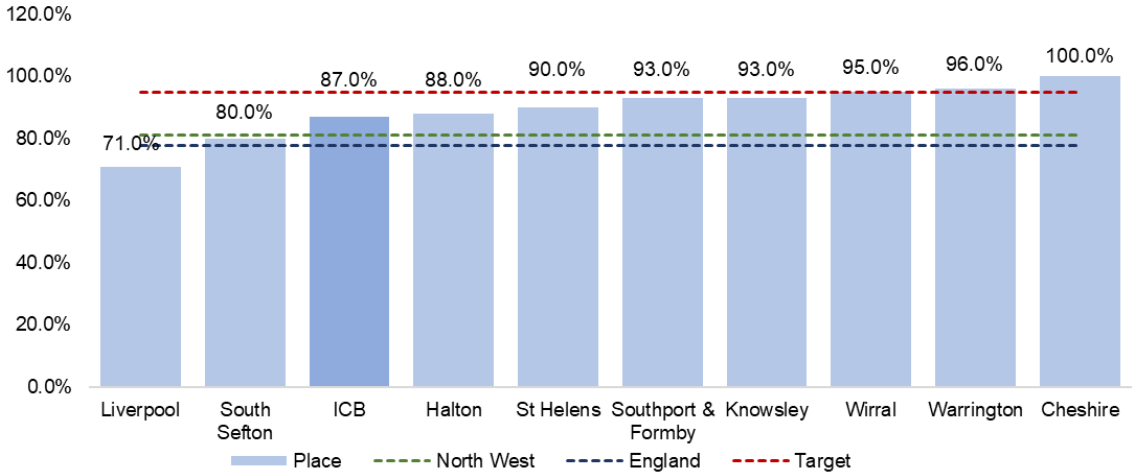
Delivery

- Historic annual data indicates a downward trend through the year with a surge in Q4 which minimises the opportunity of follow-up on non-attendance. There is a risk this trend may not be repeated this year because of QOF income protection based on last year's activity, which was below target.

5. Exception Report – Mental Health

CYP Eating Disorders Routine

Latest ICB Performance (Feb-25)	87.0%	National Ranking	10/41
Place Breakdown (Feb-25)			Deteriorated



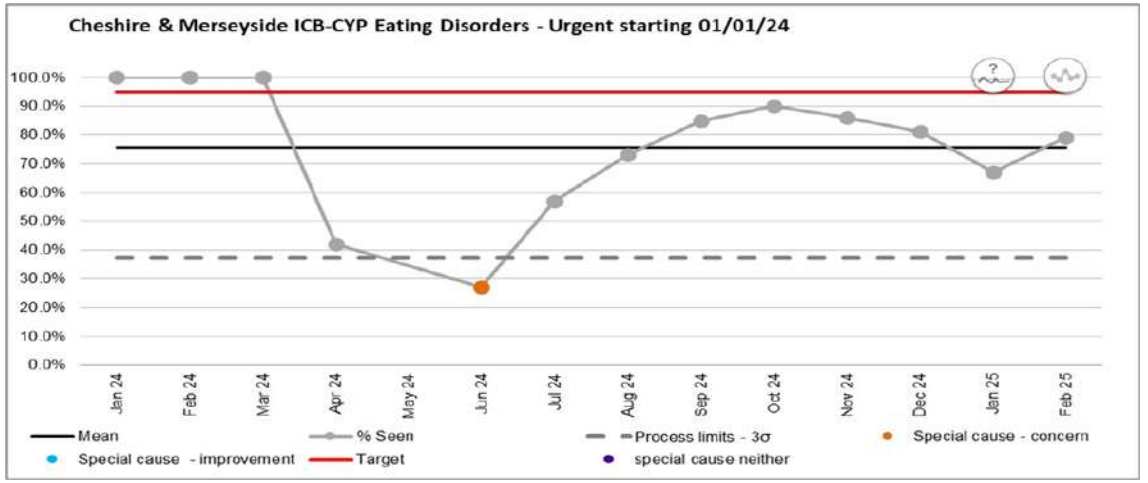
Issue
- National data indicates a drop in performance of 1% between Jan and Feb 25 and the routine waiting time standard of 95% seen within 4 weeks is not being achieved.
- Data quality issues still exist in the MHSDS, predominantly at Alder Hey.

Action
- C&M providers are being supported by the C&M Mental Health Programme Team to address data quality issues in the MHSDS.
- Work is also underway to review how pathways can be improved across community eating disorder teams to provide more effective and efficient care.

Delivery
- Alder Hey report that Waiting times for routine Eating Disorder referrals are back up to required levels but with enhanced monitoring to ensure improvement is sustained.
- CWP is achieving 100% of patients seen within 4 weeks.
- Mersey Care has seen increased demand from Mid Mersey places which is leading to breaches of routine waiting time standards. A business case has been drafted to inform increased capacity requirements to meet increased demand and acuity.

CYP Eating Disorders Urgent

Latest ICB Performance (Feb-25)	79.0%	National Ranking	16/22
ICB Trend (Feb-25)			Improved



Issue
- Nationally published data shows a 12% increase in performance since Jan 25, however, C&M is not achieving the urgent waiting time standard for CYP with Eating Disorders (target 95% seen within 1 week).
- Data quality issues are ongoing, and the number of urgent referrals made is small, leading to significant changes in % variation when breaches occur.

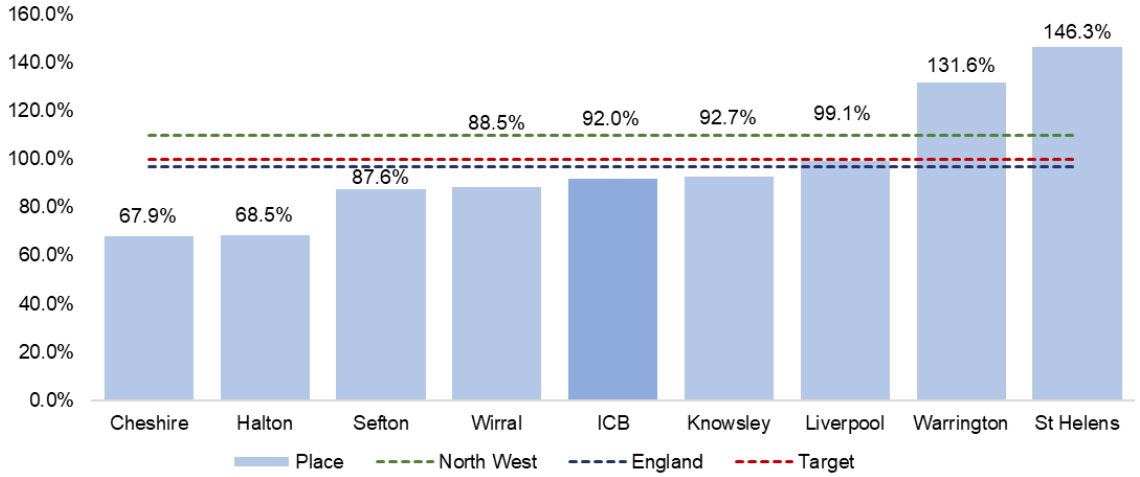
Action
- C&M providers are being supported by the C&M Mental Health Programme Team to address data quality issues in the MHSDS, to ensure that all activity and performance is accurately reflected going forwards.

Delivery
- CWP is achieving 100% of urgent patients seen within 1 week
- Providers continue to monitor service waits locally

5. Exception Report – Mental Health

CYP 1+ Contacts: % LTP trajectory achieved

Latest ICB Performance (Feb-25)	92.0%	National Ranking	28/42
Place Breakdown (Feb-25)			No Change



Issue

- There has been no change in access rates reported this month and access remains below target by circa 3,000 CYP. NHS Cheshire and Merseyside has consistently delivered between 92% and 94% of trajectory throughout 2024/25.
- Not all VCSE services are able to flow data to the national dataset so this activity is not captured in its totality.

Action

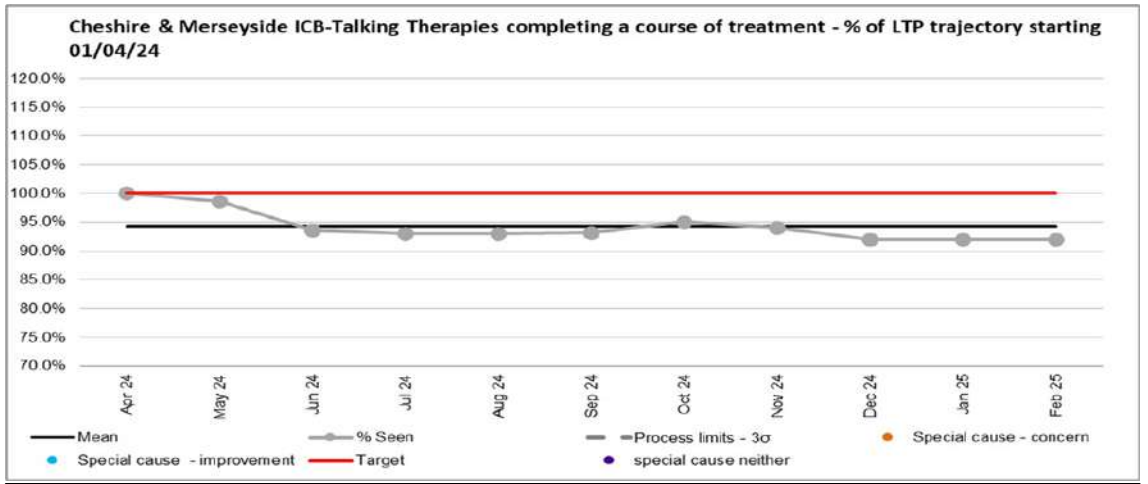
- Roll out of 5 new wave 11 MH in school teams will support increased access over the coming months (Liverpool, South Sefton, Cheshire, Wirral & Knowsley)
- C&M CYP Access Development Workstream reviewing trajectories at sub-ICB level to identify actions to address continued downward trends in Cheshire and Knowsley which are masking improvement in other places.
- Good practice is being shared across Places.

Delivery

- There has been no significant change in overall C&M access rates during 2024, however there is more significant variance in place level trends.

Talking Therapies completing a course of treatment - % of LTP trajectory

Latest ICB Performance (Feb-25)	92.0%	National Ranking	23/42
ICB Trend (Feb-25)			No Change



Issue

- The number of people completing a course of treatment has remained static at 92% and remains below target levels.

Action

- Significant workforce expansion is underway aligned with additional funding committed via the Autumn Statement for a 5-year period.
- Additional trainee therapists have started in post and attraction and recruitment of additional qualified therapists from outside of Talking Therapy services is being progressed.
- A single Cheshire and Merseyside Service Specification has been developed to ensure consistency of delivery of best practice.
- A “readiness for therapy” video has been developed to minimise the number of people not completing their course of treatment.

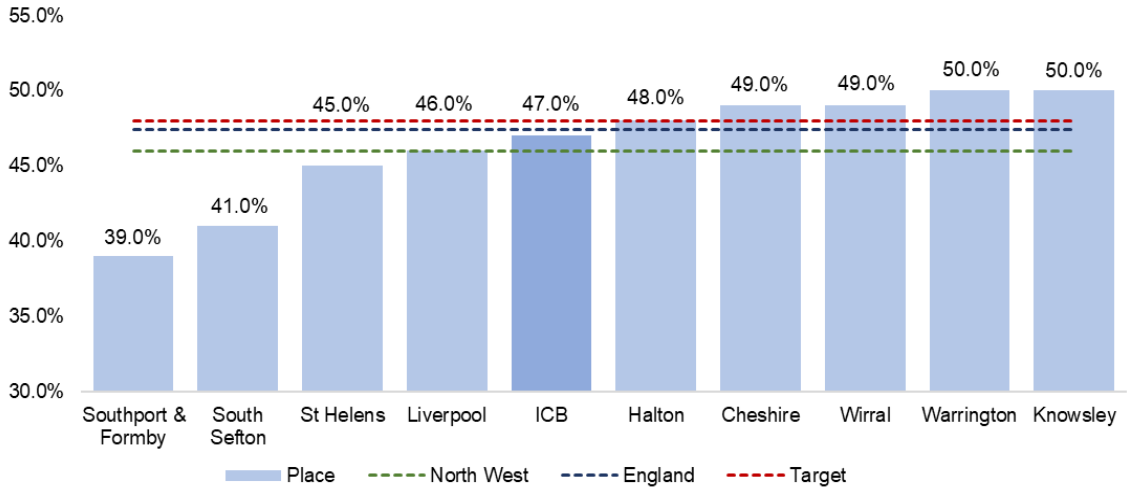
Delivery

- Trajectories have been set at place level and shared with each of C&M’s five talking therapy providers and activity will be monitored at this level.

5. Exception Report – Mental Health & Learning Disabilities

Talking Therapies Reliable Recovery

Latest ICB Performance (Feb-25)	47.0%	National Ranking	24/42
Place Breakdown (Feb-25)			No Change



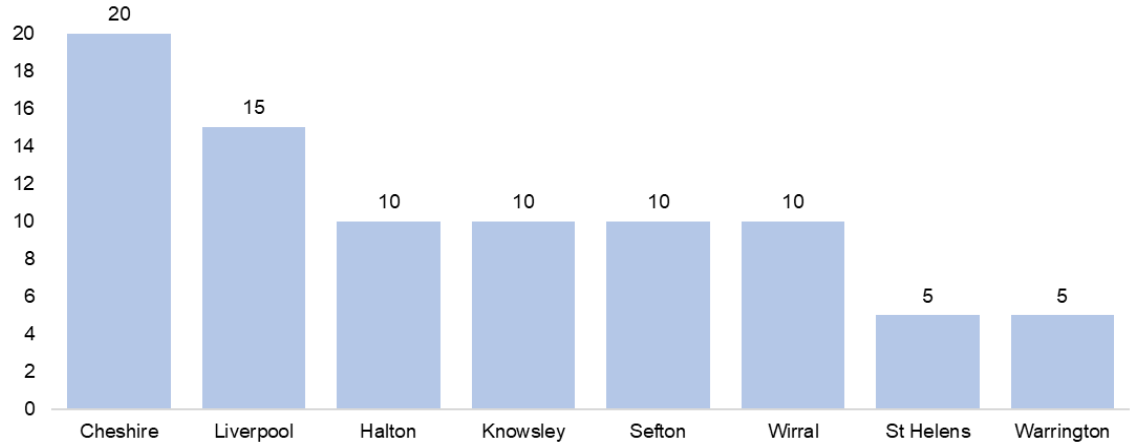
Issue
- Reliable recovery rates remain one percent below target this month.

Action
- Further work taking place locally on workforce modelling in the absence of a national tool
- Single Cheshire and Merseyside service specification developed to facilitate consistency across services..
- Planning to rebalance the ratio of low intensity to high intensity therapists to improve reliable recovery and reliable improvement rates, aligned with national guidance.

Delivery
- Cheshire, Halton, Knowsley, Warrington and Wirral places have all achieved reliable recovery targets for Feb 25.
- Liverpool rate has remained broadly static and is the only place to have not achieved reliable recovery rates in any month of this financial year.
- There has been a marked reduction in reliable recovery rates in Sefton for Feb 25.

Adult inpatients with a learning disability and/or autism

Latest ICB Performance (Mar-25)	80 *	National Ranking	25/42
Place Breakdown * (Mar-25)			



Issue
- There were 78 adult inpatients, of which 47 are Specialised Commissioning (Spec Comm) inpatients commissioned by NHSE, and 31 ICB commissioned. The target identified for C&M (ICB and Spec Comm) is 46 LD/A or fewer by the end of Q4 2026 and 28 Autism only.

Action
- The Transforming Care Partnership (TCP) has scrutinised those clinically ready for discharge. Of those 78 adults, 11 individuals are currently on Section 17 Leave. There have been discharges during Q4, but it is expected that some of the existing section 17 leave individuals will be discharged in Q1 pending MOJ Clearance and transition progress.
- Data quality checks continue to be completed on Assuring Transformation to ensure accuracy.
- 2.Weekly C&M system calls ongoing to address Delayed Discharges with Mersey Care and CWP.
- Housing Lead continues to work to find voids which can accommodate delayed discharges.
- Desk top reviews take place to address section 17 leave progress and long length of stay
- Adult Autism only MaDe calls set up monthly to address all admissions to adult MH wards.

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

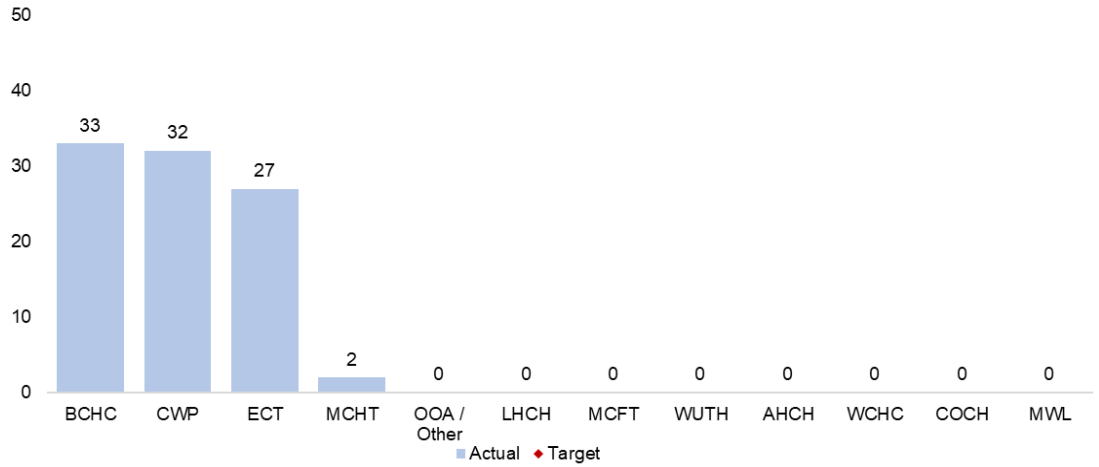
***** *Data rounded up/down to nearest 5: therefore, Place subtotals may not add up to the ICB total*

5. Exception Report – Community

NHS Cheshire and Merseyside

Community Services – Adults waiting over 52 weeks

Latest ICB Performance (Feb-25)	94	National Ranking	n/a
Provider breakdown (Feb-25)			Improved



Issue

- OOA/other waits that were [previously attributed to NHS C&M incorrectly have now been removed resulting in an improved position for this month.
- ECT long waits relate predominantly to their dietetics and SALT services where there recognised issues with referral management and capacity that are being addressed. It is unlikely however that a significant improvement will be seen within the next 3- 6 months
- CWP have identified an inaccuracy in the reporting of long wait patients that is being addressed.
- BCHC waits are primarily within the Adult podiatry service and a capacity and demand review is in progress to address this issue.

Action

- Capacity and demand review of podiatry service at BCHC.
- Review of inappropriate referrals to SALT and dietetics service at ECT.
- CWP to work with ICB BI leads around data inaccuracy in the reporting of long wait patients.

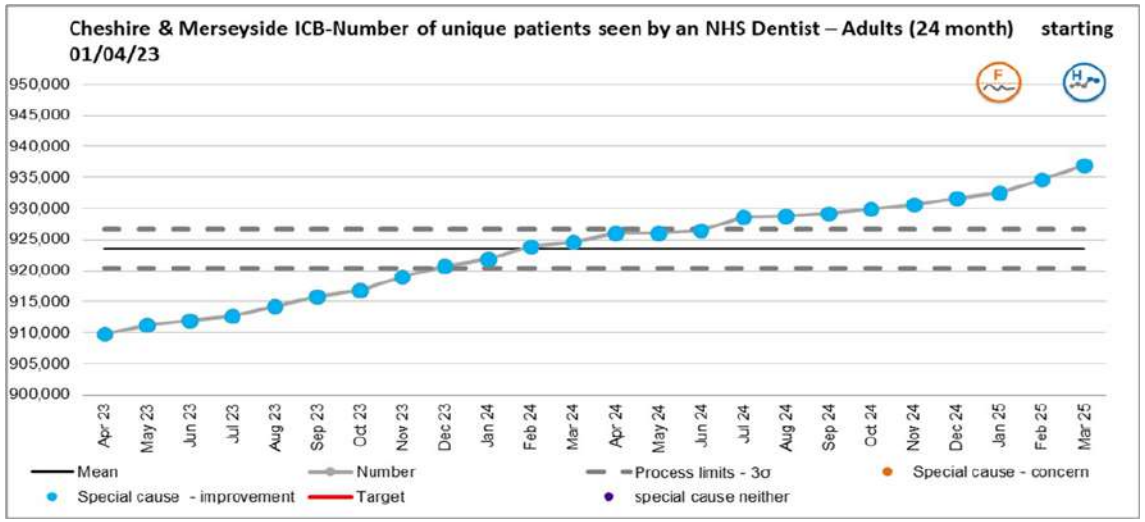
5. Exception Report – Primary Care

NHS Cheshire and Merseyside

Number of unique patients seen by an NHS Dentist – Adults

Latest ICB Performance (Mar-25)	937,018	National Ranking	n/a

ICB Trend (Mar-25)



Issue

- Performance continues to increase but C&M does not currently meet the target.

Action

- Continue to support network of providers to see new patients (Adults Children and Vulnerable groups) who require an NHS dentist delivering Pathway 1/2/3 in local dental plan

Delivery

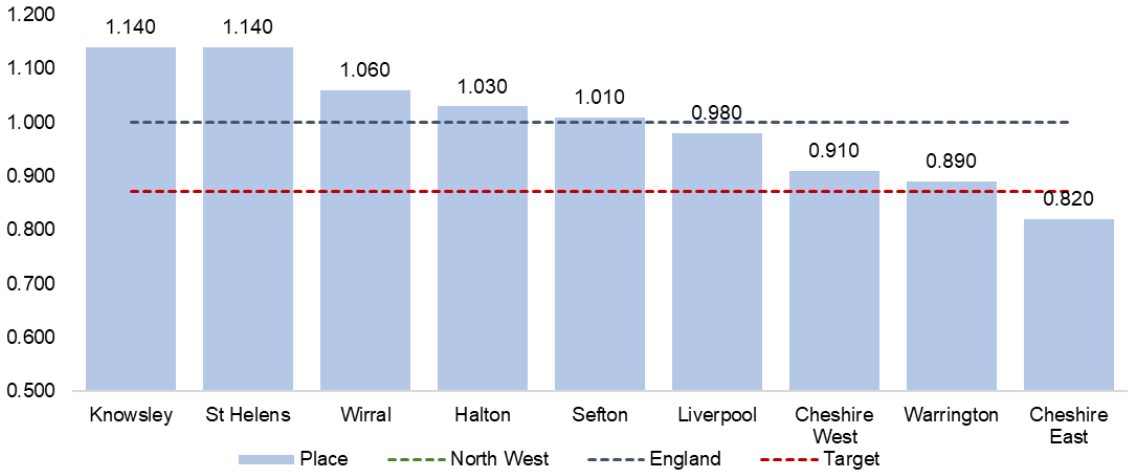
- Commissioners are using flexible commissioning arrangements to improve activity**.**
- 7 C&M practices allocated Golden Hello funding and 2 dentists have been appointed as of 1/4/25
- Commissioners are working with LDC to analyse contract delivery and link to deprivation to understand how contractors can be supported in areas of highest need.

5. Exception Report – Primary Care

NHS Cheshire and Merseyside

Total volume of antibiotic prescribing in primary care

Latest ICB Performance (Feb-25)	0.98	National Ranking	n/a
Place Breakdown (Feb-25)			Improved



Issue
- C&M does not currently meet the target set for the volume of prescribing of antibiotics.

Action
- All Places continue the cascade of education, public communication work, reviewing prescribing data and decisions in relation to antibiotic prescribing.
- UKHSA 'Keep antibiotics working' campaign now launched and being circulated by NHS C&M communications team.
- Completion of PISCES audits underway across NHS C&M
- Hydration pilot roll out continues across all places not involved in the pilot.
- Central NHS C&M penicillin de-labelling inbox to be created to ensure appropriate communication across the system while patient numbers are relatively low, governance to be agreed.
- Initiative around original pack dispensing for community pharmacies shouldn't have impact on shorter antibiotic courses as the change to a full pack wouldn't fall in a 10% change

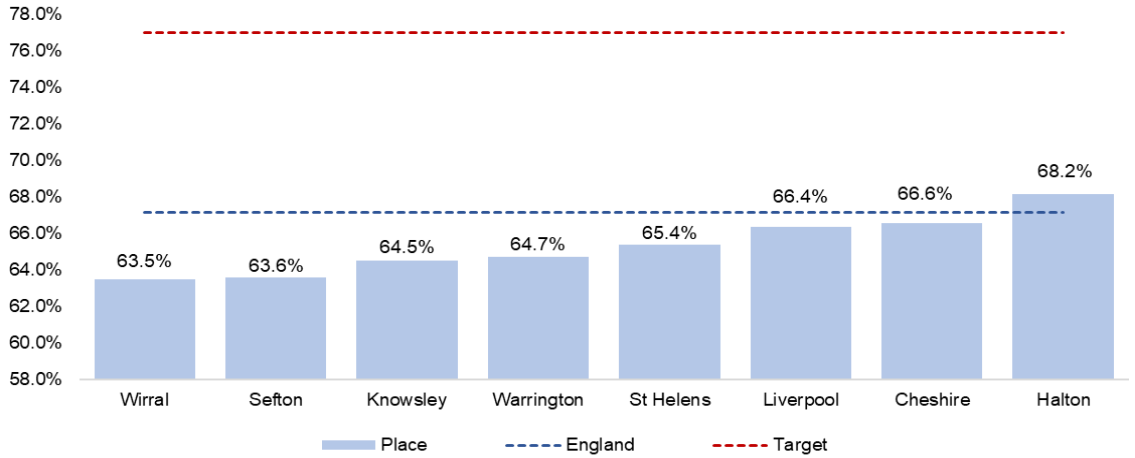
Delivery
- Analysis to continue with Q4 2024/25 data at Place and ICB level to inform areas to focus at Place and C&M level.

5. Exception Report – Health Inequalities & Improvement

NHS Cheshire and Merseyside

% of patients (18+), with GP recorded hypertension, BP below appropriate treatment threshold

Latest ICB Performance (Q3-24/25)	65.5%	National Ranking	29/42
Place Breakdown (Q3-24/25)			Deteriorated



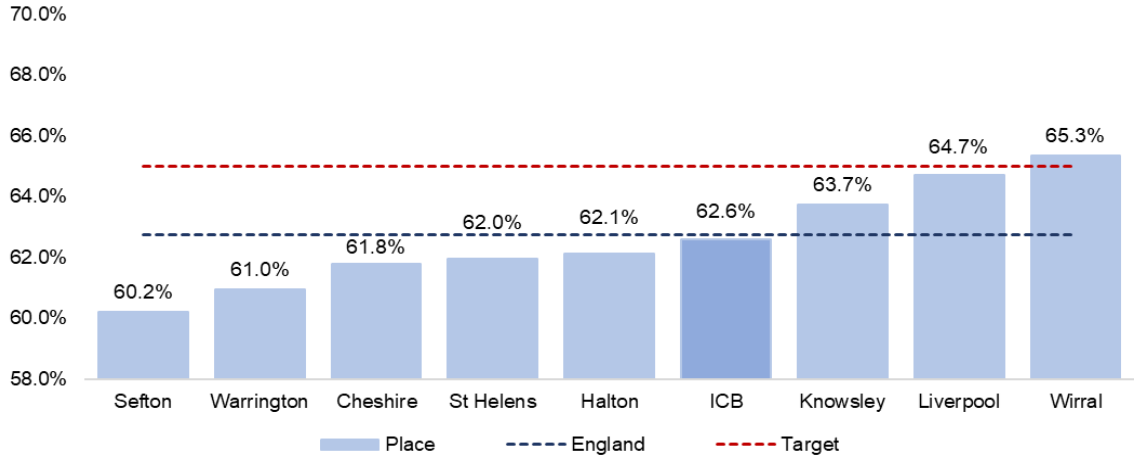
Issue
- Considerable variation in C&M, reductions in capacity & funding continue to affect performance; C&M does not currently meet the national target ambition.

Action
- The hypertension case finding in optometry pilot has received interest from practices in every Place and will go live in Q1 25/26.
- Cycle 1 of the CLEAR programme has begun. Work will start with the first 5 tranche of PCNs to adopt a new model of care around their chosen aspect of CVD prevention which may include hypertension.
- The Health Inequalities blood pressure optimisation project is underway, with 17 practices on boarded and completing work plans. Evaluation will be undertaken Q1 25/26.

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

% of patients identified as having 20% or greater 10-year risk of developing CVD are treated with lipid lowering therapies

Latest ICB Performance (Q3-24/25)	62.6%	National Ranking	19/42
Place Breakdown (Q3-24/25)			Improved



Issue
- Considerable variation in C&M, reductions in capacity & funding continue to affect performance; C&M does not currently meet the national target ambition.

Action
- A clinically led lipid management group has been established to ensure lipid management opportunities are being explored along the pathway.
- A mapping exercise is being explored to assess the current state of lipid services.
- Support for primary care to access the new offer for inclisiran prescribing and changes to QOF.
- Develop a suite of usable resources for primary care colleagues to support lipid management
- Cycle 1 of the CLEAR programme has begun. Work will start with the first 5 tranche of PCNs to adopt a new model of care around their chosen aspect of CVD prevention which may include lipid management..

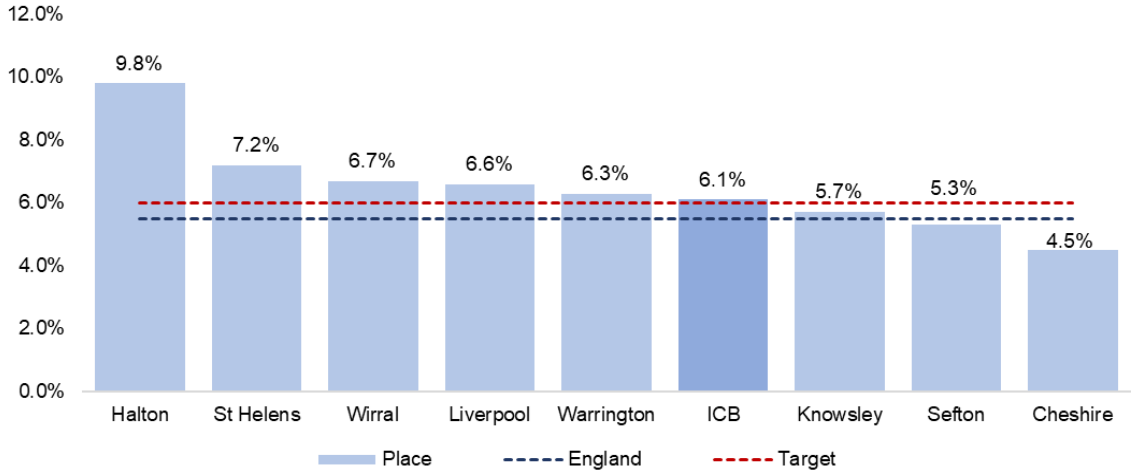
Delivery
- CVDP SRO, Programme lead and CVDP Board is the vehicle to coordinate C&M wide NHS activity alongside local Place CVD Prevention plans.
- The role of primary care in achieving this ambition is key.

5. Exception Report – Health Inequalities & Improvement

NHS Cheshire and Merseyside

Smoking at Time of Delivery

Latest ICB Performance (Q3-24/25)	6.1%	National Ranking	27/42
Place Breakdown (Q3-24/25)			Improved



Issue

- Cheshire and Merseyside's (C&M) smoking at time of delivery continues to be higher than the England average, rates also vary significantly by place. But rates are declining quarter on quarter during 2024/25, with rates reducing from 6.8% in quarter 2 to 6.1% in quarter 3.

Action

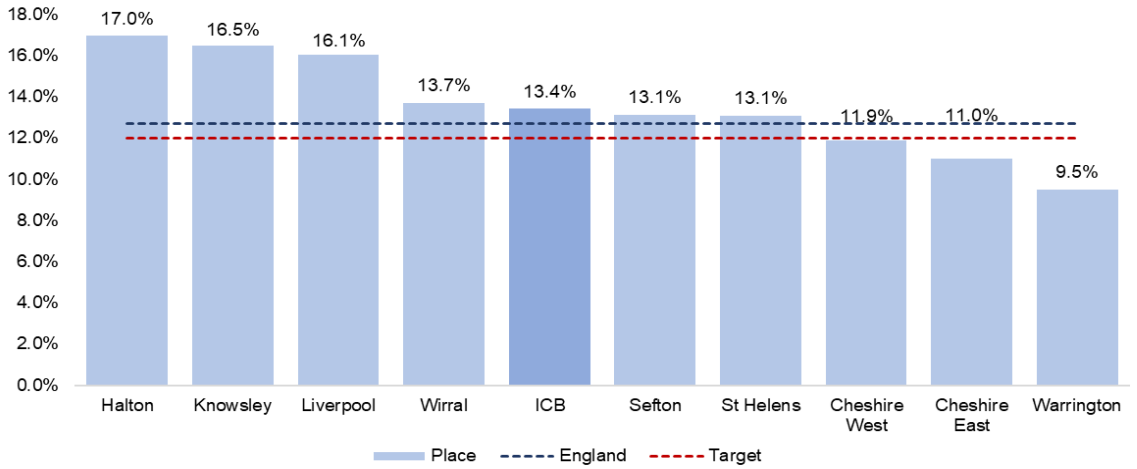
- Three maternity sites have gone live with the national incentive scheme with the intention of expanding this programme further subject to national funding.
- Work continues to train all student midwives in the treating tobacco dependency model.
- Services are delivering support flexibly within the community to ensure the service is as accessible as possible to women.

Delivery

- Currently SATD continues to improve each quarter with the ongoing ambition that C&M will reach the England average by the end of the financial year.

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

Latest ICB Performance (Feb-25)	13.4%	National Ranking	n/a
Place Breakdown (Feb-25)			Improved



Issue

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

Action

- The public facing communication campaign "Smoking Ends Here" was launched on No Smoking Day (12 March 2025) in Liverpool and Chester with significant media coverage.
- The new website https://smokingendshere.com has been developed and launched, the website is a one stop shop for smokers from across Cheshire and Merseyside to find information on stopping smoking and details of their nearest stop smoking services.
- A workforce training and development review has been completed and a workforce training and development plan has been developed.

Delivery

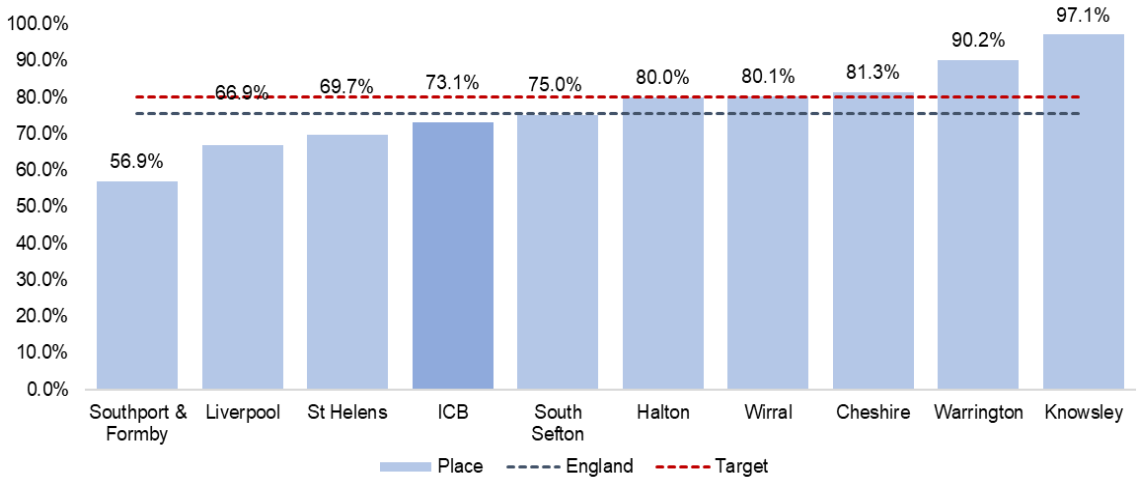
- Smoking prevalence continues to decline in C&M but requires a continued Whole System Approach to ensure progress is maintained.

5. Exception Report – Continuing Healthcare

NHS Cheshire and Merseyside

Standard Referrals completed within 28 days

Latest ICB Performance (Q3-24/25)	73.1%	National Ranking	29/42
Place Breakdown (Q3-24/25)			Improved



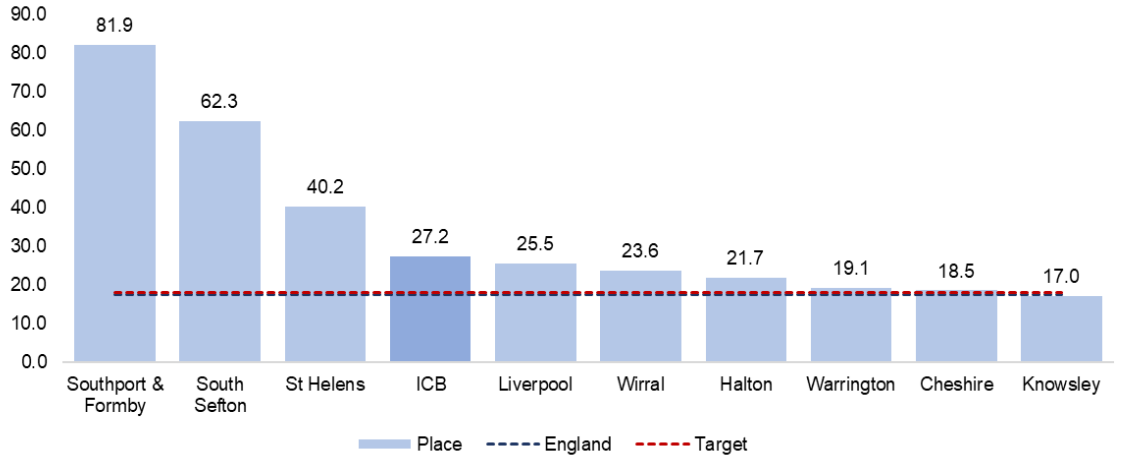
Issue
- Cheshire and Merseyside ICB is not currently meeting the NHS England KPI for Standard CHC referrals to be completed within 28 days.

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

Delivery
- The ICB delivery is slightly below the quarterly trajectory agreed with NHS England. The Q3 projection was ≥75% to 77.9% although an overall improvement is being seen..

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

Latest ICB Performance (Q3-24/25)	27.18	National Ranking	36/42
Place Breakdown (Q3-24/25)			Improved



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

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

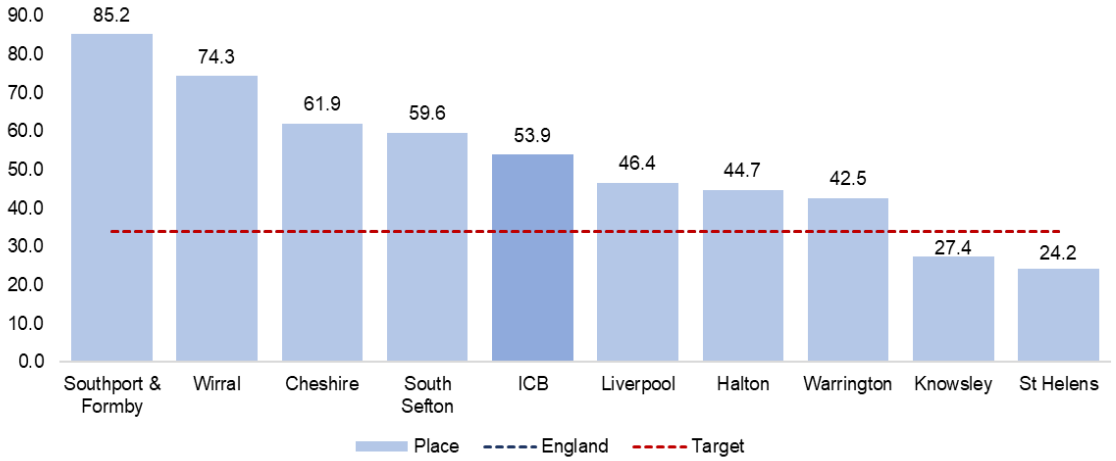
Delivery
- A focused piece of work in Liverpool and Sefton through outsourcing of Fast Track reviews as well as the implementation of the revised structure should ensure that only those individuals who are eligible for Fast Track are in receipt of the funding.

**snapshot at end of quarter*

5. Exception Report – Continuing Healthcare

NHS Cheshire and Merseyside

Number eligible for standard CHC per 50,000 population *			
Latest ICB Performance (Q3-24/25)	53.85	National Ranking	39/42
Place Breakdown (Q3-24/25)			Improved



Issue

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

Action

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

Delivery

- Delivery is not expected to be improved significantly within this financial year but the Management of Change and consistent application of processes is intended to support a revised position over the financial year of 25/26. (Figures may also be impacted by demographics.)

**snapshot at end of quarter*

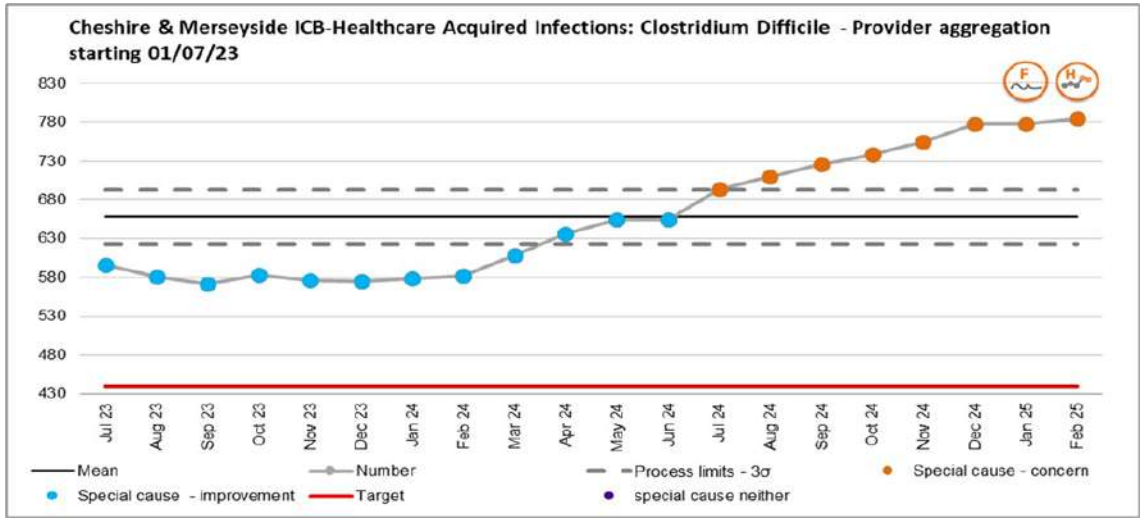
5. Exception Report – Quality

NHS Cheshire and Merseyside

Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation

Latest ICB Performance (12 months to Feb-25)	784	National Ranking	n/a

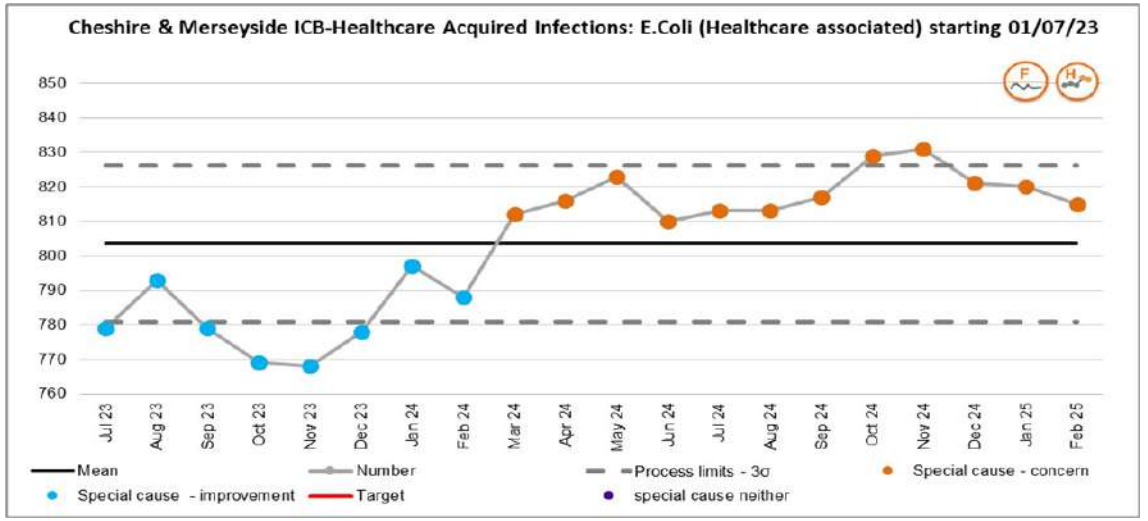
ICB Trend (rolling 12 months to Feb-25)



Healthcare Acquired Infections: Clostridium E.Coli (Hospital onset)

Latest ICB Performance (12 months to Feb-25)	815	National Ranking	n/a

ICB Trend (rolling 12 months to Feb-25)



Issue

- The C&M rate of CDI continues to increase, although slower, across a range of providers with five providers seeing an increase in (CDI) healthcare associated infections based on a rolling 12 months. The greatest impact in system rates is contributed to by WUTH and COCH where we continue to see high rates of infection. In month changes have been seen with the greatest increases at MWL and MCHT and the greatest decrease at LUFT. Despite the increases at MWL and MCHT they remain below the system average.
- The C&M rate of E. Coli has reduced again this month showing and improving position. This has been positively impacted upon by improvements in WUTH, LUFT and ECT.
- Despite the recent improvement at LUFT they continue to have a high overall rate of E. Coli infection. Despite lower numbers of cases both LWH and CCC have seen a significant increase in rate of infection over the last quarter and moving CCC into a high outlier position.

Action

- There has been a newly established HCAI Review Group to increase oversight with regards to HCAI rates and actions being taken to reduce. All providers with increased rates of HCAI are supported with regular discussions through the quality contract meetings to seek assurance and challenge progress.
- The development of a CDI improvement programme via CMAST has been shared with all acute Trusts to implement key actions.
- Place-based teams are seeking to understand positive learning from providers with low outlier positions.

Delivery

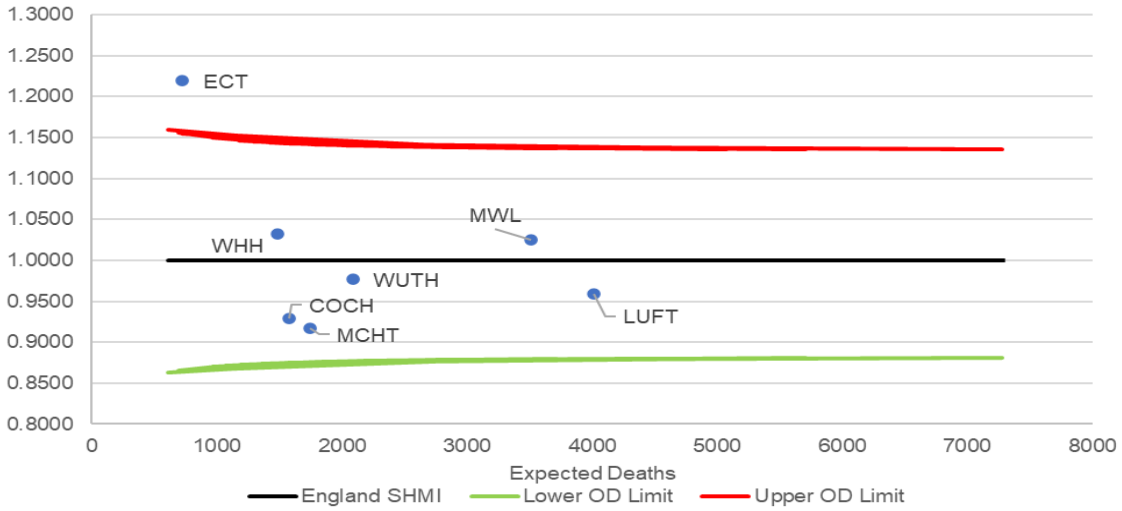
- Year-end expectations will see all providers other than MCHT and Walton breach nationally set tolerances and for E. Coli AHCH, COCH, LHCH, LUFT, CCC, WHH and WUTH are expected to breach nationally set tolerances.

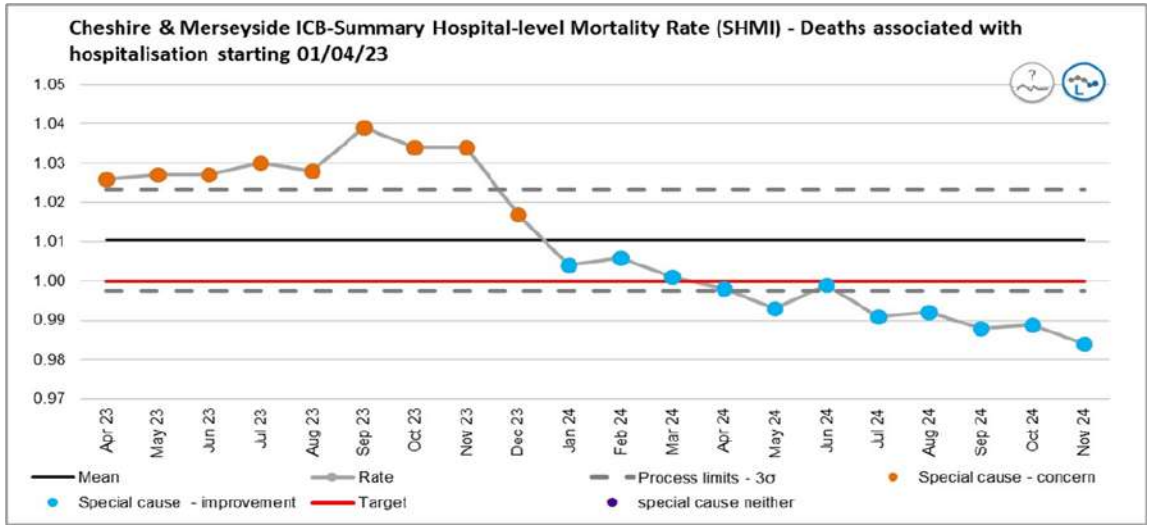
5. Exception Report – Quality

NHS Cheshire and Merseyside

Summary Hospital-level Mortality Indicator (SHMI)

Latest ICB Performance (Nov-24)	0.984	National Ranking	n/a
Provider Breakdown (Nov-24)*			Improved





Issue
- C&M trusts are within expected tolerances except ECT, with a current value of 1.2041 against the upper control limit for ECT of 1.1445.

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

Delivery
- Some CRAB metrics have shown positive improvement, although not yet defined as sustained.
- The improvement culture in the trust is palpably improved and a Board to Board review in November has led to next steps including a review using HSMR+ that has demonstrated a significantly frail elderly population and clear improvement in mortality when measured using the HSMR+ methodology. It is not yet into the normal range, but inside the 95% confidence interval on a funnel plot (in contrast to SHMI) and thus oversight continues.

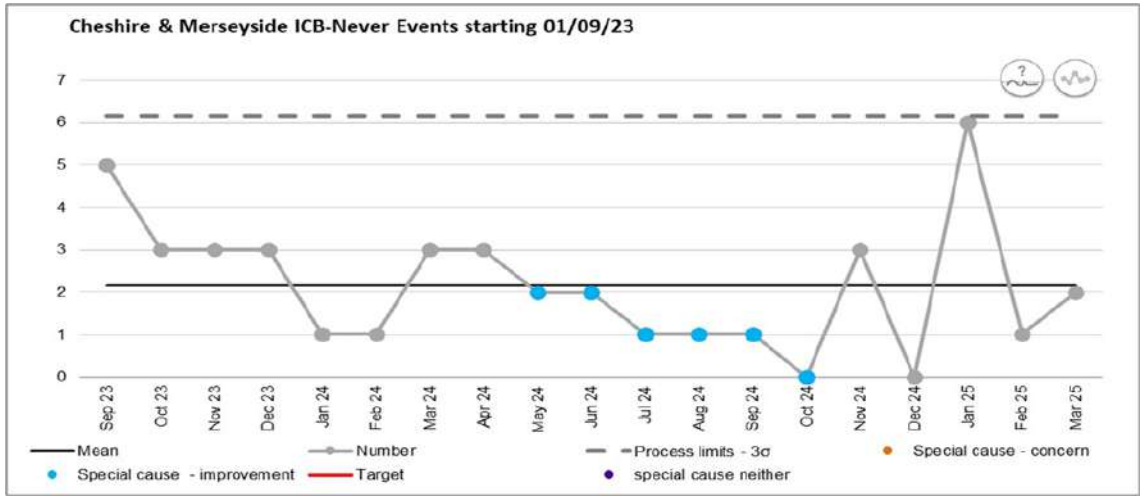
** OD, overdispersion, adds additional variance to the standard upper and lower control limits*

5. Exception Report – Quality

NHS Cheshire and Merseyside

Never Events

Latest ICB Performance (Mar-25)	2	National Ranking	n/a
ICB Trend (Mar-25)			Deteriorated



Issue

- C&M have had 22 Never Events over the last 12 month rolling period, which continues to demonstrate a reduced rate from previous years, however the spike in January to 6 cases has made a specific impact.
- Whilst 6 cases in January represents a spike in rates, there are no patterns with all cases at different trusts.
- Both cases in March 2025 were surgical related incidents and will undergo a PSIRF response.

Action/s

- All incident will be reviewed via the newly formed Safety Standards for Invasive Procedures Group and learning shared across the system.

Delivery

- There has been 2 Never Events in March within the normal variation and slowly reducing trend.

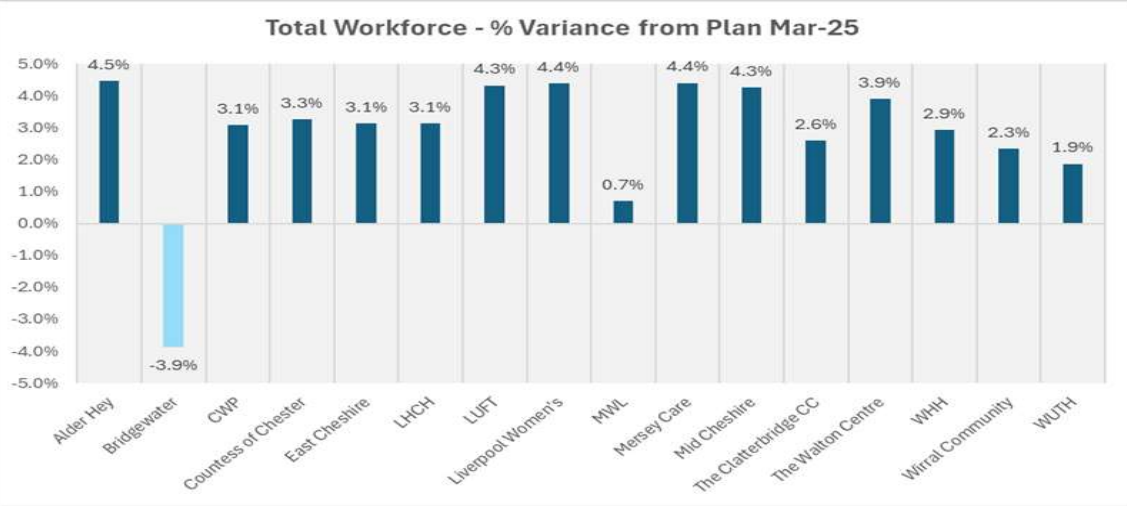
5. Exception Report – HR/Workforce

NHS Cheshire and Merseyside

Total SiP (Substantive + Bank+ Agency) Variance from Plan % - via PWRs

C&M ICB Performance (Mar-25)	3.1%

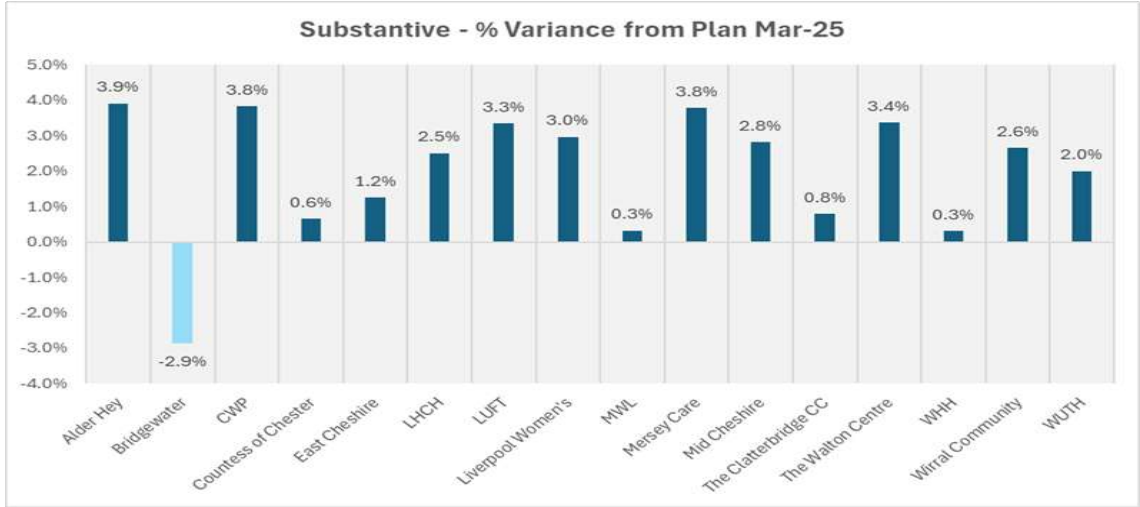
Provider Breakdown (Mar-25)



Substantive Variance from Plan % - via PWRs

C&M ICB Performance (Mar-25)	2.3%

Provider Breakdown (Mar-25)



Issue

- In Mar-25, fifteen of the sixteen C&M Trusts reported their total workforce WTEs were above their plan as at M12, with a C&M variance from plan of +3.1% (2,454.4 WTE).
- Fifteen of sixteen C&M Trusts reported substantive staff in post numbers higher than that forecast in their operational workforce plans (as re-submitted on 4th October 2024). The total system performance was a variance from plan of +2.3%. At a system level, substantive staff utilisation increased by 149.9 WTE / 0.2% from the previous month.

Action

- NHS C&M co-ordination of the 25/26 operational (annual) workforce plans has been completed with submissions to NHSE nationally on the 27th March 2025 – with a key focus on productivity & efficiency opportunities. NHS C&M is supporting Trusts with their workforce, activity & finance triangulation. Further work expected to aligned to the financial plans across the system & ensure 24/25 WTE baseline is accurate – to track delivery of Operational Workforce plans in 25/26.
- All Trusts have in place vacancy authorisation processes/panels & enhancing their establishment control. Greater scrutiny of workforce and pay costs data at organisational and system level is now taking place. The workforce WTE monitoring dashboard is shared with Trusts monthly – for review and feedback; where individual performance can be interrogated in terms of WTE numbers & assumptions for the coming quarter.

Delivery

- NHSE C&M co-ordination of operational (annual) workforce plans has concluded – with key lines of enquiry being developed as the plans iterate throughout Feb/March.
- Proactive monitoring of workforce data & proposed actions now takes place with Trust Chief People Officer & workforce/resourcing teams as part of the C&M Trust PDN Network focussed workstream on workforce planning & pay affecting workforce issues

Please note that the WTE operational plan figures were re-forecast for M5 to M12 24/25, following a request from NHSE for risk-adjusted financial plans to the end of the year.

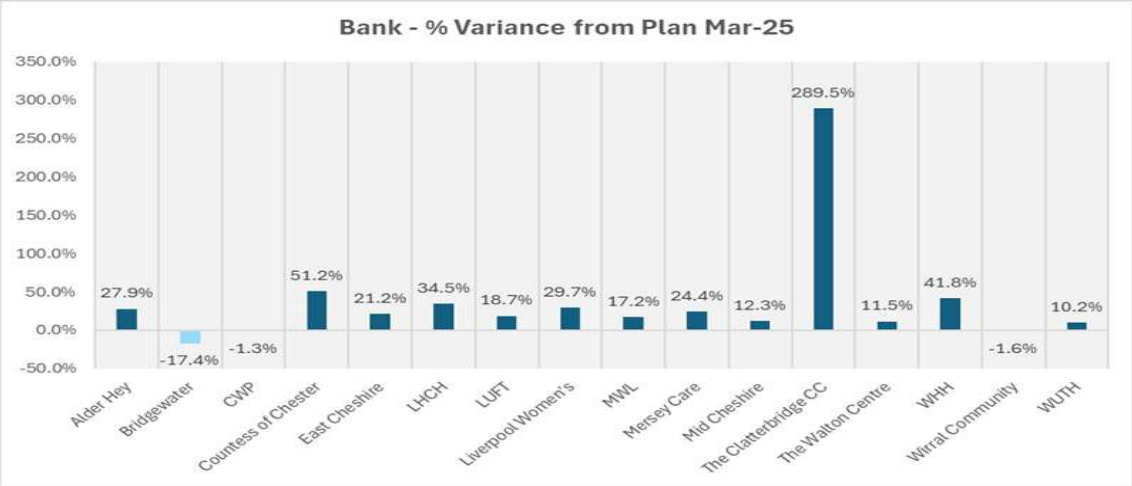
5. Exception Report – HR/Workforce

NHS Cheshire and Merseyside

Bank Variance from Plan % - via PWRs

C&M ICB Performance (Mar-25)	21.0%

Provider Breakdown (Mar-25)



Issue

- Thirteen of sixteen C&M Trusts had Bank usage higher than that forecast in their operational workforce plans for the month of Mar-25. The total system performance was a variance from plan of +21%
- At a system level, the total bank usage increased by 169 WTE / 3.2% from the previous month.

Action

- All Trusts are reviewing their internal workforce resourcing processes & specific organisational actions around temporary staffing data, premium staffing costs (WTEs Utilised and Rates Charged) & cross-checks between financial & workforce returns, which continues to be a focus for all Trusts, as part of the 25/26 planning process.

Delivery

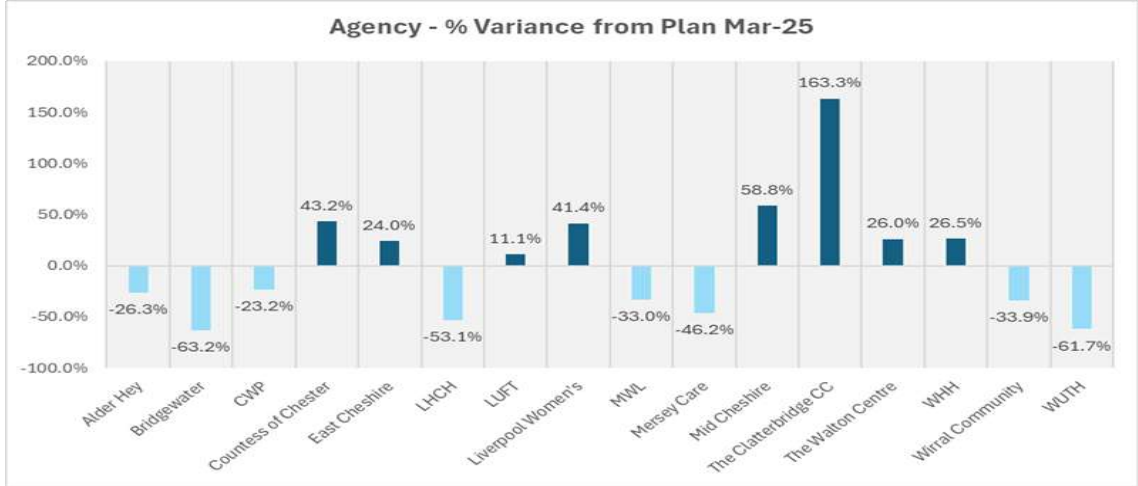
- Proactive monitoring of workforce data & proposed actions/controls with Chief People Officers C&M Trust PDN Network focussed workstream – ongoing KLOE's and 25/26 plan reviews incorporate reviews of 24/25 performance against plan.

Please note that the WTE operational plan figures were re-forecast for M5 to M12 24/25, following a request from NHSE for risk-adjusted financial plans to the end of the year.

Agency Variance from Plan % - via PWRs

C&M ICB Performance (Mar-25)	-17.2%

Provider Breakdown (Mar-25)



Issue

- Eight of sixteen C&M Trusts had Agency usage lower than that forecast in their operational workforce plans for the month of March. The total system performance was a variance from plan of -17.2%
- At system level, Agency usage reduced by -26.5 WTE / 3.4% from the previous month.

Action

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

Delivery

- Proactive monitoring of workforce data & proposed actions/controls with Chief People Officers C&M Trust PDN Network focussed workstream – in Mar-25 and objectives for 25/26 to be reset.
- Proactive communication to Chief People Officers, Workforce & Resourcing Teams about Off-Framework and Agency Spend data (by staff group) is shared monthly with additional input provided by NHSE North West.

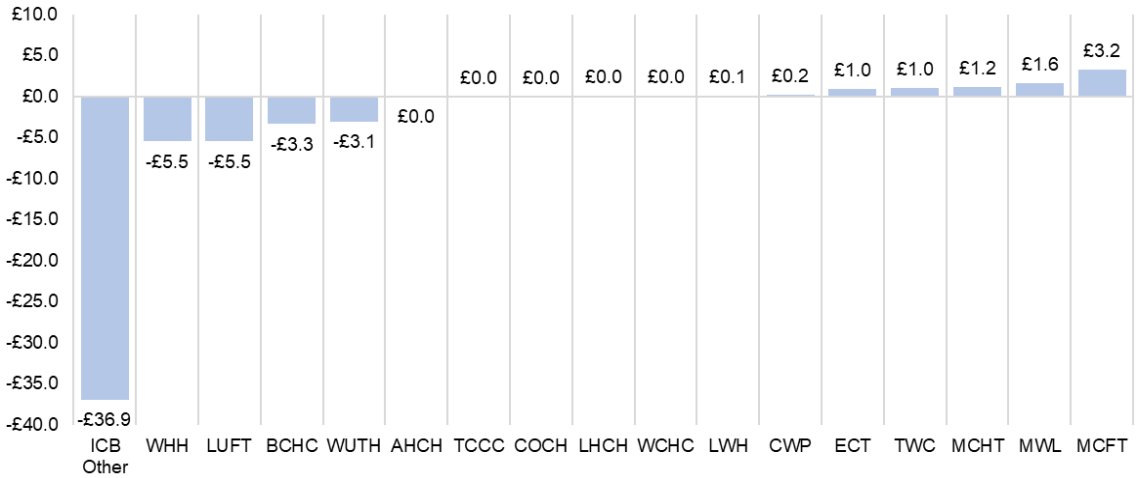
Please note that the WTE operational plan figures were re-forecast for M5 to M12 24/25, following a request from NHSE for risk-adjusted financial plans to the end of the year.

5. Exception Report – Finance

Overall Financial position Variance (£m)

Latest ICB Performance (Mar-25)	-45.9	National Ranking	n/a

Provider Breakdown (Mar-25)



Issue
- System Deficit support funding has been agreed of £178m in order for the ICB to submit a planned breakeven financial plan for 20252/26.
- ICB plan is for a £50m surplus with providers planning for a £50m deficit
- Plan to deliver MHIS and remain within running cost allocation
- Anticipated further running cost and payroll savings in the final quarter of 25/26 as part of model ICB design.

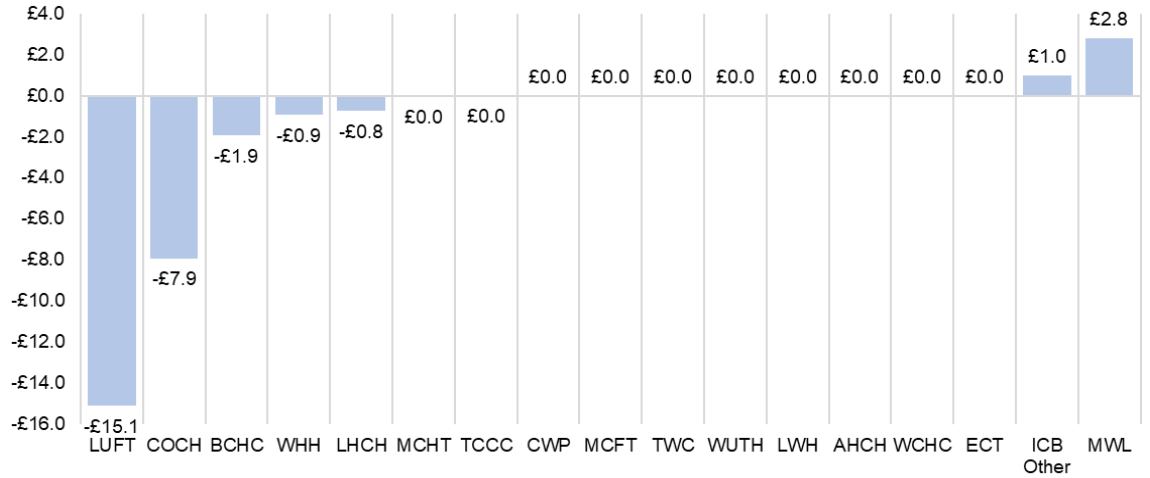
Action
- Financial reporting to NHSE is required at summary level only at month 1. System reports financial position in-line with plan at this very early stage.

Delivery
- Financial position reported to board and FIRC on a monthly basis.
- Bi-weekly review of efficiencies achieved and savings realised.

Efficiencies Variance (£m)

Latest ICB Performance (Mar-25)	-22.8	National Ranking	n/a

Provider Breakdown (Mar-25)



Issue
- 2025/26 plan is based on the delivery of £572m efficiencies (£139m ICB and £433m providers)
- Efficiency savings required equates to 7% of the ICB's allocation and 5.9% of providers gross operating expenses.
- As at month 1, total system efficiency plans were classified as £213m fully developed, £142m plans in progress, £180m opportunity and £37m as yet to be identified.
- £540m of the £572m efficiency plans are recurrent

Action
- Chief Officer for System Improvement and Delivery in post from April-25
- Efficiency savings to be monitored and challenged bi-weekly

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

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

29 May 2025

Highlight report of the Chair of the Quality & Performance Committee

Agenda Item No: ICB/05/25/09

Committee Chair: Tony Foy, Non-Executive Member

Highlight report of the Chair of the Quality & Performance Committee

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Meeting date (s)	10 April 2025 and 08 May 2025

Key escalation and discussion points from the Committee meeting

Alert

Safeguarding

- Operational pressures were noted to be challenging as the safeguarding functions remain in business continuity. The workforce risk remains unchanged at 16 with clear progress made in recruitment of vacant posts (with all designated nurses/professionals either recruited to or pending interviews). A business continuity plan has been enacted to mitigate risks and cover cover/statutory functions.

Care Home Quality

- Organisational safeguarding and enhanced quality surveillance in place for St Catherines (sister home to Winsford Grange in Cheshire West Place). Concerns relate to poor improvement and progress to Action Plans set out in September 2024. A CQC inspection report published in March 2025 and home rated inadequate. Weekly oversight meetings, joint with Local Authority and Park Homes, are now established.

CQC Inspections – Countess of Chester Hospitals

- The Care Quality Commission completed an unannounced site inspection at the end of February of Trust Urgent Care Services. The Trust received written feedback at the end of the inspection noting improvements and areas that needed addressing. This was subsequently followed up on 1st April with a formal CQC Section 29a Warning Notice. Concerns raised relate to inconsistency in assessing and managing risk, poor patient experience, governance systems and long delays in ED.

Marie Curie

Following the initial closure of beds due to staffing issues the Marie Curie National team has subsequently indicated that the service model of maintaining the bedded unit in Liverpool is not sustainable. All system partners, including Marie Curie, agree that all efforts must be made to re-open the beds, even as an interim, until a new model of palliative/ end of life care can be agreed across Liverpool that incorporates beds, IMPACT, STARS and virtual wards.

Advise

Performance

UEC debrief

- During Winter 2024/25, the system faced sustained and significant operational pressures. These challenges were mirrored across the Northwest region and nationally. Several acute hospital sites declared critical incidents, necessitating coordinated support and oversight from both senior Integrated Care Board (ICB) leaders and NHS England (NHSE) regional teams.

- The system's overriding priority throughout this period was to safeguard patient safety and minimise the risk of harm.
- Despite the collaborative development of comprehensive winter plans, the scale and persistence of demand resulted in notable service delays: ambulance handover and response times, extended stays in emergency departments, delays in discharge processes, and limited access to sub-acute and mental health services.

The report summarised the key challenges experienced, highlighting cross-cutting themes and reflections from system and place leaders to support continuous improvement in future winter resilience planning. Key areas of focus include a review of successful initiatives, identification of improvement opportunities, and the translation of lessons learned into actionable planning for the upcoming winter period.

Quality Contract Schedule covers 7 areas – Workforce, Governance, EDI, Patient Safety, Clinical Reporting, Maternity, Patient Experience with 34 specific measures linked to National guidance.

- The Place Quality Leads have reviewed the 2024-25 Schedule alongside the 2025-26 Planning Guidance and contract documents to agree the quality indicators required for 2025-26. Further discussions have taken place with ICB specialist leads (EDI, Chief People Officer, Director Patient Safety Etc.) to ensure they are receiving the required assurance for their area over the coming year. The final Schedule has been reviewed and agreed by the Place Quality Leads and is now processing through the governance routes for ICB sign off. The year 2025/26 will be used to develop consistent mechanisms for assessing levels of assurance across the place teams.

Initial Health Assessments (IHA)

- Quarterly performance for 2024/25 of the ability to conduct an initial health assessment within 28 days (20 working days) of a child entering care shows significant variance. For children placed in area Cheshire East shows a marked reduction Q1 to Q3 (84-32%) with Cheshire West and St Helens improving (54-76%) and (20.5- 82.1%) respectively, Liverpool and Sefton show consistently high rates (over 70-80%). Rates for children placed out of area are generally much lower.
- Monthly IHA Progress meetings continue between providers and Designated Nurses for Children in Care (NHS Cheshire & Merseyside ICB) to outline progress against IHA recovery trajectory and improvement plan.

Quarter 4 Complaints report
Key issues

- Total contacts in Q4 1170 – 825 PALs and 197 dealt with as a complaint. Of the contacts received 137 were MP/Councillor contacts
- The highest number of secondary care complaints received in Q4 relate to Wirral University Teaching Hospital NHSFT (WUTH) (8 cases), Mersey and West Lancashire Teaching Hospitals NHS Trust (8 cases). Complaints about both Trusts, feature consistently throughout the last year.

- All Age Continuing Care complaints are consistently highest in Wirral Place. Further work is being carried out to identify themes and support the All Age Continuing Care Strategic Group.
- Compliance with complaint statutory timescales (acknowledgement and response) remain positive despite high volumes of patient contacts.
- Patient dental access contacts remain consistently high (140 in Q4, 126 in Q3, 126 in Q2, 412 in Q1).
- Three enquiries have been received from the Health Service Ombudsman during the reporting period, two of which related to All Age Continuing Care cases.
- The Committee also noted a wide range of learning examples.

Assure

Quality Impact Assessment Policy The policy relates to Quality Impact Assessments that are undertaken when making commissioning decisions (investment and disinvestment), developing business cases, projects and other business plans. It applies to all staff that undertake Quality Impact
Assessments, as well as those who scrutinise and approve Quality Impact Assessments.
The policy should be read in conjunction with the ICB Equality Impact Assessment Policy

- The Committee approved the updated policy and was assured that the QIA process was robust and effective.

Maternity

- **C&M Trust Progress against 3 Year Delivery Plan**
  The LMNS are required to seek assurance from all C&M Providers on a quarterly basis (as directed by the North West Regional Team), progress against each of the deliverables within the three-year delivery plan for maternity and neonatal services. Compliance is assessed against the evidence requirements included in the Maternity
  Performance Oversight Panel (MPOP) Support Tool, devised by the Regional Team.
  Overall good progress has been reported, with the majority of deliverables (90%) either complete or on track across all providers, with full compliance against the three-year plan to be achieved by March 2026.
- **Saving Babies Lives Care Bundle Version 3 (SBLv3) Quarter 4 Position**
  SBLv3 follows a quarterly cycle of evidence submission and review, in line with the
  national SBLv3 Implementation tool and locally agreed trajectories set by the LMNS. The
  Quarter 4 position reporting a positive increase in compliance compared with the previous
  quarter (see tables 2 and 3 below), with Warrington and Halton maintaining 100%
  compliance with each of the 6 elements. Of particular note, Liverpool Women's achieved
  80% compliance in Element 4 (previously 60%).
- **Performance (May)**
  C&M Clinical Quality Metrics Reporting Pack (derived from

the Regional Maternity Dashboard) highlights variation by provider and exceptions at a C&M level. As an LMNS, C&M is performing well against most of the quality and safety metrics included in the Reporting Pack, with exceptions reported to QPC. **Exceptions –** Breast milk at first feed; Induction of Labour (no concerns); Post Partum Haemorrhage (no serious incidents); Caesarean section rates at LWH (LMNS following up)
Quarterly Risk Review There are 8 current risks held on the Quality & Performance Risk Register. 6 have been previously reported, with 2 new risks being received. Of these 8, East Cheshire Trust SHMI is currently rated as critical (20) and remains on the ICB Board corporate risk register. Place leads have reviewed their controls and assurances, and including further mitigations to some Place based scores, the committee were asked to consider the ICB wide score for 2 risks - QU04 Safeguarding recruitment and QU14 SEND Data. In line with the ICB Risk Management Strategy, an ICB wide risk score for a risk-in-common should mirror that of the highest place risk score. For QU04 this would mean the ICB wide score rises to 16 to mirror Cheshire East. For QU14, with Halton place reporting a score of 9, the recommendation is that the ICB score also rises to 9.

Committee risk management

The following risks were considered by the Committee and the following actions/decisions were undertaken.

Corporate Risk Register risks	
Risk Title	**Key actions/discussion undertaken**
QU04	Following review and discussion at the Quality Risk Sub-Group, QU04 is recommended for retirement, and a newly re-worded risk established. This would make redundant the need to escalate the ICB wide score for QU04
QU14	With Halton place reporting a score of 9, the recommendation is that the ICB score also rises to 9.

Achievement of the ICB Annual Delivery Plan

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

Service Programme / Focus Area	Key actions/discussion undertaken
Urgent and Emergency Care	Review of learning from Winter experiences across the system and plans to improve ahead of Winter 2025/6

Service Programme / Focus Area	Key actions/discussion undertaken
Maternity	Review of performance standards – exception reporting
Safeguarding	Challenge of operational pressures
Quality Impact Assessment	Revised Policy approved

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

29 May 2025

Highlight report of the Chair of the ICB Audit Committee

Agenda Item No: ICB/05/25/10

Committee Chair: Tony Foy, Non-Executive Member, Audit Committee Chair

NHS
Cheshire and Merseyside

Highlight report of the Chair of the ICB Audit Committee

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	08 April 2025

Key escalation and discussion points from the Committee meeting

Alert

The Audit Committee at its 08 April 2025 meeting:

- received, reviewed and **APPROVED** the ICBs Internal Audit Workplan for 2025-2026. The internal audit plan is built from a risk assessment which has considered core assurances, national and local system risks, place-based developments, and local strategic risk assessment. The plan will remain flexible to allow for responses to emerging challenges that the ICB may face.
- received, considered and **APPROVED** the ICBs Anti-Fraud Workplan for 2025-26. The plan is risk-based taking into account core and mandatory requirements. Work will be undertaken across all areas covering each of the NHS Counter Fraud Authority (NHSCFA) Strategic Pillars – 'Assure', 'Understand', 'Prevent' and 'Secure' and will remain dynamic and flexible to allow for responses to emerging challenges, risks and threats that may materialise in year.

Advise

The Audit Committee at its 08 April 2025 meeting:

- received an update report regarding the current position of finance, contracting and procurement policies for the ICB following their annual review. Committee members were informed that with the introduction of the new ISFE2 financial letter expected on 01 October 2025, several policies will need to be reviewed and updated to reflect the new procedures. The Committee noted the update
- received a Quarter 4 Progress report on the performance and delivery of the ICB Information Governance (IG) Service. The Committee received assurance regarding the completion of the implementation plan of the new IG service provided by MIAA following transition of the service from MLCSU. Committee members received information on the progress around the new service plan that aligns with the June 2025 submission date of the DSPT toolkit, the rollout of IG training, the number of data incidents that had occurred in quarter 4, of which none were reportable to the Information Commissioners Office, as well as details regarding cyber security requirements and the internal audit on the cyber assessment framework that is scheduled for May. A further report on this is due to come back to the Committee. The Committee noted the report.
- received the quarter 3 update on the performance of the ICBs Subject Access Request (SAR) service, with the report highlighting where there had been a deterioration in response times, concerns regarding the performance as well as internal processes to support the SAR service, planned actions and mitigations to address the performance issues, including the bedding in of a new IT system to help with the caseloads and collection of information. The Committee noted the report.

• received the updated draft of the ICBs 2024-2025 Annual Report and Accounts for review and discussion regarding improvements to content and style. Committee members provided comprehensive feedback on the current draft which was to be taken into account to help shape the further draft that will return to the June 2025 Audit Committee prior to receipt by the Board to review and approve at its meeting on 19 June 2025. The Committee noted the current draft of the report. • received a verbal update from the ICBs External Auditors stating that the final works have been largely completed and they are in a good position to complete the final accounts. The Committee noted the update.
Assure
n/a

The next meeting of the Committee is scheduled for **10 June 2025.**

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

29 May 2025

Highlight report of the System Primary Care Committee

Agenda Item No: ICB/05/25/11

Report approved by: Erica Morriss, ICB Non-Executive Member

NHS
Cheshire and Merseyside

Highlight report of the System Primary Care Committee

Committee Chair	Erica Morriss
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	20 February 2025 and 17 April 2025

Key escalation and discussion points from the Committee meeting

Alert

Primary Care Financial Position M10 – Pharmacy overspend (20m) although this is 5.5m better than expected outturn through Recovery Interventions and Medicine Management. Optimisation.

Advise

APMS (2)

1 - The Committee **approved** a direct award and noted the maximum contract period of 3 years commencing 1/4/25 to 31/3/28.
2 - The Committee **noted** the use of the (Regulation 20) Selection Criteria Document Part 1 and Part 2 and **approved** the Provider Selection Regime documentation to undertake a competitive procurement.
- The Committee **noted** the identified risks & **approved** the use of the electronic tendering systems and NECS.

Patient Experience – Healthwatch's presented an initial summary of their findings of their survey to understand patient experience in relation to measures introduced as part of recovering access to primary medical services – but also wider patient experience of access. There are still challenges for patients in accessing appointments and understanding some of the changes put in place – Healthwatch's report will be finalised in due course and sent to the ICB – an update to the Board is planned for July along with measures finalised for access improvement for 25/26 as part of the planning guidance response.

Primary Care (Medical) Commissioning - ICB's have been asked to produce action plan by the end of June, to assure NHS England of plans for contract and commissioning oversight of primary medical, in respect of improving access and reducing variation. A draft will be presented to the Committee in June and highlights reported to the Board in July as part of the response to the Healthwatch survey above.

Assure

Primary Care Quality – further work to refine a single set of common indicators and a single template report for this is ongoing and a further update will be given at the August meeting (currently place specific dashboards are used, with some commonality across the places) – reporting and escalation processes for optometry, community pharmacy and dental contractor groups are overseen by exception through the system primary care quality group and relevant operations group, but for primary medical this is managed through each place.

Freedom to Speak Up – an update on the current position with all four contractor groups was given, following a scoping exercise. How this is supported in future and the ICBs role should be clearer once the future operating model is agreed/understood. By 2026 it is the aim to ensure that all primary care have access to FTSU and have a process to speak up. This is an ongoing piece of work across all contractors and will remain a standing item for SPCC.

Primary Care Contracting – an update on the contract for Primary Medical and Community Pharmacy for 25/26 was given which were agreed nationally after the February meeting and therefore not able to be discussed - the implementation of these will be overseen by the Committee who were assured of actions progressing/planned – a further update will be given at the August meeting

Digital – Connecting Care – a specific update on this was given and it was identified that there is further scope for all four contractor groups to be involved in this work with an update to the Committee in 6 months time.

Workforce – although an update from the Workforce Steering Group was given, it was recognised that future reporting was dependant on the role of the ICB in workforce in the future, outside of commissioning/contracting asks.

Estates & Digital Capital 25/26 - SPCC meeting in April received a joint paper for both digital and estates capital allocation. Appropriate Estates governance has been agreed, with a panel established to prioritise and a summary paper would then go to the Strategy Estates Board to endorse the decision which in turn would then come to SPCC for approval. Noted that the criteria for the two funding pots are different. - the utilisation funding is purely for estates and does not include any digital investment, therefore key to note that any digital investment comes out of the BAU capital allocation.

Performance Metric Update - Committee Noted update we continue to drive for consistency across 9 Places, with expectation that only a minor number of metrics will be bespoke to each Place and will be influenced by imminent planning guidance.

Committee risk management

16 committee risks including 1 BAF risk delegated by the Board, 3 corporate risks, 3 place risks in common and 9 unique place risks, escalated as scoring high and above in accordance with the Risk Management Strategy.

The report highlighted the two most significant risks, in relation to GP collective action and sustainability and resilience of primary care workforce, which are rated extreme and which are escalated to the Corporate Risk Register.

It was noted that this was an update since the October report, and included the following changes:

- 6PC: dental provider contract management risk potentially leading to loss of provider and impact on general dental provision, recommended for closure.

- 13DR: a risk that the introduction of new core clinical system suppliers through the GP IT Futures Tech Innovation Framework Early Adopter Programme results in a more fragmented infrastructure and has a negative impact on record sharing, has been allocated to this Committee.
- Estates risks in relation to general practice meeting the criteria for committee escalation as identified by four Places and therefore deemed a risk in common.

SPCC

- Approved the closure of risk 6PC.
- Noted the current position in relation to the risks escalated to the committee.
- Noted the review of all primary care risks (across 4 contractor groups), oversight and reporting arrangements currently underway.

Achievement of the ICB Annual Delivery Plan

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

Focus Area	Key actions/discussion undertaken
Pharmacy Access	Weekend coverage/impact on deprivation/PNA process & Rota fee.
Dental Access	Focus on routine care, access and urgent care. Impact on deprivation and underperformance. Formal triage from Medical to Dentist.
Estate and Digital Capital 25/26	25/26 proposals will be submitted to SPCC in April 25.
Risk Review	Commentary above.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

29 May 2025

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

Agenda Item No: ICB/02/25/12

Committee Chair: Prof. Hilary Garratt, Non-Executive Member

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

Committee Chair	Prof. Hilary Garratt
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	19 March 2025

Key escalation and discussion points from the Committee meeting

Alert

N/A

Advise

The Committee considered the following at its meeting in March:

Public Engagement Report

A six-week period of public engagement launched on 15 October 2024 and ran until 22 November 2024, the week after the Board of NHS Cheshire and Merseyside approved the case for change.

The engagement asked people to reflect on the case for change, share their own experiences of hospital gynaecology and maternity services in Liverpool and advise what things they felt were important to them in thinking about the future of services. The engagement was not a public consultation and proposals or potential options for the future were not made. Views, insights and feedback gathered during the engagement period have been compiled into a report by Hood & Woolf, an independent company.

The Committee:

- Acknowledged the engagement report.
- Acknowledged that the engagement report will be published with the papers for the NHS Cheshire and Merseyside Board, and that communications will be issued to coincide with this, aimed at both 'closing the loop' for people who took part in the process, and providing a wider update on next steps for the programme.
- Acknowledged that the engagement report findings will be used to inform the next stage of the Women's Hospital Services in Liverpool programme, and in particular, the options process.
- Acknowledged that the formal engagement process that took place in autumn 2024 only reflects the first stage of involving people in the programme, and that there is an ongoing need to ensure there is capacity and resource to deliver this as work continues.

Clinical Engagement Update

Feedback from Events held on 16 December 2024 & 14 February 2025 was received. An update was provided to give the committee assurance that clinicians are being engaged with, and are given the opportunity to feed into the process.

Clinical engagement is being led by the Clinical Leaders Group with senior clinical leaders from the ICB and providers. A wide group of clinicians are involved in the Clinical Reference Group (CRG) who attended the May and December 2024 sessions. A smaller subset of the CRG will be involved in the options appraisal workshops planned for May and June 2025. Dedicated events are being held to engage LWH clinicians including the one that took place on 14 February 2025.

The committee noted the update.

Options Appraisal Process and Framework for Content

The Committee received a paper setting out the plans and timescales for the options appraisal process. Members were also invited to give feedback on the draft hurdle and evaluation criteria as part of the soft engagement process. The Committee will approve the final hurdle criteria and evaluation criteria at the May meeting which will be used in the assessment of the long list in June.

The Committee noted that the draft evaluation criteria have been developed based on recent clinical engagements and reflect the need to mitigate the five key risks identified in the case for change.

Decision

The Committee approved the options appraisal process and supported the proposed hurdle and evaluation criteria, with the suggestions agreed at the meeting.

Budget Report and Resources for 25/26

The Committee was advised that £96,000 of the notional £100,000 programme budget for 2024/25 has been spent. The Committee were asked to support the ask for a further £130,000 for 2025/26 to support modelling and analysis for the development of options and any future business case. Figures have been submitted to the ICB for approval.

The Committee supported the request for £130,000 for 2025/26.

Assure

The Committee considered the following:

Programme Update

The Chair of the Programme Board provided an update on programme activity since the November 2024 meeting. This included:

- A Clinical Reference Group (CRG) engagement event was held on 16 December 2024 to inform model of care design work, which was very well attended. A dedicated event was held for LWH staff on 14 February 2025 to provide a general update on the programme and to review and contribute to the CRG work to date.
- The Case for Chage public engagement report was completed and review by Programme Board.
- The lived experience panel met to review the outcomes of the engagement report, discuss involvement in the options process and attendance at Women's Services Committee.

- Planning for options appraisal, including scoping of resource and requirements was discussed at Programme Board on 10 March 2025.
- Work is underway to complete an inequalities analysis of women using Liverpool Women's Hospital services and will be shared at the next committee meeting.
- A full time Programme Manager commenced secondment on 6 January 2025.
- Work continues to deliver shorter term quality improvements in women's services through the Trust improvement plan.

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

Risks Review

The Committee reviewed all risks in the current risk register which remain relevant. All risks with scores above 12 remain the same, including access to future finance to support delivery of the programme (16), the risk to develop a sustainable model of care (15) and confidence in the delivery of the programme (12). The ongoing clinical safety risk is still 20 and the clinical leads who reviewed the risk have identified that the risk needs to remain at 20 until some of the planned improvements are fully implemented.

There will be a more comprehensive risk update at the May committee meeting, following on from the options process event.

Once the details are known on the proposed changes to staffing in ICBs / NHS England, a new risk will be added to the risk register.

The Committee approved the current programme risks and risk scores.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

Proposal regarding ICB funded Gluten Free Prescribing across Cheshire and Merseyside

29 May 2025

Agenda Item No: ICB/05/25/13

Responsible Directors: Prof. Rowan Pritchard Jones, Medical Director
Dr Fiona Lemmens, Deputy Medical Director

1. Purpose of the Report

1.1 The purpose of the paper is to seek a decision from the Board of NHS Cheshire Merseyside ICB following a period of public consultation, regarding ICB funded gluten free (GF) prescribing.

1.2 This paper provides an update on the work undertaken to date, an overview of the options appraisal provided at the November 2024 Board meeting, along with the detail of the Public Consultation period and further post consultation Equality Impact Assessment (EIA) completed.

1.3 Following the Public Consultation process a period of conscientious consideration to the feedback and post consultation EIA has been undertaken, which has led to the development of further options. This paper provides the information required for the Board as part of their decision-making process.

2. Background

2.1 On formation of the Integrated Care Board (ICB), clinical policies were inherited from the nine predecessor CCGs which covered patients registered with a GP Practice within the geographic areas of the nine Cheshire and Merseyside local authority areas. This meant that patients had different access to services and care, based on their postcode/where they were registered with a GP Practice. The ICBs Reducing Unwarranted Variation programme set out to harmonise this approach to ensure we work to address health inequalities and provide a consistent offer across Cheshire and Merseyside.

2.2 It is of note that since the start of this review the NHS financial challenges have significantly increased, necessitating careful balancing of population needs, clinical risk, and commissioning decisions to address health inequalities.

2.3 This paper is written in the context of ensuring commissioning decisions prioritise the most pressing needs of the population, recognising the potential for increased demand in areas like mental health, urgent care and community services, whilst addressing unwarranted variation and the need for a consistent offer.

3. Gluten Free Current Policy Position:

3.1 Across the Local Authority areas in Cheshire and Merseyside, there are GP Practices within 8 Local Authority areas that currently offer gluten free prescribing in line with the 2018 national Department of Health and Social Care (DHSC) consultation outcome, which was to reduce prescribing to bread and bread mixes only. It is of note that St Helens CCG and NHS Cheshire West CCG opted to withdraw prescribing completely (noting this was prior to the national Department of Health and Social Care (DHSC) consultation as detailed above). For the Cheshire West and Chester Local Authority area, the area that

was covered by the former NHS Vale Royal CCG did not opt to withdraw prescribing, and as such there are still parts of Cheshire West and Chester were Gluten Free prescribing can be undertaken (Winsford, Northwich and surrounding area).

3.2 In Cheshire and Merseyside, over 13,300 patients have a diagnosis of coeliac disease or other conditions which requires management through a gluten free diet. Most people choose to purchase their gluten free foods at supermarkets or other retailers however 2,314 patients receive their gluten free bread and bread mixes via prescription. It should be noted that of the gluten free prescriptions issued, 99% are exempt from prescription charges, with 73% being due to age (under 16 or 18 if in full time education, or over 60 years old) and over 60% of these being over the age of 60.

4. Options considered

4.1 Under the ICBs Unwarranted Variation Recovery programme, a number of options were considered in order to address the unwarranted variation. The option to maintain the current arrangements was not considered, due to the current unharmonised position, and the need to ensure equity across Cheshire and Merseyside. In order to achieve this, the two main options considered were to either fully prescribe across Cheshire and Merseyside at an estimated additional cost of £130k per year (increase annual spend on the service of c.£655k) or to withdraw prescribing completely, offering an estimated annual saving of £525k. (The full options appraisal can be found in **Appendix One** of this report).

4.2 In the context of NHS Cheshire and Merseyside needing to consider how and where to allocate the fixed resources allocated by NHS England to best meet the healthcare needs of the population they serve, the Unwarranted Variation programme proposed that gluten free prescribing is stopped across Cheshire and Merseyside due to the following rationale:

- availability of gluten free foods is much greater than it was when the original policies were implemented, and in the six years since the DHSC consultation. It should also be noted that bread is not classed as an essential food item and people can maintain a healthy diet without bread through choosing naturally gluten free foods
- whilst the cost of gluten free bread is still more expensive than non-gluten free there are other gluten free products (e.g. pasta) which are the same price. In addition, improved food labelling and increased awareness enables people to make informed and healthy choices
- Coeliac UK now say that 40% of ICBs have stripped or reduced prescribing. Our research shows that 32% have stopped completely, 61% prescribe bread and bread mixes and 6% offer to under 18s only
- consideration was given to prescribing to under 18s only, however, Cheshire and Merseyside data shows that over 60% of gluten free prescriptions are for patients 60 years old, and therefore could be seen as discriminatory against the older population

- gluten free prescriptions are in the main received by patients who have exemptions from payment, with the majority of this being due to age (73%). Because age exemption does not take into account financial capacity, it is difficult to evidence the individual financial impact on the impacted patients.
- withdrawing prescribing has already been implemented in St Helens and part of Cheshire West and to date we are not aware of any unforeseen consequences
- ceasing ICB funded gluten free prescribing across Cheshire and Merseyside would enable achievement of a harmonised policy and remove existing unwarranted variation in access to these products based on the rationale set out in this document. In addition, it would harmonise the approach to prescribing other foods for conditions impacted by “standard” products e.g. lactose intolerance, as NHS Cheshire and Merseyside does not currently prescribe food alternatives for other food allergies / intolerances.
- a number of neighbouring ICBs including Lancashire and South Cumbria and Shropshire, Telford and Wrekin have already stopped prescribing.

5. Public Consultation Process undertaken

5.1 At the meeting of the Board held in November 2024, it was approved to commence Public Consultation based on the preferred option to cease prescribing of Bread and Break mixes to all adults and children.

5.2 NHS Cheshire and Merseyside ran a six-week public consultation from 28 January to 11 March 2025 on a proposal to stop making gluten free bread and bread mixes available on prescription.

5.3 A questionnaire and supporting information were produced. These were available online, printed/in alternative formats/languages on request. People could provide their responses over the phone, if required. Information was shared across NHS Cheshire and Merseyside channels. Partners, including GP practices and pharmacies, were sent a toolkit to help promote the consultation.

5.4 In total 1,064 people responded to the engagement questionnaire. 601 indicated they had coeliac disease. A further 57 had another diagnosed condition which requires them to follow a gluten free diet, and 229 were the parent/guardian/carer of a child with either coeliac disease or another diagnosed condition. Responses were received from people residing in each of Cheshire and Merseyside’s nine Local Authority areas.

6. Key themes and conclusions from the Public Consultation Report

6.1 Feedback has been analysed and compiled into a report by an independent organisation.

6.2 Overall, 768 respondents (78%) of 1,064 people who responded disagreed or strongly disagreed with the proposal to stop providing gluten free bread and bread mixes on prescription, compared with 20% who agreed or strongly agreed.

6.3 The report provides further detail on people's level of agreement or disagreement, broken down by different groups within the respondents. For example, the majority of those who indicated that they had coeliac disease, or another diagnosed condition requiring a gluten free diet, or who were a parent/guardian/carer for someone who did, disagreed or strongly disagreed with the proposal.

6.4 However, those respondents who stated that they didn't have coeliac disease or another diagnosed condition, and who weren't a parent/guardian/carer of someone who did, were more likely to strongly agree or agree with the proposal.

6.5 The detailed Public Consultation Report can be found within ***Appendix Two.***

7. Post Public Consultation Equality Impact Assessment (EIA)

7.1 Following the feedback received during the public consultation period, the EIA was revisited to ensure this examined some of the points raised during the process.

7.2 The EIA concluded that the proposal to cease funding for gluten free bread and bread mixes is not in of itself discriminatory as it is in line with NICE guidelines NG20, it is much more widely available in the marketplace; it is not an essential ingredient of maintaining a gluten free diet. GP services will continue to support in line with guidelines.

7.3 In addition it drew particular attention to the impact on children and young people as they have no agency to source and buy Gluten Free bread and bread mixes or plan a Gluten Free diet. This is further compounded by children who reside in low-income households or who are in care. This places significant financial constraints on families to purchase Gluten Free bread and bread mixes from the marketplace, as the costs are higher, this could impact the effective adherence to a Gluten Free diet. Furthermore, low-income families are more likely to have low levels of health literacy and could and therefore be more susceptible to not adhere to a Gluten Free diet and develop medical complications.

7.4 It is also important to acknowledge children occupy a different space to adults, in terms of both their dietary behaviours and development. Providing free prescriptions to children and vulnerable people is also supported by the following key clinical organisations:

- **British Society of Paediatric Gastroenterology, Hepatology and Nutrition (BSPGHAN):** BSPGHAN supports the provision of gluten-free

prescriptions for children diagnosed with coeliac disease. They highlight the clinical necessity and the role of these prescriptions in ensuring adherence to a strict gluten-free diet, which is crucial for managing the condition. BSPGHAN Position Paper

- **Royal College of Paediatrics and Child Health (RCPCH):** The RCPCH advocates for the provision of gluten-free prescriptions for children with coeliac disease, stressing the importance of these prescriptions in preventing nutritional deficiencies and ensuring proper growth and development. RCPCH Consultation Response
- **British Dietetic Association (BDA):** The BDA supports the continuation of gluten-free prescriptions for children, highlighting the role of dietitians in managing coeliac disease and the need for accessible gluten-free foods to ensure dietary compliance. *BDA Policy Statement*

7.5 In summary, the EIA taking account of the Public Consultation process highlighted the following recommendations for due consideration:

- the proposal to cease funding for gluten free bread and bread mixes is not in of itself discriminatory as it is in line with NICE guidelines NG20, they are much more widely available in the marketplace and they are not essential ingredients of maintaining a gluten free diet. GP services will continue to support in line with N20 guidelines.
- however, with regard to Advancing Equality of Opportunity (PSED Objective 2, above) and 'due regard' it is important that decision makers consider the impact on children and young people, disabled/ vulnerable children and adults, women, and pregnancy. Children and young people are of significant concern, as affordability, children and young people's behaviours in relation to food, their inability to source and plan GF, the increased likelihood of nonadherence to a GF diet could result in poor outcomes.
- Health Inequalities duty (s.14T); has identified that low income and low levels of health literacy will impact peoples ability to afford, source and plan GF diet. This will impact children and young people and vulnerable adults.
- Take into account the consultation feedback, specifically from primary stakeholders who expressed overwhelming rejection of the proposal. Also consider the range of concerns on clinical needs and risks, affordability, access, health literacy and supporting their children or vulnerable adults to adhere to a GF diet who are risk of dietary neglect (including all pregnant women). The practicality of determining low income and poverty is challenging.

7.6 Please refer to **Appendix Three** for the revised EIA following Public Consultation period.

8. Further options for consideration following Public Consultation and revised EIA

8.1 In addition to the original options appraisal considered by board in November 2024 (**Appendix One**), it is important that due consideration is now given as a result of the Public Consultation undertake and the revised EIA completed.

8.2 To support this, further options have been prepared **(see table 8.5)** to further mitigate the potential impact in relation to ceasing funding prescribing for gluten free bread and bread mixes.

8.3 Following review of the Public Consultation report, the revised EIA and further options provided, **the Executive Committee still recommended Option 3 as the preferred option, with a view that Board should provide due consideration to Option 4 to Prescribe to Children.**

8.4 It should be noted, that it is the intention within the new policy to have a process to enable GPs to recommend prescribing for those vulnerable adults particularly with learning difficulties and therefore may not be able to consistently source their own gluten free bread and bread mixes. In addition, any exceptional circumstances outside of the clinical policy once approved can apply for consideration within the Individual Funding Request (IFR) process.

Table 8.5 Further options for consideration following Public Consultation and revised EIA

No	Description	Outcome	EIA Feedback*	QIA Feedback*	Financial Impact
1	Do nothing ***-discounted option***	Inequity of prescribing for patients across C&M	No EIA completed	No change to current situation, but unwarranted variation across C&M	Current **annual spend of circa £547,000** will be maintained
2	NHS C&M adopt prescribing to national guidelines across all Places – ***-discounted option on the basis of affordability***	Harmonised C&M policy in line with evidence base.	In line with DHSC EIA guidance following extensive public consultation and EIA completion If not prescribed will be contrary to national published guidance, however, this EIA is now 8 years old. Minimal equality impact identified.	Equity across C&M and improves access to patients in the Places who do not currently receive prescribed gluten free goods. **Overall Risk rating: 1 Green – Low risk**	Estimated increase in spend of £130,000. **Estimated annual spend £677,000**
3	NHS C&M to withdraw prescribing across all Places **Option endorsed by Board November 2024 and consulted on.**	Harmonised C&M policy contrary to published guidance however, this is now 6 years old. This option does not consider the feedback from the consultation or the EIA, however, does support the ICB with the financial position.	Initial EIA identified a number of groups of patients who could be at risk of dietary neglect including children and vulnerable adults, females, pregnant women, families on low income Post consultation EIA: 90% of parents / guardians / carers of a child with coeliac disease or other diagnosed condition requiring a GF diet disagreed or strongly disagreed with the proposal – children & young people do not have agency to purchase or plan their own GF diet and noted the impact of malnutrition or dietary deficiencies during these formative years can have long lasting impact. In C&M the majority of patients receiving GF prescriptions are over 60yo, and consideration should also be given to these, and vulnerable adults (physical disabilities or learning difficulties / mental illness)	Withdrawal of prescribing would impact those patients who receive free prescriptions who are likely to be vulnerable due to low income, holding medical certificates which implies wider health needs and age. There is a risk in this current economic climate that people on low income would consume non-GF bread and bread mixes which could have longer term health impacts and therefore increase health inequalities. (see **Appendix 4** for QIA)	Most current spend would cease leading to an estimated saving of £547,000 with further estimated cost avoidance of £130k **Estimated annual spend £0**

No	Description	Outcome	EIA Feedback*	QIA Feedback*	Financial Impact
			Whilst it advised that the proposal was not discriminatory in itself, there would be a greater impact on patients due to financial burden and health equity (low income households who may struggle to afford gf products)	**Overall Risk rating: 4 Amber – moderate**	
4	Prescribe to under 18s only – **Board are asked to consider this as an alternative option**	Harmonised policy but only for young people. This option does take into consideration much of the feedback from the consultation and the EIA, however, does reduce the savings which would be delivered from the programme.	Post EIA consultation: The consultation feedback has outlined concerns that go significantly beyond inconvenience and support Coeliac UK argument to maintain GF prescriptions for under 18 years (25 for people with additional needs). For people with coeliac disease, a strict gluten-free diet is not a lifestyle choice but a medical necessity. Ensuring access to these products through prescriptions can help manage their condition effectively. The impact of removing GF bread and bread mixes would disadvantage children and vulnerable adults (disability) from low-income households, who are at risk of 'dietary neglect'. Children and young people have no agency to source and buy GF bread and bread mixes and plan a GF diet. See **Appendix 3** for Post Consultation EIA and **Appendix 5** for revised QIA in relation to this option.	Withdrawal of prescribing would impact those patients who receive free prescriptions who are likely to be vulnerable due to low income, holding medical certificates which implies wider health needs and age. There is a risk in this current economic climate that people on low income would consume non-GF bread and bread mixes which could have longer term health impacts and therefore increase health inequalities. Whilst this option would support younger people, they make up less than 15% of the C&M population receiving GF prescriptions.	Based on 10% of current spend **estimated annual spend would be £74.5k**
5	Prescribe to under 18yo and adults receiving income-based benefits –	Harmonised policy but only for young people and adults receiving income based benefits.	Initial EIA identified a number of groups of patients who could be at risk of dietary neglect including children and vulnerable adults,	Withdrawal of prescribing would impact those patients who receive free prescriptions who are likely	Based on 20% of current spend **estimated annual spend would be £108.5k**

No	Description	Outcome	EIA Feedback*	QIA Feedback*	Financial Impact
	not supported due to challenge of identifying the adult cohort and practicalities to implement	This option does take into consideration much of the feedback from the consultation and the EIA, however, does reduce the savings which would be delivered from the programme.	females, pregnant women, families on low income Post consultation EIA: 90% of parents / guardians / carers of a child with coeliac disease or other diagnosed condition requiring a GF diet disagreed or strongly disagreed with the proposal – children & young people do not have agency to purchase or plan their own GF diet and noted the impact of malnutrition or dietary deficiencies during these formative years can have long lasting impact. In C&M the majority of patients receiving GF prescriptions are over 60yo, and consideration should also be given to these, and vulnerable adults (physical disabilities or learning difficulties / mental illness) Whilst it advised that the proposal was not discriminatory in itself, there would be a greater impact on patients due to financial burden and health equity (low income households who may struggle to afford gf products)	to be vulnerable due to low income, holding medical certificates which implies wider health needs and age. There is a risk in this current economic climate that people on low income would consume non-GF bread and bread mixes which could have longer term health impacts and therefore increase health inequalities. Whilst this option would support younger people and those on income based benefits, they make up around 20% of the C&M population receiving GF prescriptions.	

9. Engagement and Consultation with Local Authority Health Scrutiny Function

9.1 Following Board approval at its meeting in November 2024 the ICB undertook its duty to formally engage separately with each of the Cheshire and Merseyside Local Authority Health Oversight and Scrutiny Committees (HOSC) where this proposal would impact on their local populations (eight out of the nine Local Authority areas). These meeting were the formal opportunity to inform them of the ICBs proposals, meet our duty to confirm with them the key dates for decision making and to seek their determination as to whether they thought our proposals constituted a substantial development or variation (SDV) in services, which would result in the requirement for the ICB to formally consult with the HOSC(s).

9.2 Seven of the eight HOSCs agreed the proposal constituted as an SDV and as such the Cheshire and Merseyside Joint HOSC protocol was enacted resulting in the establishment of Joint HOSC (JOSC) meetings (of the seven Local Authorities)[1] . These meetings were arranged for during April and May 2025 to enable the ICB to formally consult with and for the JOSC to scrutinise the ICBs proposals, and enable the ICB to receive feedback from the JOSC in a timely manner to inform its final recommendations to the Board. At its first meeting in April 2025[2], the Cheshire and Merseyside JOSC requested additional information of the ICB to provide answers to the queries raised throughout the engagement with the eight Local Authority HOSCs, access to the EIA, further information on any impact of having from the historic CCG decisions to withdraw prescribing in the two areas within Cheshire and Merseyside, the findings of the consultation exercise and to provide additional details.

9.3 The response to the further information requests can be found in Appendix Six which was to be considered at the JOSC meeting scheduled for 07 May 2025. Unfortunately on the 07 May 2025, following arrival and attendance to the meeting, ICB officers were informed that the meeting could not proceed due to the meeting not being quorate due to the late receipt of Councillor apologies. To help accommodate the JOSC to meet in advance of the May ICB Board meeting and to enable the ICB to receive formal feedback from the JOSC on the findings of the consultation a further meeting was agreed to be arranged on the 23 May 2025. Further information regarding the proposal and consultation findings was provided to the JOSC (Appendix Seven) to be considered at this meeting.

9.4 Unfortunately, during mid-morning of the 23 May 2025 the ICB was informed of the cancellation of the JOSC meeting, again due to the meeting being unable to be quorate due to Councillor apologies. This therefore means, despite making best efforts to undertake the formal consultation process with health scrutiny, the ICB has not received formal feedback on its proposals, other than that received during the engagement with the eight HOSC and the first meeting of the JOSC.

[1] Joint HOSC on behalf of the following 7 Councils: Cheshire East, Halton, Knowsley, Liverpool, Sefton, Warrington and Wirral.
[2] https://councillors.liverpool.gov.uk/ieListDocuments.aspx?CId=2006&MId=21479&Ver=4

9.5 On the afternoon of the 23 May 2025, the ICB did receive correspondence from Councillor Jane Corbett (Liverpool City Council), who was the appointed Chair of the JOSC considering the ICBs gluten free proposal. The correspondence below cannot be considered as the formal response of the JOSC, however it is important that the Board is sighted on the response from Councillor Corbett.

To – Cheshire and Merseyside NHS

Following considerations at individual OSCs across Cheshire & Merseyside, I was appointed Chair of the statutory joint health scrutiny committee to undertake a scrutiny on Gluten Free Prescribing.

Unfortunately for logistical reasons the Joint Committee were unable to complete its scrutiny in the timeframes you required. However I would like the following to be considered when your governance considers the future of the prescribing concerned –

Thank you for submitting the further information as requested, included in Action Responses following JOSC 16/04/2025, the Equality Impact Assessment including references to Section One of the Equality Act, the letter submitted by Coeliac UK dated 10th February 2025 and the ICB's response, and the letter sent my Connor Naismith MP on behalf of a constituent and the ICB's response.

I am very concerned that this further information highlights in greater detail the negative impact and risks to health relating to the proposal to withdraw the prescriptions for gluten free bread and bread mixes. The full EIA highlights the impact not only for the protected groups but also in relation to Section One of the Equality, the intersectionality and the accumulative negative impact across the 7 places in Cheshire & Merseyside, including the damaging long term health effects on babies and children. The high level of disadvantaged, deprivation and inequalities in Liverpool and Knowsley were highlighted.

I understand the aim of the proposal was 'to ensure a harmonised approach across Cheshire & Merseyside to prescribing food products for patients with coeliac disease and with other food intolerances / allergies'. The original intention was 'under the policy harmonisation programme, and based on the DHSC consultation and clinical opinion' was to 'reinstate prescribing for bread and bread mixes'. It is surprising therefore that instead of ensuring all 9 places receive gluten free prescribing, the proposal is to take away the gluten free prescribing across all 9 places ensuring none of the 9 places receive it.

The reasoning given for this upside down thinking is purely financial, no cost benefit analysis has been provided, however Coeliac UK in 1.2 and 1.3 of their submission have shown the long term cost to the NHS of this proposal highlighting the fact it much greater than the savings predicted to be achieved by the current proposal.

I feel that this proposal in its current form goes against the values and the principals set out within the Prof Michael Marmot's Fair Society, Health Lives Report 2010, and Build Back Fairer 2020 Report which the ICB has been proud to support and sign up to. Your own Cheshire and Merseyside and Place documents also indicate they adopt these principle and the Marmot framework.

Thank you for allowing me to submit this as Chair of the Joint Scrutiny Committee.

Councillor Jane Corbett, Sent 23.05.25

9.6 Whilst it is common practice and expectation for the receipt of formal feedback from Local Authority health scrutiny functions on NHS run public consultations to be considered as part of the evidence to help influence the final decision making consideration of an NHS Board, the Board can still make its final decision if this formal response has not been received within the decision making timeframe that has been clearly communicated to health scrutiny.

10. Recommendations

10.1 As described within the options table presented, **the Executive team have selected Option 3 as their preferred option to recommend to Board based on the need to carefully balance the needs of the population, clinical risk, and commissioning decisions to address health inequalities in the context of significant financial challenges**.

10.2 In addition, this Policy stance would be consistent a vast number of ICBs nationally (Coeliac UK now say that 40% of ICBs have stripped or reduced prescribing. Our research shows that 32% have stopped completely, 61% prescribe bread and bread mixes and 6% offer to under 18s only).

10.3 It is of note that a number of neighbouring ICBs including Lancashire and South Cumbria and Shropshire, Telford and Wrekin have already stopped prescribing.

10.4 Board members are asked to consider the additional options presented and give due consideration to the decision taking account of the Public Consultation feedback and the revised EIA document.

11. Ask of the Board Members:

11.1 **The Board members are asked to:**

- to note the work undertaken to date, the Public Consultation Feedback and the efforts made to achieve its duty and obligations to formally consult with Local Authority Health Oversight and Scrutiny Committees

- to consider the additional options provided following a period of conscientious consideration to reflect the Public Consultation feedback and re-visited EIA

- to take account of the Executive Committee's preferred option to proceed with the original proposal to cease all prescribing of Gluten Free Bread and bread mixes

- to note the risks and mitigations as described within the Options, QIA and EIA documentation

- to make a decision on a single option, to determine the Policy position for NHS Cheshire and Merseyside, so that a harmonised policy position can be implemented.

12. Appendices

ALL APPENDICES CAN BE ACCESSSED BY CLICKING HERE

Appendix One: Options Appraisal document (Original as of Board November 2024)

Appendix Two: Public Consultation Report

Appendix Three: EIA Post Public Consultation Period

Appendix Four: QIA (original as of Board November 2024 proposal)

Appendix Five: Post Public Consultation QIA to consider further option (applicable for Option 4)

Appendix Six: Response to Information Requests from C&M JOSC for meeting of 07 May 2025

Appendix Seven: Expanded Briefing report to C&M JOSC for meeting of 23 May 2025

Appendix One

Proposal for ICB funded Gluten Free products Prescribing across Cheshire and Merseyside

ICB Board 28th November 2024

Contents

Glossary

Term	Definition
Coeliac Disease	Coeliac disease is a lifelong autoimmune disease caused by a reaction to gluten. Once diagnosed, it is treated by following a gluten free diet for life
Gluten	Gluten is a protein found in wheat, rye and barley.

1 Executive Summary

Currently NHS Cheshire and Merseyside has unwarranted variation in the prescribing of gluten free products across all Places. St Helens CCG and Cheshire West CCG opted to withdraw prescribing completely (to note the footprint previously under Vale Royal CCG within Cheshire West Place still undertake some prescribing) prior to the national Department of Health and Social Care (DHSC) consultation the outcome of which was to reduce prescribing to bread and bread mixes only in 2018.

In Cheshire and Merseyside, over 13,300 patients have a diagnosis of coeliac disease or other conditions which requires management through a gluten free diet. Most people choose to purchase their gluten free foods at supermarkets or other retailers however 2,314 patients receive their gluten free foods via prescription. It should be noted that of the prescriptions issued, 99% are exempt from prescription charges, with 73% being due to age (under 16 or 18 if in full time education, or over 60 years old) and over 60% of these being over the age of 60.

Under the Unwarranted Variation Recovery programme, a number of options were considered in order to address the unwarranted variation, but the 2 main options were to either fully prescribe across Cheshire and Merseyside at an estimated additional cost of £130k per year (increase annual spend on the service of c.£655k) or to withdraw prescribing completely offering an estimated annual saving of £525k.

Initially the review of the current gluten free prescribing policies was carried out under the Clinical Policy Harmonisation programme and involved a clinical working group who recommended reinstating prescribing across all of Cheshire and Merseyside which is in line with the DHSC consultation outcome. However, this position was not supported by our Finance, Investments and Resources Committee due to the financial challenges faced by NHS Cheshire and Merseyside.

In the context of the financial challenge facing NHS Cheshire and Merseyside, the Unwarranted Variation programme has reviewed all options and are proposing that gluten free prescribing is stopped due to the following rationale:

- Availability of gluten free foods is much greater than it was when the original policies were implemented, and in the six years since the DHSC consultation. It should also be noted that bread is not classed as an essential food item and people can maintain a healthy diet without bread through choosing naturally gluten free foods.
- Whilst the cost of gluten free bread is still more expensive than non-gluten free there are other products (e.g. pasta) which are the same price. In addition, improved food labelling and increased awareness enables people to make informed and healthy choices.
- Coeliac UK now say that 40% of ICBs have stopped or reduced prescribing, our research shows that 32% have stopped completely, 61% prescribe bread and bread mixes and 6% offering to under 18s only.
- Consideration was given to prescribing to under 18s only, however, C&M data shows that over 60% of the population receiving prescriptions are over 60 years and therefore could be seen as discriminatory against the older population.
- Gluten free products are in the main received by patients who have exemptions from payment, with the majority of this being due to age (73%) and because exemption does not take into account financial capacity, it is difficult to evidence the individual financial impact on the impacted patients.
- Withdrawing prescribing has already been implemented in St Helens and part of Cheshire West and to date we are not aware of any unforeseen consequences.
- NHS Cheshire and Merseyside do not currently prescribe food alternatives for other food allergy / intolerances e.g. lactose intolerance.
- A number of our ICB neighbours including Lancashire and South Cumbria and Shropshire, Telford and Wrekin have already stopped prescribing.

A decision to withdraw gluten free prescribing would require a public consultation in 8 of the 9 Places including engagement with our Local Authority colleagues through Oversight and Scrutiny committees.

The options appraisal paper was initially discussed with the Associate Directors of Quality where the proposal was acknowledged and supported for progression. It was subsequently presented to the Recovery Committee on 16th September and was then considered by the Strategy and Transformation (S&T) committee at the meeting on 19th September. The S&T committee supported the recommendation to present the preferred option, to cease prescribing to the Board for approval to progress to a public consultation to inform the final decision.

It is of note that the options appraisal was also reviewed and considered by the Clinical Effectiveness Group on 2nd October and the group supported progress of the proposed option to withdraw prescribing across Cheshire and Merseyside.

The Board is asked to approve the recommendation to progress a proposal for a non-prescribing option for gluten free bread and bread mixes in order to commence a public consultation starting in January 2025. The feedback from this exercise, together with that of our Oversight and Scrutiny Committees will inform the decision whether to continue with this recommended option. In addition, the Board is asked to receive the feedback from this exercise at the first available board meeting.

2 Background

Currently NHS Cheshire and Merseyside has unwarranted variation in the prescribing of gluten free products across all Places. St Helens CCG and Cheshire West CCG opted to withdraw prescribing completely prior to the national Department of Health and Social Care (DHSC) consultation the outcome of which was to reduce prescribing to bread and bread mixes only in 2018. Further information about this consultation and the revised regulation subsequently put in place is available on the NHS England website (NHS England » Prescribing Gluten-Free foods in Primary Care: Guidance for Clinical Commissioning Groups – frequently asked questions). For Cheshire West Place, the area that was covered by the former Vale Royal CCG did not opt to withdraw prescribing, and as such there are still part of Cheshire West were prescribing can be undertaken (Winsford, Northwich, Middlewich and surrounding area).

Coeliac disease is an autoimmune condition associated with chronic inflammation of the small intestine, which can lead to malabsorption of nutrients. Population screening studies suggest that in the UK 1 in 100 people are affected. The complications of coeliac disease (which may or may not be present at diagnosis) can include osteoporosis, ulcerative jejunitis, malignancy (intestinal lymphoma), functional hyposplenism, vitamin D deficiency and iron deficiency. People with conditions such as type 1 diabetes, autoimmune thyroid disease, Down's syndrome and Turner syndrome are at a higher risk than the general population of having coeliac disease. First-degree relatives of a person with coeliac disease also have an increased likelihood of having coeliac disease.

Management of coeliac disease is a lifelong GF diet. Historically, availability of GF foods was limited and expensive, so patients obtained these products via prescribing, however, all major supermarkets now commonly stock a wide range of GF foods and the price differential is reducing as demand grows. It should be noted that there have been a number of recent national news articles on the higher cost of these “free from” alternatives and the impact of withdrawing prescribing in context of cost-of-living increases.

Initially the former CCGs gluten free prescribing policies were reviewed as part of the Clinical Policy Harmonisation programme and involved a clinical working group who recommended to reinstate prescribing across all of Cheshire and Merseyside in line with the DHSC consultation outcome.

However, as this would result in additional annual expenditure of C.£130k, this position was not supported by our Finance, Investments and Resources Committee due to the financial challenges faced by NHS Cheshire and Merseyside

The review was then progressed under the Unwarranted Variation programme and the non-prescribing option was considered in context of the patient safety risks, and the requirement to support NHS Cheshire and Merseyside to deliver the financial objectives of the Recovery Programme.

It is difficult to evidence the impact of stopping GF prescriptions and understanding whether the impacted patients would continue to follow a GF diet. Whilst there are known risks to not adhering to a GF diet, which could have long term health impacts and lead to greater demand on wider health services, there is greater availability of GF foods in supermarkets and other retailers, improved food labelling and greater awareness of the impact of non-adherence, which all support the patient to make good food choices for a healthy diet.

The options appraisal paper was initially discussed with the Associate Directors of Quality where the proposal was acknowledged and supported. It was subsequently presented to the Recovery Committee on 16th September and was then considered by the Strategy and Transformation (S&T) committee at the meeting on 19th September. The S&T committee supported the recommendation to present the preferred option, to cease prescribing to the Board and that we progress to a public consultation to inform the outcome. In addition, the Clinical Effectiveness Group also supported progression of the proposed option on 2nd October.

3 Approach

The gluten free prescribing policy was initially reviewed under the Clinical Policy Harmonisation Programme (CPH) the objective of which was to review existing policies and the latest evidence base to recommend a single set of policies which would enable all patients to have equitable access. The review of the gluten free prescribing policy focused on the published evidence base DH&SC and Coeliac UK recommendations with input from clinicians, dieticians and pharmacists and was led by the CPH Steering Group which includes commissioners, GP, Pharmacist and public health leads. An options appraisal was carried out to consider a number of options to harmonise the prescribing position and an EIA and QIA were developed to consider all options. Therefore, the option to continue with the current arrangements was discounted.

The CPH programme recommended that the harmonised policy be to implement gluten free prescribing in accordance with DHSC guideline, however, this comes at an additional annual cost of C.£130k and this was not able to be supported by the Finance, Investment and Resources Committee at the time. It is of note that this work was placed on hold, due to the financial pressures and pre-election activity so it was brought into the scope of the Reducing Unwarranted Variation Recovery Programme (noting that 3 members are consistent with the previous Clinical Policy Steering Group) and review has also been completed by the Deputy Medical Director and Clinical Lead for Reducing Unwarranted Variation (RUV) Programme.

In the context of the ICB financial recovery plan, the RUV programme carried out a further review which considered Cheshire and Merseyside data, prices and availability of GF foods in supermarkets and other retailers, both instore and on-line, improvements in food labelling and increased information via websites on how to maintain a GF diet. Following discussions on these findings with Place Clinical Directors and Associate Directors of Quality, the Reducing Unwarranted Variation Steering group **is recommending as a financial decision, prescribing is stopped across Cheshire and Merseyside** and this view is supported by the Deputy Medical Director and Programme Clinical Lead.

The group recognised that this goes against the latest published guidance, however, it should be noted that this is now 6 years old, and this is not a medicine or prescription for an essential food item (as it is for bread or bread mixes only). In addition, the group noted that this is a similar stance as taken with other food allergies / intolerances and dietary requirements where we do not offer alternative food items by prescription and increasing affordable gluten free products are available at supermarkets. This

recommendation would result in a financial saving of circa. £525k and avoid additional expenditure of £130k.

3.1 Current Cheshire and Merseyside Activity and Spend on Gluten Free Prescribing

Across Cheshire and Merseyside, 8 Places still have a Policy that includes GF prescribing at an annual cost of circa £525k for the year 2023/2024. Prior to the establishment of the ICB, two of the former CCGs (St Helens and West Cheshire) withdrew GF prescribing as a cost cutting policy, although it is of note that GP practices in the former Vale Royal CCG footprint still prescribe as shown within the table below.

Cheshire and Merseyside - Gluten Free Prescribing 2023/24

Row Labels	Sum of Items	Sum of Actual Cost	Weighted Pop	per 1,000 Wtd Pop. Items	per 1,000 Wtd Pop. Actual Cost
Sefton	3816	£87,559	310666	12.28	£281.84
CHESHIRE EAST	4909	£97,731	429865	11.42	£227.35
Knowsley	2156	£46,220	196251	10.99	£235.52
Halton	1551	£32,413	149417	10.38	£216.93
Wirral	3724	£77,017	385940	9.65	£199.56
Liverpool	5953	£122,669	646320	9.21	£189.80
Warrington	1953	£41,160	232237	8.41	£177.23
CHESHIRE WEST & CHESTER	939	£19,396	410116	2.29	£47.29
St Helens	20	£413	231122	0.09	£1.79
Grand Total	**25021**	**£524,579**	**2991933**	**8.36**	**£175.33**

Gluten Free Prescribing Exemption in Cheshire and Merseyside

In Cheshire and Merseyside over 13,300 patients have a diagnosis of coeliac disease, with only 17.4% (2,314) receiving prescription gluten free food.

The table below details the breakdown of GF prescriptions across Cheshire and Merseyside and shows that 99% of prescriptions issued are currently exempt from prescription charges.

	Chargeable at Current Rate		Exempt	
Row Labels	Number of Items	Proportion	Number of Iter	Proportion
Cheshire East	21	1.03%	2020	98.97%
Cheshire West	11	2.72%	393	97.28%
Halton	6	0.93%	637	99.07%
Knowsley	5	0.57%	869	99.43%
Liverpool	24	0.96%	2465	99.04%
Sefton	5	0.32%	1556	99.68%
St Helens		0.00%	10	100.00%
Warrington	6	0.76%	785	99.24%
Wirral	14	0.93%	1488	99.07%
Cheshire and Merseyside	92	0.89%	10223	99.11%

Of these exemptions, 73% is due to age (under 16 or 18 if in full time education, or over 60 years old), with the majority being over the age of 60.

According to Coeliac UK, most people are diagnosed from 50 years old and coeliac disease is most common in people aged between 50-69 years old.

	Exempt	
Row Labels	Number of Items	Proportion
Aged 60 Or Over	6253	61.17%
No Declaration/Declaration Not Specific	1950	19.07%
Under 16 / Aged 60 Or Over	898	8.78%
Pre-Payment Certificate	315	3.08%
Aged 16-18 And In Full Time Education	311	3.04%
Medical Exemption	287	2.81%
Income Support	87	0.85%
Universal Credit	64	0.63%
HC2 Charges	19	0.19%
NHS Tax Credit Exemption Certificate	19	0.19%
Maternity Exemption	15	0.15%
Income Based Job-seekers Allowance	3	0.03%
HRT Pre-payment Certificate	1	0.01%
Pension Guarantee Credit	1	0.01%
Unassigned		0.00%

3.2 Current Prescribing Approaches across England (where available)

Coeliac UK state that 40% of ICBs have stopped or reduced prescribing. Where the information was published, our research shows that 32% have stopped completely with 61% prescribing bread and bread mixes, 6% prescribing to under 18s only and 6% prescribe bread only. (see appendix E).

The table below shows the policy stance of local ICBs:

Prescribe bread & bread mixes	Do not prescribe – all ages
• Greater Manchester – all ages • Staffordshire – for those under age of 18 only	• Lancashire and South Cumbria • Shropshire, Telford and Wrekin

3.3 Guiding principles:

- To reduce unwarranted variation and harmonise access to services across Cheshire and Merseyside.
- Use the latest evidence base to develop harmonised policies
- Consider sustainability of Cheshire and Merseyside ICB in context of financial requirements

3.4 Strategic Context

The main objectives identified are:

Objective 1	
Objective	Tackling health inequality, improving outcomes and access to services
Current Arrangement	7* of 9 Places currently offer gluten free prescribing in line with the national Department of Health and Social Care (DHSC) consultation the outcome of which was to reduce prescribing to bread and bread mixes only in 2018. It is of note that for the remaining 2 Places, St Helens CCG and Cheshire West CCG opted to withdraw prescribing completely (noting this was prior to the national Department of Health and Social Care (DHSC) consultation as detailed above). *For Cheshire West Place, the area that was covered by the former Vale Royal CCG did not opt to withdraw prescribing, and as such there are still part of Cheshire West were prescribing can be undertaken (Winsford, Northwich, Middlewich and surrounding area). In addition, there are other patients who are diagnosed with food related allergies / intolerance conditions who do not receive prescriptions to manage their diet and therefore could be argued that those patients are disadvantaged by a prescribing option.
Gap/Business Needs	In order to harmonise the position across C&M, there are 2 options, one to implement prescribing across all 9 Places at a potential additional cost of £130k per year; a total estimated cost of £655k per year or to withdraw prescribing across all 9 places at a potential saving of £525k per year.
Objective 2	
Objective	Enhancing quality, productivity and value for money
Current Arrangement	7* of 9 Places currently offer gluten free prescribing in line with the national Department of Health and Social Care (DHSC) consultation the outcome of which was to reduce prescribing to bread and bread mixes only in 2018. It is of note that for the remaining 2 Places, St Helens CCG and Cheshire West CCG opted to withdraw prescribing completely (noting this was prior to the national Department of Health and Social Care (DHSC) consultation as detailed above).

	*For Cheshire West Place, the area that was covered by the former Vale Royal CCG did not opt to withdraw prescribing, and as such there are still part of Cheshire West were prescribing can be undertaken (Winsford, Northwich, Middlewich and surrounding area). In addition, there are other patients who are diagnosed with food related allergies / intolerance conditions who do not receive prescriptions to manage their diet and therefore could be argued that those patients are disadvantaged by a prescribing option. There is a risk to patient safety if patients do not follow a GF diet (quality) and potential impact on wider services in the future.
Gap/Business Needs	In order to harmonise the position across C&M, there are 2 options, one to implement prescribing across all 9 Places at a potential additional cost of £130k per year; a total estimated cost of £655k per year or to withdraw prescribing across all 9 places at a potential saving of £525k per year.

4 Options and considerations

No	Description	Outcome	EIA Feedback*	QIA Feedback*	Financial Impact
1	Do nothing ***-discounted option***	Inequity of prescribing for patients across C&M	No EIA completed	No change to current situation, but unwarranted variation across C&M	Current **annual spend of circa £525,000** will be maintained
2	NHS C&M adopt prescribing to national guidelines across all Places	Harmonised C&M policy in line with evidence base. Public involvement exercise could be minimal as there has already been a full consultation by DHSC.	In line with DHSC EIA guidance following extensive public consultation and EIA completion (see appendix F). If not prescribed will be contrary to national published guidance, however, this EIA is now 8 years old. Minimal equality impact identified. (see appendix A)	Equity across C&M and improves access to patients in the Places who do not currently receive prescribed gluten free goods. **Overall Risk rating: 1 Green – Low risk** (see appendix B)	Estimated increase in spend of £130,000. **Estimated annual spend £655,000**
3	NHS C&M to withdraw prescribing across all Places	Harmonised C&M policy contrary to published guidance however, this is now 6 years old. Public consultation exercise would be required in 8 Places	A number of groups of patients could be at risk of dietary neglect as clear links were identified between: - age (those aged under 16, those aged 16, 17 and 18 in full time education, and those aged 60 or over are eligible for prescription exemptions) - Gender (reported cases of coeliac disease are two to three times higher in women than men), -pregnancy and maternity (e.g. Poorly controlled coeliac disease in pregnancy can increase the risk of developing pregnancy-related complications) (see appendix C)	Withdrawal of prescribing would impact those patients who receive free prescriptions who are likely to be vulnerable due to low income, holding medical certificates which implies wider health needs and age. There is a risk in this current economic climate that people on low income would consume non-GF bread and bread mixes which could have longer term health impacts and therefore increase health inequalities. (see appendix D)	Most current spend would cease leading to an estimated saving of £525,000 with further estimated cost avoidance of £130k **Estimated annual spend £0**

			- Families on low income (due to eligibility for exemptions from prescription charges)	**Overall Risk rating: 4 Amber – moderate**	
4	Prescribe to under 18s only – ***discounted option***	Harmonised policy but only for young people, therefore inequity of access for patients across C&M. Public consultation would be required in all 9 Places.	This option is against published guidelines (& this would benefit less than 15% of the C&M population receiving GF prescriptions). A number of groups of patients could be at risk of dietary neglect as clear links were identified between: - age and in particular those aged 60 or over are eligible for prescription exemptions - Children and young people are not financially independent so this option would support them to adhere to a GF diet - Gender (reported cases of coeliac disease are two to three times higher in women than men), -pregnancy and maternity (e.g. Poorly controlled coeliac disease in pregnancy can increase the risk of developing pregnancy-related complications) - Families on low income (due to eligibility for exemptions from prescription charges)	Withdrawal of prescribing would impact those patients who receive free prescriptions who are likely to be vulnerable due to low income, holding medical certificates which implies wider health needs and age. There is a risk in this current economic climate that people on low income would consume non-GF bread and bread mixes which could have longer term health impacts and therefore increase health inequalities. Whilst this option would support younger people, they make up less than 15% of the C&M population receiving GF prescriptions.	Based on 10% of current spend estimated costs would be £50,000 - £60,000 per annum. This results in a saving of £465,000 - £475,000

4.1 Risks, Constraints & Dependencies

The following risks, constraints and dependencies have been highlighted as part of the development of the case for change.

Risks

The following risks have been identified with the achievement of the programme outcomes:

Risk	Mitigating actions
It is difficult to evidence the impact of Coeliac patients not being able to access Gluten Free (GF) bread and bread mixes, but there are known risks to not adhering to a GF diet which could have long term health impacts and lead to greater demand on wider health services. An example given by Coeliac UK states it costs £195 a year per patient to support GF on prescription, but the average cost to the NHS of an osteoporotic hip fracture is £27,000.	A published DHSC Impact Assessment examines the issue of adherence in detail and concludes that adherence to a GF diet cannot be isolated to any single cause. Evidence shows that many factors are at play including product labelling, cost and information when eating out and managing social occasions. Adherence requires a range of knowledge and skills to avoid all sources of gluten. Gluten free foods are now much more readily available in supermarkets, with clear gluten free labelling. It should be noted that although GF bread and bread mixes are still more expensive the cost of these products has been reducing over time and there are other GF foods at comparable prices to standard foods for example 500g of GF pasta being the same price as 500g of standard pasta. It is also worth noting that bread is not an essential food item and there are many naturally free GF foods e.g. potatoes, rice. If the option to stop prescribing was accepted, signposting on how to adhere to a gluten free diet would be made available on the ICB website and GPs would continue to monitor these patients as usual. Also engagement with supermarkets in Cheshire and Merseyside would be undertaken to advise of the change in prescribing with a request for them to manage their stock levels accordingly.
Risk	**Mitigating actions**
There is a reputational risk to the ICB if the option to withdraw prescribing is accepted. Due to the current cost of living, there have been a number of national articles on the increased cost of “free from” foods despite them being much more available. In addition, 99% of the cohort of patients receiving prescriptions have an exemption in that they do not pay for prescriptions so	The ICB does not prescribe for other conditions that are associated with, or affected by the types of food they eat, so this would result in a fairer approach for these patients. A public consultation exercise would be held in those Places who currently prescribe in line with the approach in St Helens and the relevant area of Cheshire West.

could be seen that we are targeting our most vulnerable population.	
If the option to re-instate prescribing is accepted, there is a financial risk to the ICB in that an additional £130k per year would be required to support this, meaning an estimated annual spend of £655k. This may result in other critical funded services not being funded as a consequence of the further cost pressure.	Place based Medicines Management teams would review prescribing quantities to ensure they are in line with Coeliac UK guidance. This may mitigate some of the cost. Noting that this option is not the recommended option of the Reducing Unwarranted Variation Steering Group.

Constraints

- The review is being undertaken in context of the recovery programmes.
- Due to the significance of the change, a public consultation exercise would be required if any option to withdraw prescribing was accepted. In addition, it would be necessary to engage and consult with the Oversight and Scrutiny Committees in all affected Places. A Joint OSC meeting would need to be formed, composed of the Local Authorities where the population would be impacted. The availability and timing of these meeting would be largely dictated by the Local Authorities. This would impact the timing of benefits delivery.
- Engagement/communication would also be required with local MPs.
- Consideration is needed regarding any delays to benefits delivery caused by the potential for 'call in' to the SoS for Health & Care of any proposed service change – members of the public or organisations can write to the Secretary of State at any stage of the process.

Dependencies

- NHS Cheshire and Merseyside's communications and engagement team is currently focused on a number of pieces of public involvement work. Any public involvement requirements around gluten-free prescribing will need to be considered alongside existing work plans.
- Public involvement activity has resource implications. It is standard practice to commission independent analysis and reporting of feedback from public consultation, aside from any additional requirements around delivery of consultation activity. There is a need to scope out the requirements and identify the necessary budget.

5 Options Appraisal and Financial Case

For completeness a range of options have been considered as part of the case for change, a brief description of full range of options is below:

Option 1: Do nothing – 8 of 9 Places prescribe GF products, St Helens and part of Cheshire West do not prescribe (Option discounted)

Pros	Cons
• The financial position of the ICB does not change.	• There is unwarranted variation across Cheshire and Merseyside in unequal access to GF bread and bread mixes for our patients. • There is an increased risk of challenge by Equalities and Human Rights commission re inequality in service access. • Financial impact remains at circa £525k per annum.

Option 2: Implement Prescribing of bread and bread mixes across whole of Cheshire and Merseyside

Pros	Cons
• Harmonised access to GF bread and bread mixes across C&M • In line with evidence base • Supported by Quality and EDI Teams and Clinicians • Review of the quantities prescribed in each Place could mitigate the additional cost	• Additional estimated annual cost of £130k making a total of estimated annual cost £655k per annum • This may impact the ability to support other areas of need due to financial constraints across the Integrated Care System. • There are other patients who suffer from other food allergies or intolerances who do not receive prescribed food goods, this option could be seen as increasing inequity for these patients.

Proposed next steps and estimated timeframe for Option 2:

1) Recovery Committee (September 16th) and Strategy & Transformation Committee (STC) (19th September) supported recommendation to withdraw prescribing
2) The recommendation from STC to be considered and decision to be ratified by Board – 28th November 24
3) Public Involvement exercise in St Helens and Cheshire (West Vale Royal GP Practices) (working assumption is this would be a communications exercise)
4) Harmonised policy to be launched across all Places – no change for 8 of 9 – December 24

Option 3: Withdraw Prescribing across whole of Cheshire and Merseyside

Pros	Cons
• Harmonised access to GF products across C&M • Financial benefit to the ICB of £525k per annum • Increased fairness in prescribing policies as NHS does not provide food on prescription for other groups of patients who conditions are associated with, or affected by, the type of food they eat.	• Contrary to the latest published guidance, however, this is now 8 years old and the prices of GF goods have been reducing, therefore would be purely financial rationale • Concerns identified through the EIA and QIA process particularly around the impact on vulnerable patients (particularly age) and for those patients on low income the risk of increasing health inequalities. • Consultation required in 8 places. Time delay and potential cost to develop outcomes report. • Risk of negative publicity for ICB particularly in local press. • Increased risk of challenge by EHRC (as per above) • Increased risk of judicial review raised by individuals/organisations

Proposed next steps and estimated timeframe for Option 3:

1) Recovery Committee (September 16th and Strategy & Transformation Committee (19th September) support recommendation
2) Public consultation plan and materials to be developed.
3) The preferred option (subject to public consultation), and public consultation plan, to be approved by Board – 28th November 24
4) Public consultation exercise 8 weeks (subject to further discussion around timings and resources) – January 25 to February 25
5) Feedback and analysis report on consultation completed (approx. 4 weeks required) – March 25
6) Engagement with OSC on feedback from consultation exercise – to be confirmed
7) Feedback on consultation exercise presented to Board. Board asked to decide on whether to proceed with no GF prescribing approach – to be confirmed
8) Feedback on consultation exercise and Board decision presented to OSC - TBC
9) Subject to outcomes of public consultation and final decision-making, policy launch & benefits realisation start – to be confirmed

Option 4: Prescribe to under 18s only (Option discounted)

Pros	Cons
• Harmonised approach to prescribing of GF bread and bread mixes across C&M • Financial benefit to the ICB of £465,000 - £475,000 per annum • Would support the younger coeliac patients to follow a correct diet until adulthood.	• Contrary to evidence base • Concerns identified through the EIA and QIA process around the impact on vulnerable patients particularly age (as over 60% of issued GF prescriptions are due to patients being aged 60+) and for those adult patients on low income as there is a risk of increasing health inequalities • Would require public engagement in all 9 Places • Risk of negative publicity for ICB particularly in local press. • This option does not provide a service for the majority of patients who are currently receiving GF prescriptions (15% under 19yo) • Increased risk of challenge by EHRC (as per above) • Increased risk of judicial review raised by individuals/organisations

5.1 Financial Case: Following the initial options assessment, Options 1 and 4 have been discounted.

Options	Description (*Committed costs)	Non-recurrent Year 1	Non-recurrent Year 2	Recurrent costs (Annual)	Comments
Option 1: Do nothing – 8 of 9 Places prescribe GF products, St Helens and part of Cheshire West do not	£525,000	£525,000	£530,000	£538,000 (yr 3)	Based on ONS population growth projection
Option 2: Implement Prescribing across whole of Cheshire and Merseyside	£650,000	£650,000	£661,700	£672,287 (yr 3)	Based on ONS population growth projection, however, could increase if cost of products or activity increases. Place prescribing Teams would also review prescribing quantities to ensure all in line with guidance.
Option 3: Withdraw Prescribing across whole of Cheshire and Merseyside	-£525,000	-£525,000	-£525,000	-£525,000	Provides a consistent approach to prescribing for food intolerances. Whilst this does not adhere to published guidance, this is now 6 years old. It is of note that the £525k is a cash releasing saving with a further cost avoidance of £130k.
Option 4: Prescribe to under 18s only	-£465,000 - £475,000	-£465,000 - £475,000	-£465,000 - £475,000	-£465,000 - £475,000	Not in line with published guidance and does not reflect the need of C&M demographics

6 Recommendation

In the context of the Recovery Programme and following further review and the formation of this options appraisal, the Reducing Unwarranted Variation Steering Group recommend the progression to public consultation of option 3, to withdraw prescribing of bread and bread mixes. This recommendation has also been discussed by the Deputy Medical Director and Associate Directors of Quality, and also with the Clinical Effectiveness Group who also support based on the QIA risk scores and EIA.

The context of this recommendation is that availability of GF foods has increased since the original policies were implemented, and whilst the cost of GF bread and bread mixes is still higher, some GF products (e.g. pasta) is the same price. Food labelling is much improved supporting patients to make healthy choices, and in addition, this is not a prescribed medication and bread and bread mixes are not considered an essential food item.

In addition, the withdrawal of prescribing of GF foods has already been implemented in St Helens and part of Cheshire West and so far, we are unaware of any unforeseen consequences; and NHS Cheshire and Merseyside do not prescribe products for other food alternatives for other food allergy / intolerances.

It should be noted that 99% of GF prescriptions issued are subject to payment exemption, the reason for the majority (73%) is that of age. A number of our ICB neighbours including Lancashire and South Cumbria and Shropshire, Telford and Wrekin have already stopped prescribing.

In accordance with the framework methodology established as part of the decommissioning policy, this has been undertaken for Gluten Free prescribing and the output is as follows:

The combined impact of the individual criterion scores, when put through the Prioritisation Framework tool is an overall score of 4.86. This equates to an overall assessment of “Consider Decommission / discontinue” indicating that this investment carries a relatively low priority within the context of financial recovery. (see appendix G).

The options appraisal paper was initially discussed with the Associate Directors of Quality where the proposal was acknowledged and supported. It was subsequently presented to the Recovery Committee on 16th September and was then considered by the Strategy and Transformation (S&T) committee at the meeting on 19th September. The S&T committee supported the recommendation to present the preferred option, to cease prescribing to the Board and that we progress to a public consultation to inform the outcome.
The recommendation to withdraw prescribing is also supported by the Recovery Committee and the Strategy and Transformation Sub-Committee based on the financial case and the QIA and EIA feedback. It is of note that the options appraisal was also reviewed and considered by the Clinical Effectiveness Group on 2nd October and the group supported progress of the proposed option to withdraw prescribing across Cheshire and Merseyside.

6.1 The Ask:

The Board are asked to:

- **approve** the recommendation put forward by the Reducing Unwarranted Variation Steering Group and supported by the Recovery Committee and Strategy and Transformation sub-committee to progress a proposal for a non-prescribing option for gluten free bread and bread mixes in order to commence a public consultation starting in January 2025. The feedback from this exercise, together with that of our Oversight and Scrutiny Committees will inform the decision whether to continue with this recommended option.

Appendices

Appendix A – EIA for option 2 – prescribe across all Places

Appendix A EIA Clin070 GlutenFree S

Appendix B – EIA for option 3 – stop prescribing across all Places

Appendix%20B%20revised%20EIA%20Glut

Appendix C – QIA for option 2 -– prescribe across all Places

Appendix%20C%20CM%20ICB%20QIA%2(

Appendix D – QIA for option 3 – stop prescribing across all Places

Appendix%20D%20NHS%20Cheshire%20a

Appendix E – National Gluten Free Prescribing Offers (where available)

Appendix%20E%20England%20prescribin

Appendix F – DHSC EIA

Appendix F
Equality_impact_asses

Appendix G – NHC C&M Decommissioning Framework review

Appendix%20Ga%20
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Public consultation on stopping NHS prescriptions for gluten free bread and bread mixes in Cheshire and Merseyside

Report of Findings

Report Prepared for:

NHS Cheshire and Merseyside

By:

Praxis Evaluation and Research Community Interest Company

April 2025.

CONTENTS

MAIN FINDINGS

TABLES

APPENDICES

1.0 Introduction

In January 2025, NHS Cheshire and Merseyside Integrated Care Board (ICB) commenced a six-week public consultation about proposed changes to gluten free prescribing across Cheshire and Merseyside.

Praxis CIC (Community Interest Company) was appointed to analyse the feedback received during the public consultation and produce a report which could be used to inform final decision-making.

2.0 Public Consultation

What is being proposed?

NHS Cheshire and Merseyside is proposing that in the future, gluten free bread and bread mixes are no longer available on NHS prescription. This would mean that GPs wouldn't be able to prescribe them, so if people wanted them, they would need to buy these products themselves. If the change went ahead, it would apply to all areas of Cheshire and Merseyside, and to both adults and children.

Why is this change being proposed?

In the public consultation, NHS Cheshire and Merseyside set out four key reasons why it is proposing this change:

- To achieve consistency across different areas
- The need for the NHS to achieve value for money
- The increased availability of gluten free products
- The fact that bread and bread mixes are not the only way for people to get essential nutrients into their diet

Further detail is available in the supporting information produced for the public consultation, which is shown in appendix 22.

3.0 Consultation Methodology

NHS Cheshire and Merseyside produced supporting information about the proposal, which provided background to the issue, and included details of who would be likely to be impacted and how.

The information was accompanied by a questionnaire (appendix 23) containing both qualitative and quantitative questions, designed to gather people's views and perspectives on the proposals. Both the information and questionnaire were also made available in Easy Read format.

All materials were available on the NHS Cheshire and Merseyside website, with printed versions and alternative formats/languages available on request (via email or telephone). During the consultation period NHS Cheshire and Merseyside webpage received 2,376 page views. By email, 15 enquiries were received. People who were unable to complete the questionnaire had the option to provide their feedback over the telephone.

The consultation was promoted across NHS Cheshire and Merseyside's internal and external communication channels. Wider partners and stakeholders, including providers of

NHS services (hospitals, community and mental health providers and primary care), local authorities, Healthwatch, and voluntary, community, faith and social enterprise (VCFSE) organisations, were asked to share information using their own channels, utilising a toolkit produced for this purpose.

To ensure that those who would be most impacted by any potential change had an opportunity to share their views, NHS Cheshire and Merseyside put a particular focus on asking colleagues in general practice and local pharmacies to share information about the consultation with those who currently receive gluten free bread and bread mixes on prescription.

Analysis and Reporting

NHS Cheshire and Merseyside commissioned Praxis CIC to support analysis and reporting, based on the following requirements:

a) Analysis and reporting of responses to the consultation questionnaire addressing the engagement objectives set out above, and any differing views/needs expressed by particular groups, including equalities groups. All data was provided as a single Excel dataset. Closed questions were analysed descriptively and statistically where relevant and possible. Open questions were analysed qualitatively – and where possible undertaking a thematic analysis of the responses.

b) As part of this consultation there was a need to understand any equalities implications by exploring information presented by groups with protected characteristics. This required responses to be cross tabulated with each protected characteristic to better understand any differences of view. This is clearly identified in the report of findings to inform development of a full Equalities Impact Assessment.

c) During the consultation further feedback was received from members of the public via email to NHS Cheshire and Merseyside, a local MP on behalf of their constituent and a written response from Coeliac UK. The feedback is not included in this report but has been shared with the NHS Cheshire and Merseyside programme team leading on work around gluten free prescribing, to review and take into consideration when submitting final papers to the Board of NHS Cheshire and Merseyside.

d) The profile of respondents' indication of their interest in this consultation are shown in Tables 1 to 5 in the appendices.

4.0 Summary

A. Profile of the respondents

4.1 The analysis was based on a total sample size of 1064 respondents to the questionnaire.

4.2 601 respondents defined themselves as having coeliac disease. 77% of this sample were female and 20% male. 50% were under 54 and 50% were 55 and over.

4.3 57 respondents had another diagnosed condition which required them to follow a gluten free diet.

4.4 229 respondents were a parent/guardian/carer of a child with coeliac disease, or another diagnosed condition that required them to follow a gluten free diet.

4.5 63 respondents were a carer of an adult with coeliac disease, or another diagnosed condition which required them to follow a gluten free diet.

4.6 Of the 620 respondents who answered the question about whether they got their gluten free bread and/or bread mixes on NHS prescription 61% (379) said yes, 37% (227) said no and 2% preferred not to provide an answer.

4.7 Of the respondents who said they got their gluten free bread and/or bread mixes on NHS prescription 47% said they paid for their prescription and 50% said they did not pay for their prescription. 3% preferred not to provide an answer.

4.8 69% of parents, guardians or carers of a child or an adult with coeliac disease or another diagnosed condition which requires them to follow a gluten free diet got their gluten free bread and/or bread mixes on prescription. 28% of respondents did not and 3% preferred not to provide an answer.

4.9 23% of parents, guardians or carers of a child or an adult with coeliac disease pay for their prescription. 74% don't and 3% preferred not to say.

B. Opinions of the respondents

4.10 Of the total sample of 1064 respondents (including those with a general interest in coeliac disease) 833 respondents (78%) disagreed or strongly disagreed with the proposal to stop providing gluten free bread and bread mixes on prescription.

4.11 94% of those with coeliac disease disagreed or strongly disagreed with the proposal to stop providing gluten free bread and bread mixes on prescription.

4.12 71% of those with another diagnosed condition requiring a gluten free diet disagreed or strongly disagreed with the proposal to stop providing gluten free bread and bread mixes on prescription.

4.13 90% of parents/guardians/carers of a child with coeliac disease, or another diagnosed condition requiring a gluten free diet disagreed or strongly disagreed with the proposal to stop providing gluten free bread and bread mixes on prescription.

4.14 87% of carers of an adult with coeliac disease, or other diagnosed condition disagreed or strongly disagreed with the proposal to stop providing gluten free bread and bread mixes on prescription.

4.15 By contrast only 31% of 'interested' respondents disagreed or strongly disagreed with the proposal to stop providing gluten free bread and bread mixes on prescription. 68% strongly agreed or agreed with the proposal.

4.16 Health professionals were equally divided with 51% disagreeing or strongly disagreeing with the proposal to stop providing gluten free bread and bread mixes on prescription.

4.17 The main reasons cited in **support** of the decision to stop providing gluten free bread and bread mixes on prescription were:

- the high cost to the NHS.
- the money spent on gluten free products could be better spent elsewhere.
- there are other medical conditions just as worthy of financial support.
- there are adequate supplies of gluten free products at reasonable prices in supermarkets.
- should be stopped for people not on benefits.

- in other parts of the country gluten free products are not available on the NHS.
- NHS should be taking steps to encourage people to eat more healthily.

4.18 The main reasons cited **against** the decision to stop providing gluten free bread and bread mixes on prescription were:

- gluten free products are expensive.
- gluten free products are not always readily available in supermarkets.
- coeliac disease is a serious disease and why should treatments not be available on the NHS?
- a gluten free diet is the medical treatment for coeliac disease therefore it is not an optional dietary choice.
- coeliac disease is a lifelong autoimmune condition that nobody enjoys or wants to have.

MAIN FINDINGS

5.0 The profile of people with coeliac disease and their carers

5.1 601 respondents defined themselves as having coeliac disease.

5.2 The profile of the respondents who have defined themselves as having coeliac disease in terms of age and gender are shown in Tables 1 and 2 below. (It should be noted not all respondents who indicated they have coeliac disease indicated either their age or their gender. Therefore, the base figure (451) of respondents to each question is lower than the number of respondents (601) identifying themselves as having coeliac disease.)

Table 1: Profile of respondents with coeliac disease by age

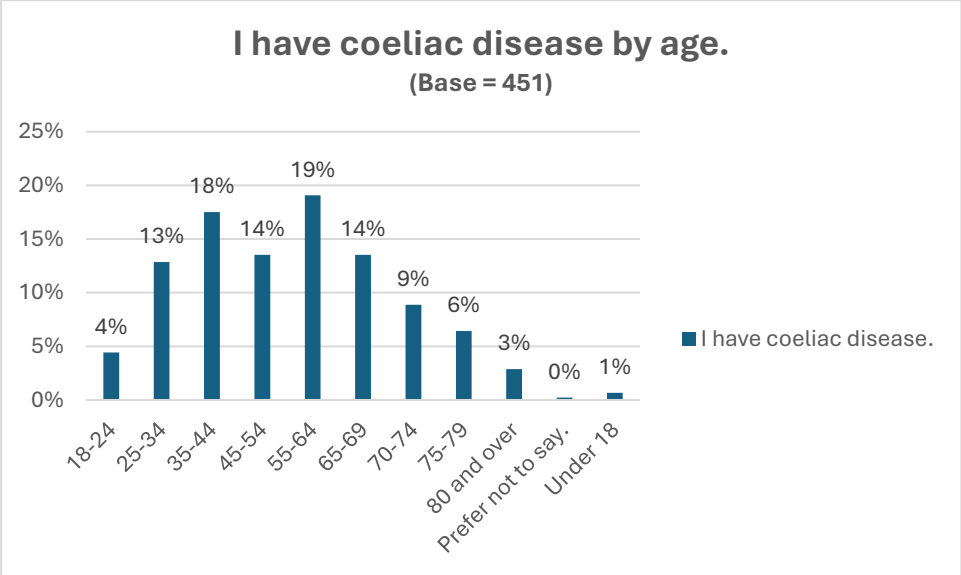
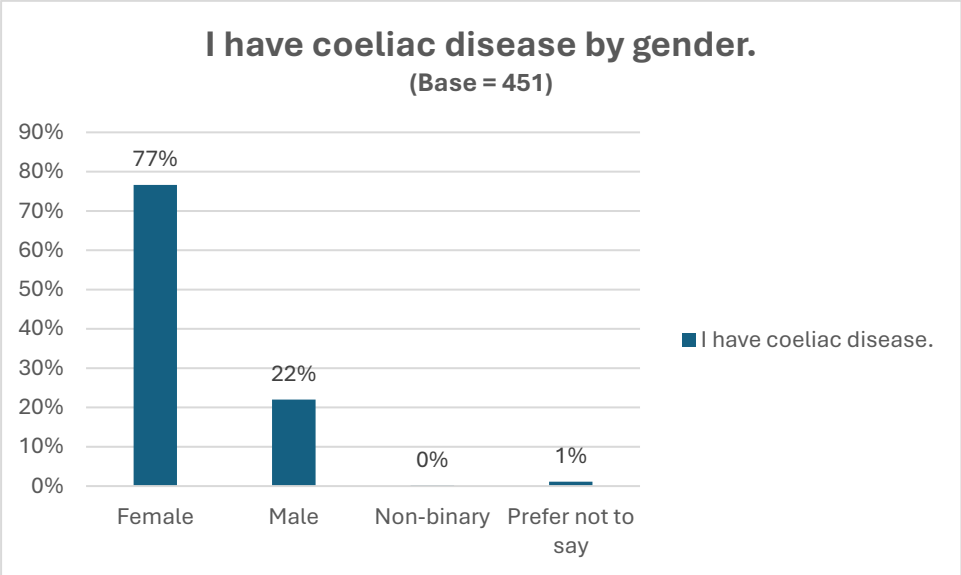


Table 2: Profile of respondents with coeliac disease by gender



5.3 57 respondents had been diagnosed with a condition which required them to follow a gluten free diet. The profile of the respondents who are diagnosed with conditions that required them to follow a gluten free diet are shown in Tables 3 and 4. (Again, it should be noted not all these respondents indicated either their age or their gender.)

Table 3: Profile of those with other diagnosed condition by age

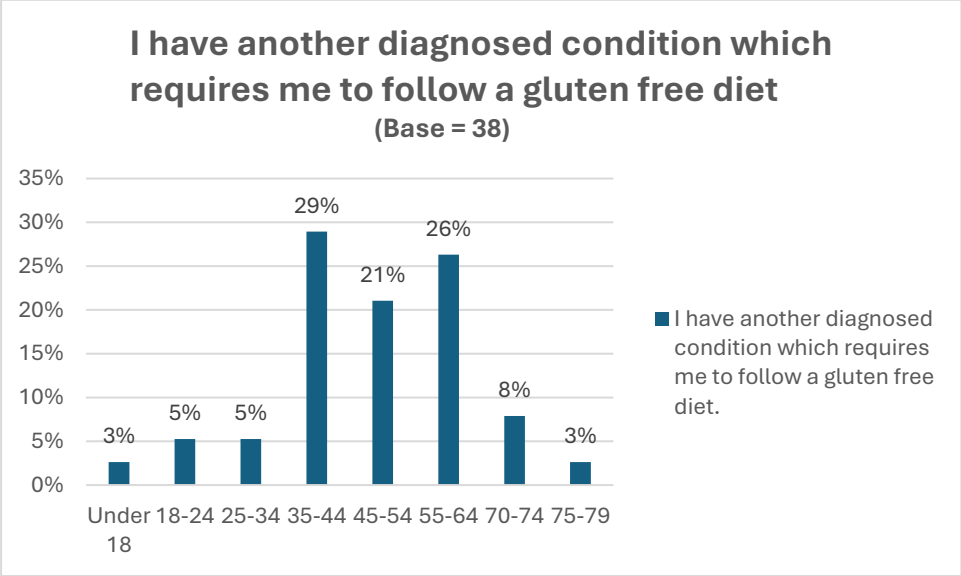
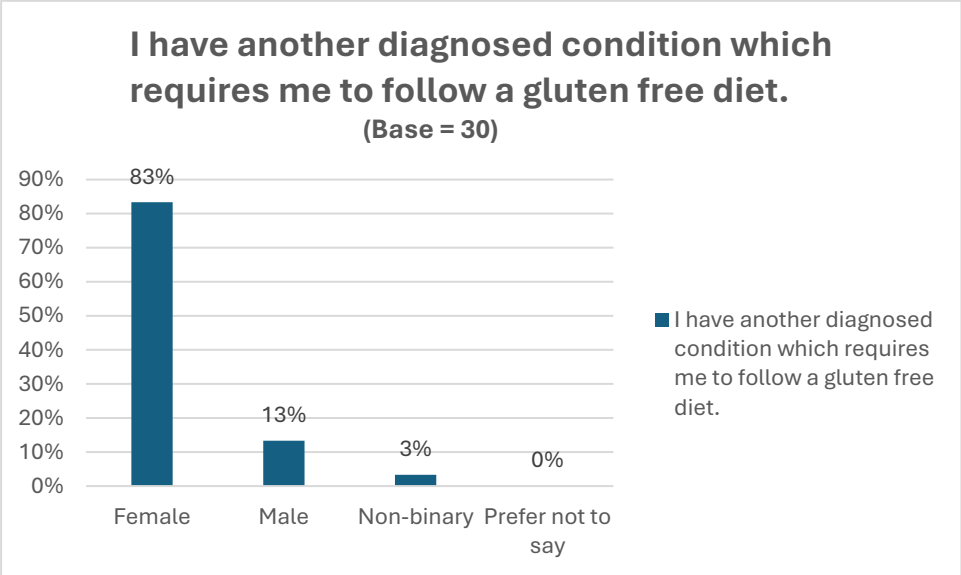


Table 4: Profile of those with other diagnosed condition by gender



5.4 229 respondents defined themselves as a parent/guardian/carer of a child with coeliac disease, or another diagnosed condition which required them to follow a gluten free diet. The profile of the parents/guardians/carers of a child with coeliac disease or other diagnosed condition by age and gender is shown in Table 5 and 6. (Again, it should be noted not all respondents indicated either their age or their gender.)

Table 5: Profile of parents/guardians/carers of child with coeliac disease or other condition by age

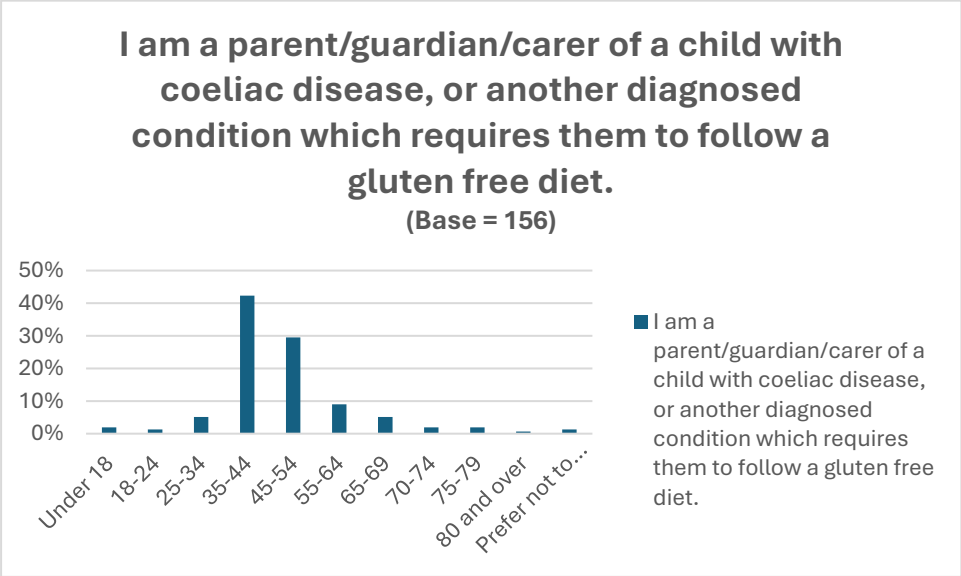
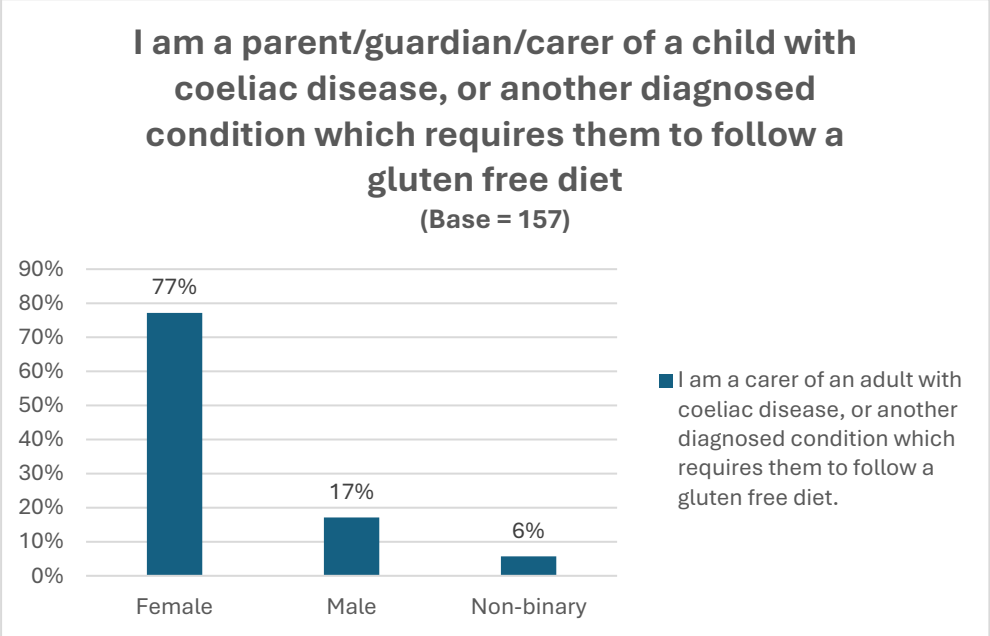


Table 6: Profile of parents/guardians/carers of child with coeliac disease or other condition by gender



5.5 63 respondents defined themselves as a carer of an adult with coeliac disease, or another diagnosed condition which required them to follow a gluten free diet. The age and gender profiles of carers of an adult with coeliac disease or other condition are shown in Tables 7 and 8.

Table 7: Profile of carers of an adult with coeliac disease or other condition by age

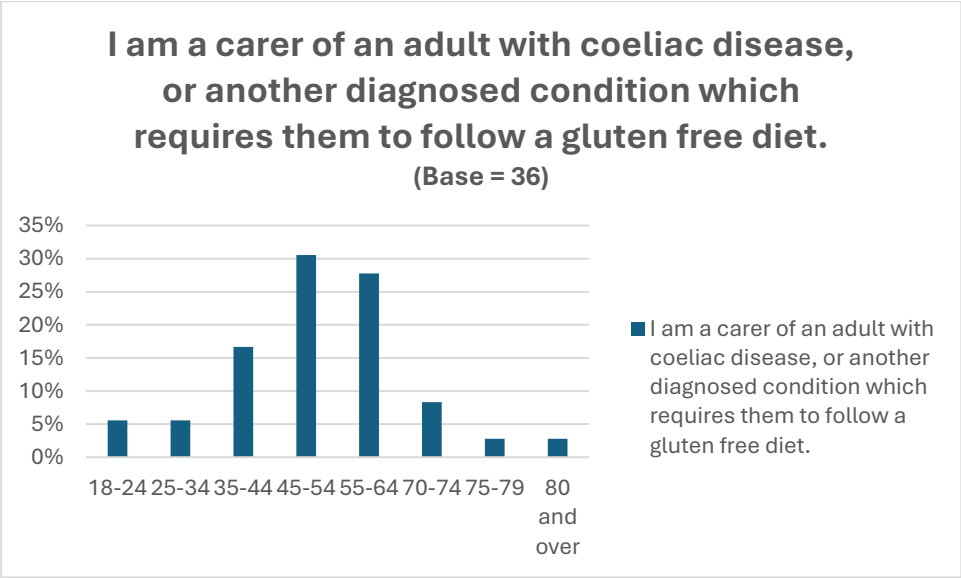
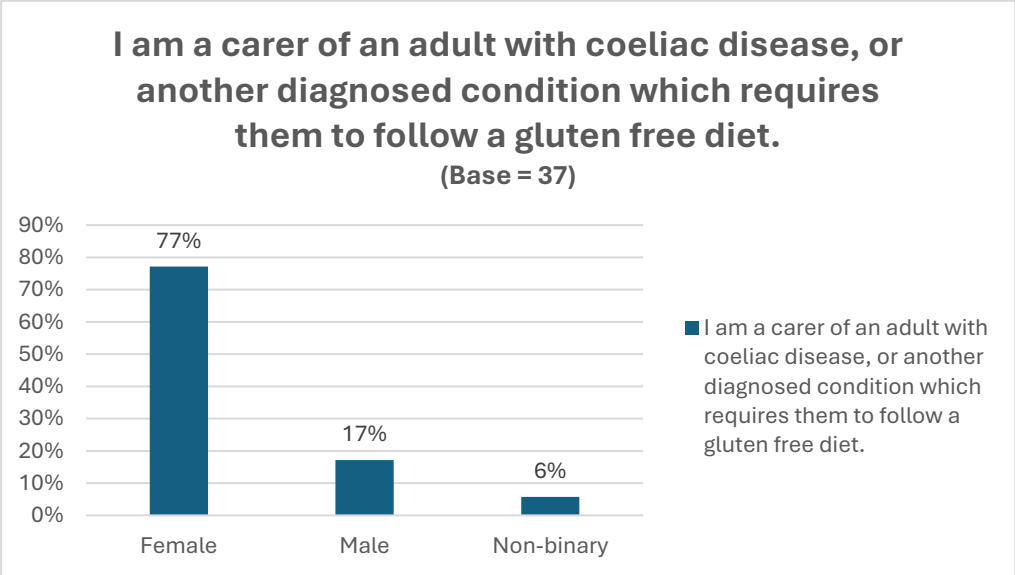


Table 8: Profile of carers of an adult with coeliac disease or other condition by gender



6.0 Those with coeliac disease or another diagnosed condition - who get gluten free bread and/or bread mixes on NHS prescription.

6.1 Of the 620 respondents who answered the question whether they got their gluten free bread and/or bread mixes on NHS prescription 61% said yes, 37% said no and 2% preferred not to provide an answer.

6.2 Of the respondents who said they got their gluten free bread and/or bread mixes on NHS prescription 47% said they paid for their prescription and 50% said they did not pay for their prescription. 3% preferred not to provide an answer.

6.3 69% of parents, guardians or carers of a child or an adult with coeliac disease or another diagnosed condition which requires them to follow a gluten free diet got their gluten free bread and/or bread mixes on prescription. 28% of respondents said they do not and 3% preferred not to provide an answer.

6.4 23% of parents, guardians or carers of a child or an adult with coeliac disease pay for their prescription. 74% of respondents said they do not and 3% preferred not to provide an answer.

7.0 Extent to which respondents agreed or disagreed with proposal to stop providing gluten free bread and bread mixes on prescription

7.1 Respondents were required to indicate their agreement or disagreement with the proposal that the NHS should stop providing gluten free bread and bread mixes on prescription. The opinions of respondents on this issue are shown in Table 9 below with the percentage distribution of responses shown in Table 10.

Table 9. Strength of agreement or disagreement to stop providing gluten free bread and bread mixes of prescription. (Actual Numbers)

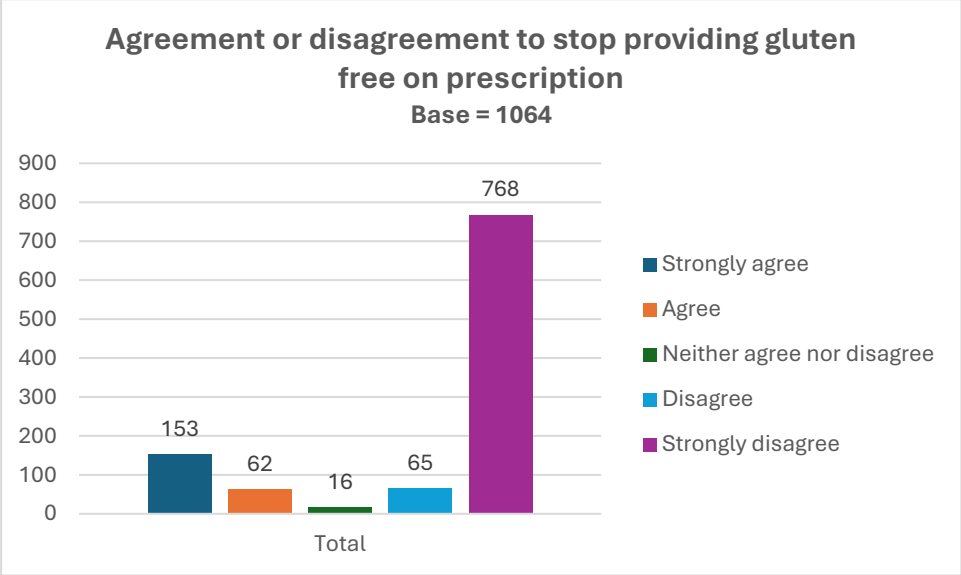
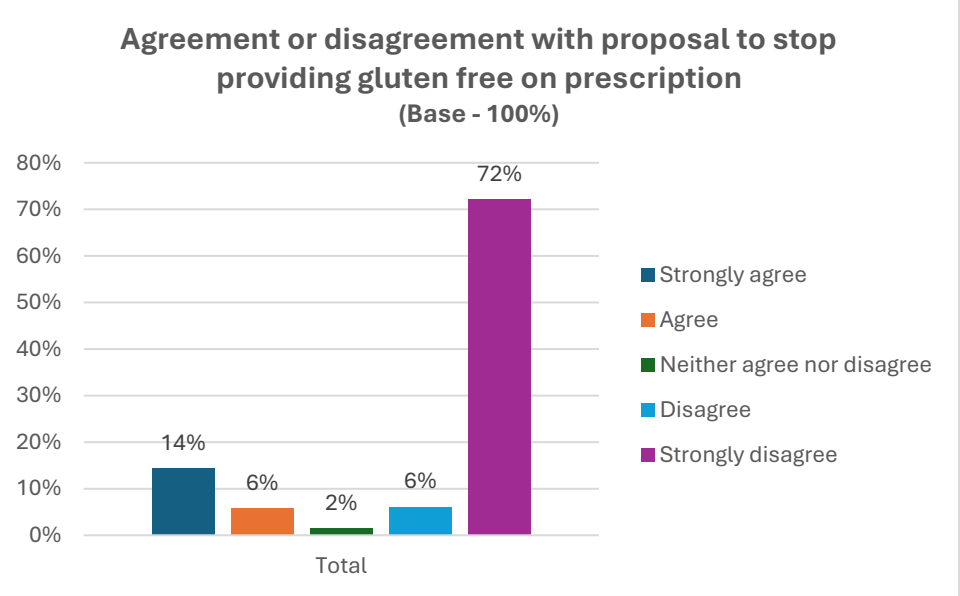


Table 10. Strength of agreement or disagreement to stop providing gluten free bread and bread mixes on prescription. (Percentage Numbers)



In total 78% of all respondents strongly disagreed or disagreed with the proposal to stop providing gluten free bread and bread mixes on prescription. This compares with 20% of all respondents who strongly agreed or agreed with the proposal.

What follows is a detailed comparison of the strength of feeling about this issue by key stakeholder groups.

7.2 Additional comments by respondents on proposed changes to gluten free prescribing

To provide insights into why respondents agreed or disagreed with the proposal to stop providing gluten free bread and bread mixes on prescription, they were asked to explain the

reason behind their decision. What followed was over 800 wide-ranging and in-depth explanations of why this decision mattered to them.

To analyse and structure 800+ comments into a meaningful summary, a thematic analysis was used to identify the most frequently occurring opinions and concerns. To provide balance to the analysis, the most frequently occurring themes were identified for both those in favour and against the proposal. It should be noted that the ratio of those expressing an opinion was 4 to 1 against the proposal to stop providing gluten free bread and bread mixes on prescription.

Table 11. Those expressing opinions in favour of the proposal

A selection of comments reflecting frequently occurring themes for those in favour of the proposal – stop providing gluten free bread and bread mixes on prescription.
There is a large range of readily acceptable gluten free products in supermarkets at reasonable cost. They are now much more affordable to all. Lots of high street shops have good and varied range of options for gluten free. I do not believe public money should be spent on prescriptions for food, whether it is because of intolerances / allergies or not.
People with allergies/diabetes don't get free prescriptions. I do not believe public money should be spent on prescriptions for food, whether it is because of intolerances / allergies or not. Everyone has to buy food, and to keep taxing the public more to pay for special food for others, means they have less money to buy food for themselves.
Should be stopped for adults and those not in receipt of benefits. Other areas in England do not offer free gluten free, even for children. All areas should be the same.
NHS should start encouraging people to take responsibility for their own health. NHS has bigger problems to deal with. Monies saved could be put to better use.
The volume of products given on prescription is very wasteful and products supplied are not my preferred choice of brand. Local supermarkets have a wide range of choice of better brands
Gluten-free products are widely available in most food retailers and appear to be similarly priced to general products. Providing them on prescription is very costly for the NHS and the money would be better spent on items which are not readily available at a reasonable cost. It would not impact me or my family, but I would rather see the money go to other more worthy causes.
I think a lot of people do struggle with this but when you look at the bigger picture the NHS has bigger problems right now than bread. As long as people are aware where they can go and places/people that can help them there shouldn't be any issues.
Gluten free products are freely available to buy and our budget for medicines should be reserved for prescription medicines.
I agree GF products should be stopped for adults, there is a lot more availability for GF products in shops at a better price than there was 10yrs ago. However, I think there should be some availability for children.
When this was introduced gluten free items were very hard to find and expensive. Whilst they may still be slightly more expensive, they are commonly available now.
GF foods are now widely available at all retail outlets, this was never the case 20+ years ago. It will be argued that these are much more expensive than 'normal' bread but it is possible to have a diet that does not require bread. We do not provide diabetics with low sugar foods.
I feel that lots of people now have to follow adapted diets due to allergies and they are not prescribed any food or drink to support this.
I am gluten intolerant and have been for more than 10 years. I have never had a prescription for gluten free bread, and this has not been detrimental in any way. I was asked if I wanted the prescription but declined as the bread that you can get on the prescription is nowhere near as nice as the breads you can buy in the supermarket.

Table 12. Those expressing opinions against the proposal

A selection of comments reflecting frequently occurring themes for those against the proposal – stop providing gluten free bread and bread mixes on prescription.
People don't choose to be born with a gluten intolerance and I think it is absolutely abhorrent to even think about taking this off prescription, as the cost of living rises so does the cost of food – and the cost for gluten free food is extortionate anyway so taking gluten free prescribing away from 30% of the population who have been clinically diagnosed with coeliac disease not counting people who medically need a gluten free diet I think is a crazy proposition to even think of.
A gluten free diet is the medical treatment for coeliac disease therefore it is not an optional dietary choice. Gluten free products are 4x more expensive than regular products so it would have a real impact on our family finances if gf prescribing was stopped.
Gluten free food is 35% more expensive without any additional help. There is very little available on prescription so stopping bread mixture and bread will impact further on people who already have ridiculous expensive food bills
These changes would be detrimental to the health of my daughter aged 11 yrs. She is Type 1 Diabetic as well and the gluten free products in the supermarkets are so expensive for us to buy that she wouldn't be able to eat a balanced diet as we can't afford the nicer gluten free bread
A food shop for a person with Coeliac disease costs 35% more. Bread is a staple, yet a gluten free loaf can cost £3.50 making it unaffordable for people on low incomes. Coeliac poverty makes people feel that they have no option but to eat food cheaper food containing gluten that then causes other health issues.
As a parent of a coeliac daughter, I'm struggling to pay for the essential foods that she needs. Like bread for her lunches. The sheer overwhelming lack of most food choices already limits my child and what gluten free food we can buy is already so much more expensive. We have no other choice; the only medical advice is to not eat gluten. Having gf flour on prescription gives us the ability to cook a lot of items we simply cannot purchase in supermarkets or are often out of stock. Such as our own pastry, bread, other items. We already have to provide our child with packed lunches as school do not provide gf and any social outings or parties we need to take our own food. We simply cannot "go out" without gf food with us. Having gf flour on prescription means we can visit places and still go out with friends. The sheer amount of extra sugar and additives in gf food which can be purchased in shops is really high and if we are forced to purchase gf bread from shops this will impact the health of our child giving longer term impact on medical requirements.
The cost of living plus the price of gluten free food in general is hitting our pockets hard. Having the free bread and bread mix helps.
I strongly believe that gluten-free bread should remain available on NHS prescription. For people with coeliac disease, a strict gluten-free diet is the only treatment, and gluten-free alternatives are often significantly more expensive and harder to access than standard bread. The NHS provides essential medications for chronic conditions and gluten-free prescriptions should be treated no differently. Maintaining access ensures equality in healthcare and prevents unnecessary strain on NHS resources from complications arising from poor dietary management. Not all supermarkets or local shops stock gluten free products. Without a prescription for gluten free products, we may have to travel further or go without for our daughter making it harder to follow a strict gluten free diet.
Gluten free food is unaffordable. We get the basic bread and /or flour on prescription. We are limited to 8 units. Schools cannot safely provide food for our children. This means I need bread products to cover breakfasts and lunches. We are a one earning household who take no benefits. The bread products required to provide even the basics like sandwiches and toast are so expensive we can't afford to pay for it on top of other ingredients we pay our selves like pasta. Either keep prescriptions or provide subsidies like in Wales in the form of

food tokens. With children especially you can't just eat 100% naturally gluten free food. This proposal is a disgrace.
My child relies on the flour and bread on prescription. I cannot afford the increased cost in the supermarkets
Coeliac disease is a lifelong autoimmune condition that nobody enjoys or wants to have. Food is on average FOUR times the cost of gluten products and it's outrageous to suggest that people should be penalised for having a medical condition.
I feel sick with worry about this. My child was diagnosed 6 months ago and getting her to eat gluten free has been a big struggle. The bread from the GP really helped and I don't know how I'm going to manage to buy the food I need for her if it's taken away.
I disagree with the proposal to withdraw gluten free bread mixes from prescriptions. I encounter a variety of people in their own homes every day. In many communities' families cannot afford sufficient nutrition to maintain their health. This is only exacerbated in those adhering to a gluten free diet and the removal of gluten free mixes from prescriptions would only worsen this issue for countless deprived families and individuals. The removal of gluten free bread mixes runs the risk of removing a staple macronutrient and energy source from these individuals and further exacerbates health inequality and increases malnutrition risk in a region where spending on oral nutritional supplements indicated for use on malnutrition far exceeds the national average. The removal of gluten free bread mixes would only be a false economy.

8.0 Comparison of opinions to the proposal to stop providing gluten free bread and bread mixes on prescription by equality monitoring groups

Tables 13 to 20 provide a comparison of opinions towards the proposal to stop providing gluten free bread and bread mixes on prescription by different groups.

From the self-selected sample of respondents to the questionnaire there wasn't any significant difference of opinion based on groups of respondents by equality characteristics or other groupings. Rather differences in opinion were based on respondents interest in the consultation i.e. whether they reported having coeliac disease, another diagnosed condition or being a parent, guardian, carer of a child or adult which required them to follow a gluten free diet.

Table 13: Opinions about stopping providing gluten free bread and bread mixes on prescription by age

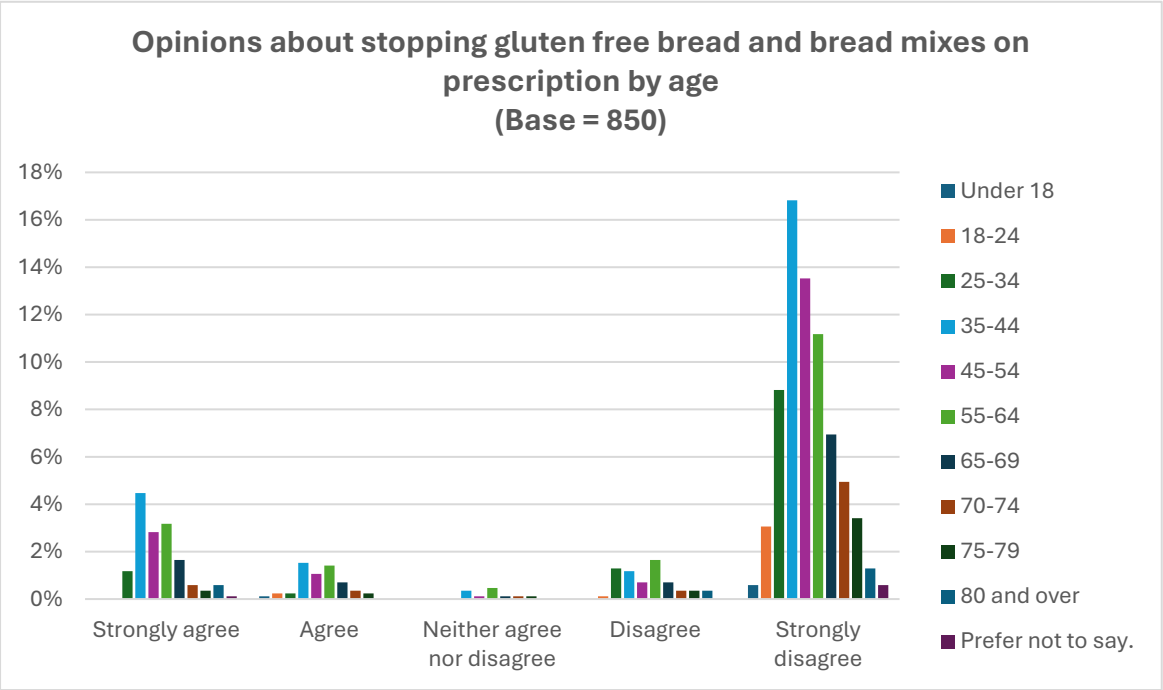


Table 14: Opinions about stopping providing gluten free bread and bread mixes on prescription by gender

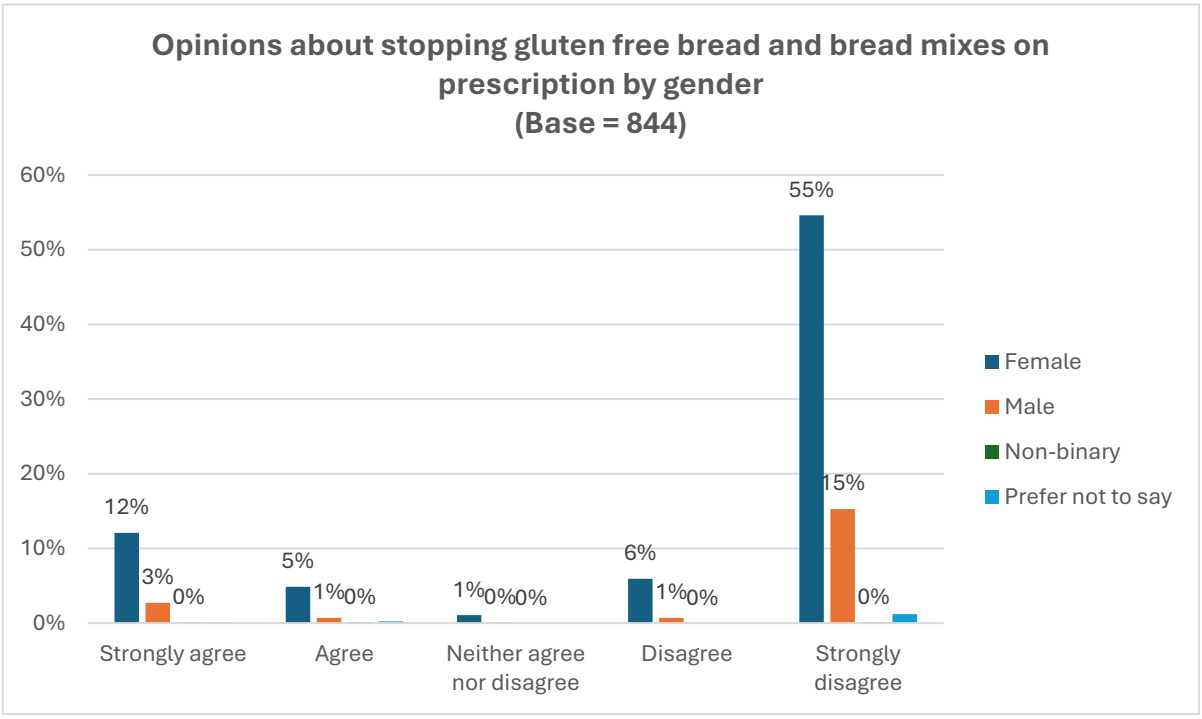


Table 15: Opinions about stopping providing gluten free bread and bread mixes on prescription by those with coeliac disease

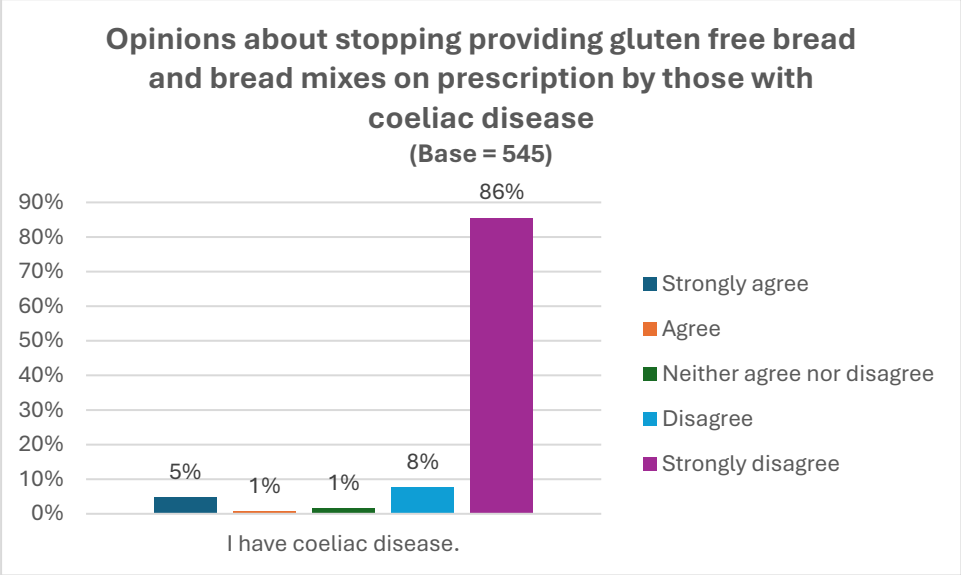


Table 16: Opinions about stopping providing gluten free bread and bread mixes on prescription by those with another diagnosed disease

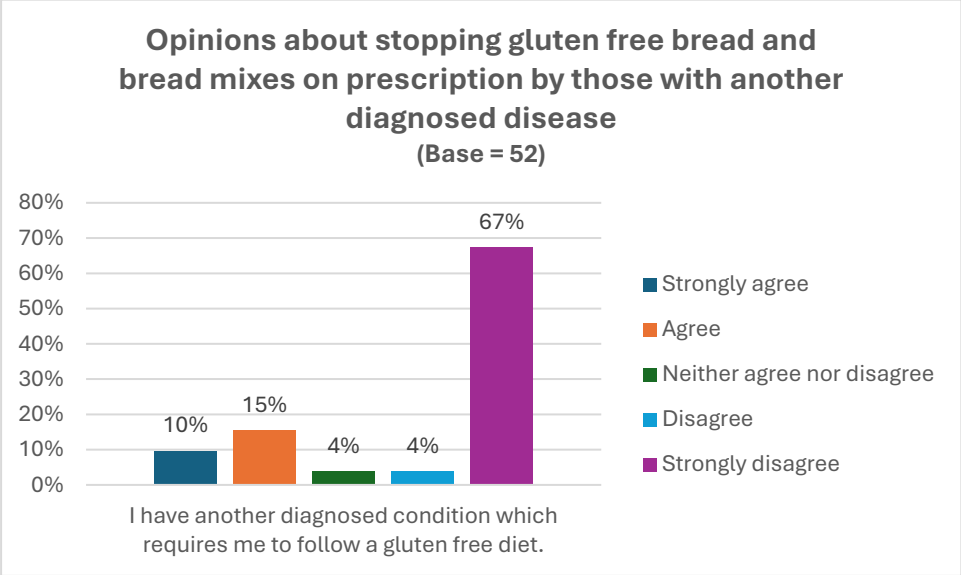


Table 17: Opinions about stopping providing gluten free bread and bread mixes on prescription by parent/guardian/carer of a child with coeliac disease

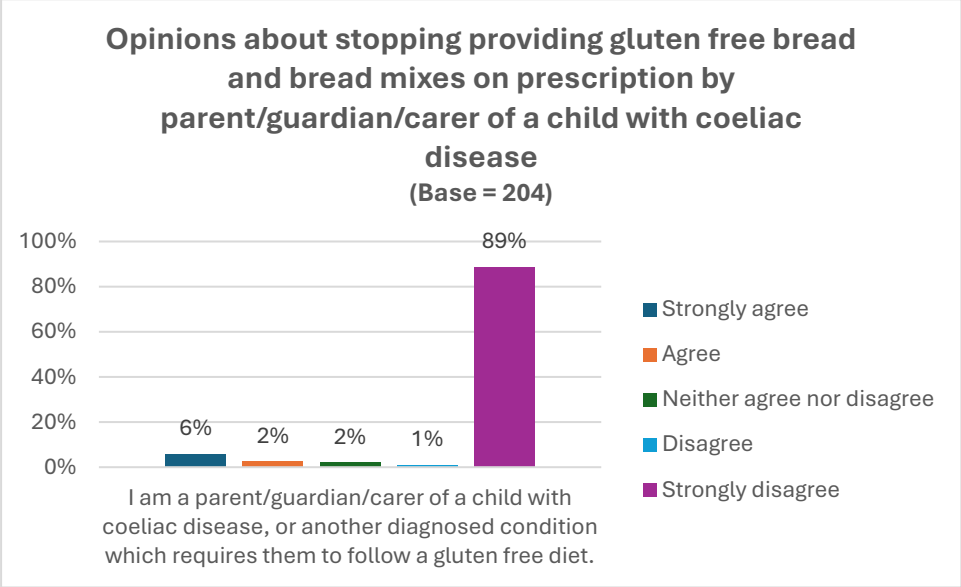


Table 18: Opinions about stopping providing gluten free bread and bread mixes on prescription by carer of adult with coeliac

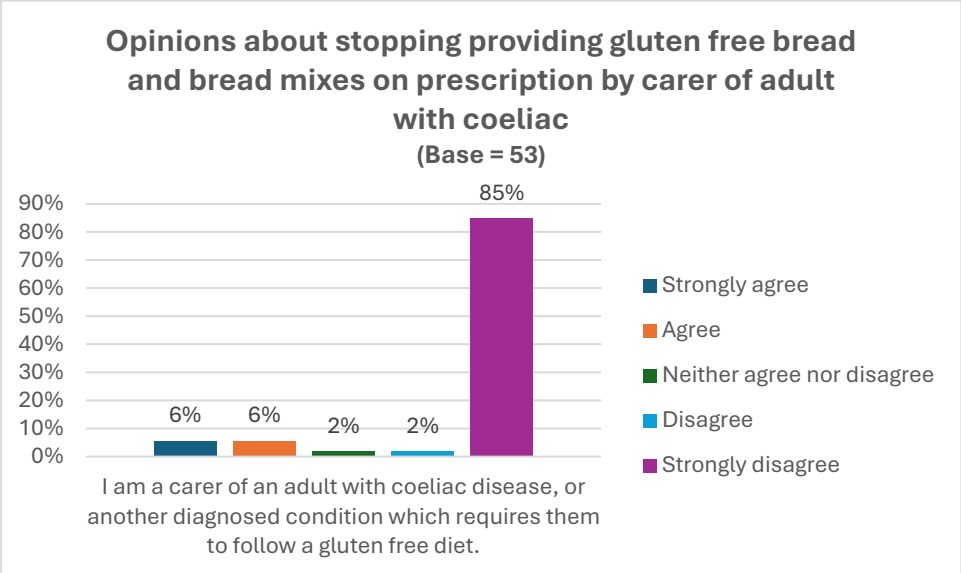


Table 19: Opinions about stopping providing gluten free bread and bread mixes on prescription by 'Interested' respondent

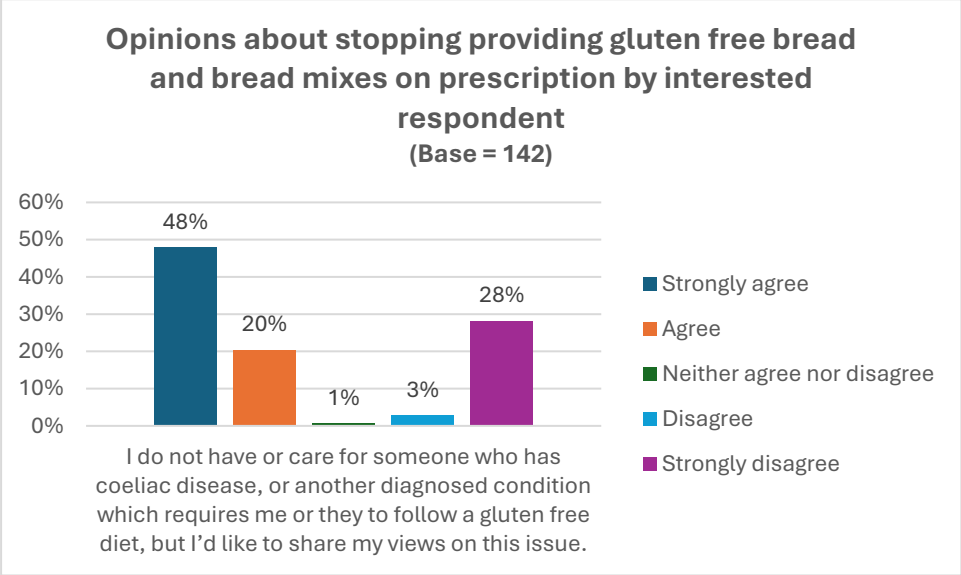
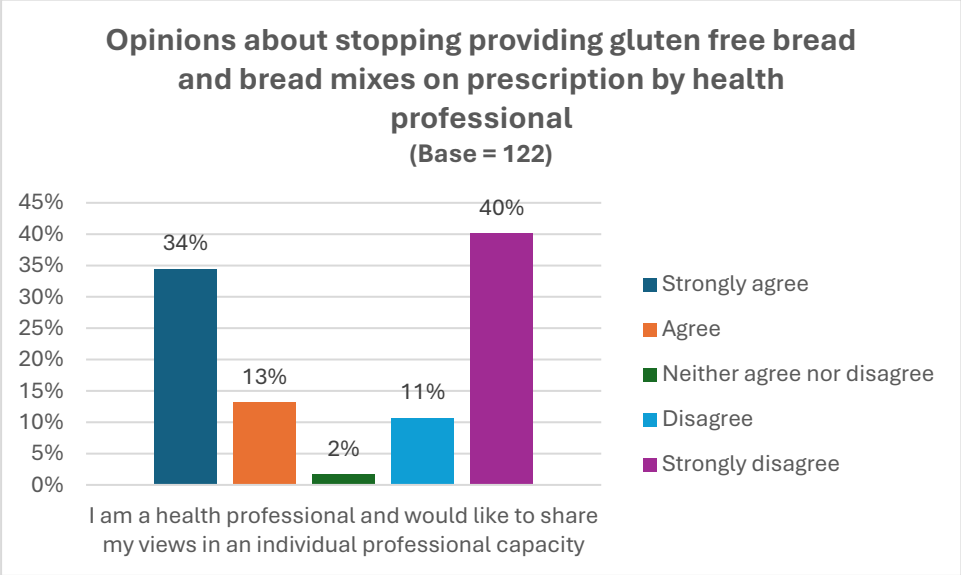


Table: 20: Opinions about stopping providing gluten free bread and bread mixes on prescription by health professional.



APPENDICES

1: Profile of respondents indicating their interest in the public consultation

Personal interest of respondents	No.	%
I have Coeliac disease	601	46.2
I have another diagnosed condition which requires me to follow a gluten free diet	57	4.4
I am a parent/guardian/carer of a child with Coeliac disease, or another diagnosed condition which requires them to follow a gluten free diet.	229	17.6
I am a carer of an adult with Coeliac disease, or another diagnosed condition which requires them to follow a gluten free diet.	63	4.8
I do not have or care for someone who has Coeliac disease, or another diagnosed condition which requires them to follow a gluten free diet, but I'd like to share my views on this issue.	162	12.5
I am a health professional and would like to share my views in an individual capacity.	136	10.5
I am responding on behalf of a group, charity or organisation	8	0.6
Other categories. Includes friends, spouses, grandparents and other relatives of someone with coeliac disease.	45	3.5

N.B. The total number of responses is 1301 indicating that some of the 1184 respondents taking part in the survey classified themselves in more than one category. The percentages are based on the total number of responses (1301) and not the total sample size (1184).

2: Home location of respondents

Home location of respondents	No.	%
Cheshire East	159	14
Cheshire West	160	14
Halton	73	7
Knowsley	64	6
Liverpool	136	12
Sefton	100	9
St Helens	32	3
Warrington	168	15
Wirral	156	14
Outside of Cheshire and Merseyside	65	6
Total	**1113**	**100%**

N.B. 71 respondents did not answer this question.

3: Work location of those responding in an individual professional capacity or on behalf of a group, charity or organisation

Location of respondents	No.	%
Cheshire East	29	12
Cheshire West	42	18
Halton	16	7
Knowsley	10	4
Liverpool	46	21
Sefton	10	4
St Helens	8	3
Warrington	38	16
Wirral	27	12

Outside of Cheshire and Merseyside	7	3
Total	**233**	**100**

N.B. The total number of respondents answering this question is 233, which exceeds the 144 respondents who self-classified themselves as health professionals or responding on behalf of a group, charity or organisation in question one.

4: Type of work-based organisation

Type of work-based organisation	No.	%
NHS organisation (Trust or ICB)	88	45
General practice (GP)	31	16
Pharmacy	11	6
Local authority	9	5
Voluntary, Community, Faith or Social enterprise	12	6
Other group	3	2
Other	42	20
Total	196	100

5: Where did you hear about this consultation?

Where did you hear about this consultation?	No	%
From GP practice	77	8
From local pharmacy	19	2
Person cared for sent an email	65	6
Social media	341	33
NHS website	38	4
Patient group/Voluntary sector	83	8
NHS staff communication	84	8
Friend or family member	123	12
Other	194	19

6: Ethnic group of respondents

Ethnic group of respondents (n=849)	No	%
White: English/Welsh/Scottish/Northern Irish/British	800	94.2
White: Irish	11	1.3
White: Gypsy or Irish Traveller	0	0
White: Any other White background	16	1.9
Mixed/Multiple Ethnic Groups: White and Black Caribbean.	2	0.2
Mixed/Multiple Ethnic Groups: White and Black African	1	0.1
Mixed/Multiple Ethnic Groups: White and Asian	2	0.2
Mixed/Multiple Ethnic Groups: Any other Mixed/Multiple Ethnic	2	0.2
Asian/Asian British: Indian	4	0.5
Asian/Asian British: Pakistani	2	0.2
Asian/Asian British: Bangladeshi	0	0
Asian/Asian British: Chinese	0	0
Asian/Asian British. Any other Asian background	1	0.1
Black/African/Caribbean/Black British: African	1	0.1
Black/African/Caribbean/Black British: Caribbean	0	0
Black/African/Caribbean/Black British: Any other background	0	0
Other ethnic group: Arab	1	0.1
Prefer not to say	6	0.7
Total	849	99.8

N.B. Percentages do not add to 100 because of rounding errors. This table uses one percentage decimal point to ensure small groups are represented.

7: Age group of respondents

Age group of respondents (n=850)	No	%
Under 18	6	1
18 – 24	29	3
25 – 34	98	12
35 – 44	207	25
45 – 54	155	18
55 – 64	152	18
65 - 69	86	10
70 – 74	54	6
75 - 79	38	4
80 and over	19	2
Prefer not to say	6	1
Total	850	100

8: Religious belief of respondents

Religion or belief of respondents (n=850)	No	%
No Religion	307	36.1
Christian	494	58.1
Buddhist	7	0.8
Hindu	4	0.5
Jewish	2	0.2
Muslim	5	0.6
Sikh	0	0
Other religion	31	3.7
Prefer not to say	0	0
Total	850	100

N.B. This table uses one percentage decimal point to ensure small groups are represented.

9: How respondents identify

How respondents identify (n=844)	No	%
Male	165	19.6
Female	663	78.6
Trans-Man	0	0
Trans-Woman	0	0
Non-binary	3	0.4
Gender-Non-Conforming	0	0
Other	13	1.5
Prefer not to say	0	0
Total	844	100

N.B. This table uses one percentage decimal point to ensure small groups are represented.

10: Sexual orientation of respondents

Sexual orientation of respondents (n = 842)	No	%
Heterosexual	754	89.5
Lesbian	4	0.5
Gay	11	1.3
Bisexual	20	2.4
Asexual	3	0.4
Other	0	0
Prefer not to say	50	5.9
Total	842	100

N.B. This table uses one percentage decimal point to ensure small groups are represented.

11: Relationship status of respondents

Relationship status (n = 849)	No	%
Married	524	61.7
Civil Partnership	4	0.45
Single	134	15.8
Lives with partner	103	12.1
Separated	6	0.7
Divorced	38	4.5
Widowed	18	2.1
Other	22	2.6
Prefer not to say	0	0
Total	849	100

N.B. This table uses one percentage decimal point to ensure small groups are represented.

12: Day to day activities

Day to day activities (n = 845)	No	%
Yes, limited a lot	98	12
Yes, limited a little	188	22
No	559	66
Total	845	100

13: Respondents consider themselves to have a disability (As defined by The Equality Act 2010)

Respondent considered to have a disability (n = 810)	No	%
Physical disability	50	8
Sensory disability	19	22
Mental health condition	29	4
Learning disability or difficulty	16	2
Long-term illness	71	9
Prefer not to say	68	8
Other	129	16
No, don’t consider themselves to have a disability	546	67

N.B. Percentages add to more than 100% because of multiple responses by some respondents

14: Respondents providing care

Providing care for someone (n = 843)	No	%
Yes – For person aged 24 and under	109	13
Yes – For adults aged 25 to 49	23	3
Yes – For older person(s) aged 50+	100	12
Prefer not to say	33	4
No	595	71

N.B. Percentages add to more than 100% because of multiple responses by some respondents

15: Respondent pregnant at time of questionnaire completion

Pregnant at this time (n = 847)	No	%
Yes	11	1
No	823	97
Prefer not to say	13	2
Total	847	100

16: Respondent recently given birth

Recently given birth (n = 844)	No	%
Yes	2	0.2
No	830	98.4
Prefer not to say	12	1.4
Total	844	100

17: Respondent served in armed services

Served in armed services (n = 847)	No	%
Yes	18	2
No	813	96
Prefer not to say	16	2
Total	847	100

18: Gender and agreement/disagreement with proposal to stopping NHS prescriptions for gluten free bread and bread mixes

	Female	Male	Non-Binary	Prefer Not to Say	No.
Strongly agree	102	23	1	1	127
Agree	41	6	1	2	50
Neither agree nor disagree	9	1			10
Disagree	50	6			56
Strongly disagree	461	129	1	10	601
Total	**663**	**165**	**3**	**13**	**844**

19: Age and agreement/disagreement with proposal to stopping NHS prescriptions for gluten free bread and bread mixes

	Under 18	18-24	25-34	35-44	45-54	55-64	65-69	70-74	75-79	80 and over	Prefer not to say.	Total
Strongly agree			10	38	24	27	14	5	3	5	1	127
Agree	1	2	2	13	9	12	6	3	2			50
Neither agree nor disagree				3	1	4	1	1	1			11
Disagree		1	11	10	6	14	6	3	3	3		57
Strongly disagree	5	26	75	143	115	95	59	42	29	11	5	605
Total	**6**	**29**	**98**	**207**	**155**	**152**	**86**	**54**	**38**	**19**	**6**	**850**

20: Day to day activities limited and agreement/disagreement with proposal to stopping NHS prescriptions for gluten free bread and bread mixes

	Yes, limited a lot	Yes, limited a little	No	Total
Strongly agree	8	18	102	128
Agree	6	12	32	50
Neither agree nor disagree	2	5	4	11
Disagree	8	11	37	56
Strongly disagree	74	142	384	600
Total	**98**	**188**	**559**	**845**

21: Disability and agreement/disagreement with proposal with proposal to stopping NHS prescriptions for gluten free bread and bread mixes

	Learning disability or difficulty	Long-term Illness	Mental health cond.	Physical disability	Sensory disability	Total
Strongly agree	1	10	1	6	2	20
Agree	2	5	3	6	1	17
Neither agree nor disagree	-	1	-	1	-	2
Disagree	-	4	-	7	-	11
Strongly disagree	13	52	25	42	16	148
Total	**16**	**72**	**29**	**62**	**19**	**198**

22: Public consultation on stopping NHS prescriptions for gluten free bread and bread mixes in Cheshire and Merseyside

Share your views

What's happening?

Gluten free bread and bread mixes are sometimes prescribed to individuals who live with coeliac disease, or other diagnosed conditions which mean that people have to follow a gluten free diet.

NHS Cheshire and Merseyside Integrated Care Board (ICB) – the organisation responsible for planning local health care services – is proposing to stop making these products available on prescription.

Between 28 January and 11 March 2025, we are holding a public consultation, so that people can find out more about this and share their views. We will then use the feedback we receive to make a final decision.

Background

Coeliac disease is a long-term autoimmune condition, where the immune system mistakes substances found inside gluten as a threat to the body and attacks them, which damages the surface of the small bowel, disrupting the body's ability to absorb nutrients from food.

Dermatitis herpetiformis is a skin condition associated with coeliac disease and gluten intolerance, which occurs as an itchy skin rash that commonly appears on the elbows, knees and buttocks.

Coeliac disease and dermatitis herpetiformis are usually treated by excluding foods that contain gluten.

In the past, GPs were able to prescribe some gluten free foods to people with coeliac disease, or other diagnosed conditions that meant they weren't able to eat gluten.

In 2018, new national guidance was released recommending that only gluten free bread and bread mixes should be made available on prescription.

Currently, most areas of Cheshire and Merseyside follow this national guidance, however there are some differences, which we describe in the next section.

Who currently gets gluten free bread and bread mixes on prescription?

Cheshire and Merseyside is made up of nine areas, sometimes known as 'places'. These are: Cheshire East, Cheshire West, Halton, Knowsley, Liverpool, Sefton, St Helens, Warrington and Wirral.

These areas used to come under separate NHS clinical commissioning groups (CCGs), which were responsible for setting health policies for people living in their area, including policies for gluten free prescribing.

In July 2022, NHS Cheshire and Merseyside took over the responsibilities of CCGs, however the previous policies for each former CCG are still in place, which means that at the moment arrangements for gluten free prescribing are not the same for all areas. This is because some CCGs had previously decided to stop prescribing gluten free products.

The current picture is as follows:

- Gluten free bread and bread mixes are currently available on prescription to all eligible patients in Cheshire East, Halton, Knowsley, Liverpool, Sefton, Warrington and Wirral.
- In Cheshire West, eligible patients registered with a GP Practice in the former NHS Vale Royal CCG footprint (Winsford, Northwich, Middlewich and surrounding areas) can be prescribed gluten free bread and bread mixes, but this is not available to patients registered with a GP practice within the former NHS West Cheshire CCG footprint (Chester, Ellesmere Port and surrounding areas).
- No GP practices within St Helens Place can prescribe gluten free bread and bread mixes.

More than 13,300 people in Cheshire and Merseyside have a diagnosis of coeliac disease or other conditions which mean they need to follow a gluten free diet.

Of these people, around 2,300 currently receive gluten free bread and bread mixes on prescription. The breakdown for each area by age is as follows:

	Age Range											
Area	**0-9**	**10-19**	**20-29**	**30-39**	**40-49**	**50-59**	**60-69**	**70-79**	**80-89**	**90+**	**Grand Total**	**% of total coeliac patients in area**
Liverpool	16	61	28	20	34	67	120	104	66	5	**521**	23%
Cheshire East	19	64	18	23	22	38	97	98	67	6	**452**	21%
Wirral	13	42	20	27	28	48	81	75	55	7	**396**	21%
Sefton	9	34	13	19	10	53	69	74	49	6	**336**	18%
Warrington	11	24	8	8	8	19	37	35	23	8	**181**	14%
Knowsley	5	22	11	11	9	21	32	35	24	2	**172**	17%
Halton	4	17	3	14	10	22	28	31	9	3	**141**	18%
Cheshire West	2	8	5	3	11	10	18	19	11	2	**89**	11%
St Helens	0	0	0	0	0	0	0	1	1	0	**2**	0%
Grand Total	**79**	**272**	**106**	**125**	**132**	**278**	**482**	**472**	**305**	**39**	**2290**	

*Separate figures for dermatitis herpetiformis are not provided as the majority of people with this condition also have a diagnosis of coeliac disease.

The NHS charges for most items given on prescription (currently this cost is £9.90 per item), however some people are eligible for free prescriptions, so don't need to pay this charge.

99% of prescriptions given for gluten free bread and bread mixes in Cheshire and Merseyside are not charged. The main category used for these free prescriptions is age: 60% are because someone is over 60, and 13% because someone is under 16 (or 18 if in full time education).

What we are proposing

NHS Cheshire and Merseyside is proposing that in the future, gluten free bread and bread mixes are no longer available on NHS prescription.

This would mean that GPs wouldn't be able to prescribe them, so if people wanted them, they would need to buy these products themselves. If the change went ahead, it would apply to all areas of Cheshire and Merseyside, and to both adults and children.

Why are we proposing this change?

1. Consistency across different areas

NHS Cheshire and Merseyside wants everyone who lives in Cheshire and Merseyside to have the same level of health care access, but currently this isn't the case for gluten free prescribing. The proposed change would mean that the same guidance would apply to everyone.

It would also mean that the approach for people who can't eat gluten is the same as for other food allergies and intolerances, such as those with lactose intolerance, who do not receive food products on prescription from the NHS.

2. Value for money

Gluten free bread and bread mixes are more expensive than the same products containing gluten, however the price paid by the NHS for these products on prescription is still much higher than in supermarkets.

It is estimated that ending the prescribing of gluten free bread and bread mixes would save the local NHS around £525,000 a year.

NHS Cheshire and Merseyside receives a fixed amount of money from NHS England for local health services, so we need to think about the best way to spend this to get the most benefit for our population.

3. Increased accessibility of gluten free products

One of the reasons gluten free foods were prescribed in the past was that their availability was limited. However, there is now increased awareness of coeliac disease and gluten intolerance, as well as a general trend towards eating less gluten, and these products are now more readily available in most supermarkets and other outlets.

4. Bread and bread mixes are not the only way to get essential nutrients in your diet

If you have coeliac disease, you must stop eating all sources of gluten for life, however it's possible to eat a balanced gluten free diet without the need for any special dietary foods. This proposal is about stopping prescribing of bread and bread mixes, and although these are a source of key nutrients, it is possible to obtain these from other naturally gluten free foods e.g. brown rice, potatoes, whole grains, leafy green vegetables to achieve a healthy diet. In addition, better labelling of foods means that people are more easily able to see whether ordinary foods are free from gluten.

What other options did we look at?

NHS Cheshire and Merseyside did not consider keeping things as they currently are, as this would mean continuing with a situation where the approach varies in different areas. Whatever decision we make, we want to make sure that we have a more consistent approach.

We did look at whether to make gluten free products available to **all** eligible patients in our area. It was estimated that to do this would cost around £130,000 extra each year. NHS Cheshire and Merseyside has a duty to make the best use of the limited funding we have available, and for the reasons set out above, we believe that ending all prescribing of gluten free products is a better approach.

We considered whether to limit prescribing to under 18s, however we felt that this would unfairly discriminate against older people, and 60% of prescriptions for gluten free bread and bread mixes are for those over 60 years old.

However, before we make a final decision, we want to understand the views of our population, which is why we are holding this public consultation.

How we will make a decision

Once this public consultation ends on 11 March 2025, an independent organisation will analyse the feedback received and present it in a report. We will use the findings in this report to make a final proposal about what we do with gluten free prescribing, which will be put to the board of NHS Cheshire and Merseyside for them to make a decision. A paper setting out what is being proposed, together with the public consultation report, will be published on the NHS Cheshire and Merseyside website with our board papers. Our plan is for this to happen at the end of May 2025. We will share the information about the decision once it has been made.

The best way to keep up to date with NHS Cheshire and Merseyside, including our engagement and consultation activity, is to sign up to receive our monthly emails https://www.cheshireandmerseyside.nhs.uk/latest/sign-up-for-updates/

How to share your views

NHS Cheshire and Merseyside wants to find out what people think about our proposal to stop prescribing gluten free bread and bread mixes.

Please complete the questionnaire to tell us your thoughts. The consultation closes on 11 March 2024 – please make sure you've submitted your views by then.

The questionnaire should take no more than ten minutes to complete. Please do not share any personal information in your response (i.e. information that could be used to identify you, such as your name).

Get in touch

If you would like some help to complete the questionnaire or need to request a printed version or an alternative format or language, please contact us using the details below. If you would prefer, we're happy for you to call us to share your questionnaire responses over the phone.

Phone: 0151 295 3052

Email: engagement@cheshireandmerseyside.nhs.uk

Ends

23: Survey questionnaire

Public consultation on proposed changes to gluten free prescribing in Cheshire and Merseyside

Introduction
This questionnaire is for you to share your views on NHS Cheshire and Merseyside proposal to stop prescribing gluten free bread and bread mixes.

You should read the supporting information booklet before answering this questionnaire. You can find the booklet on NHS Cheshire and Merseyside website Gluten free - NHS Cheshire and Merseyside

The questionnaire will close at midnight on 11 March 2025. Please make sure you have completed it by then.

How will my information be used?
NHS Cheshire and Merseyside is coordinating responses for this consultation. Your responses to these questions are anonymous - we don't link this information with any that identifies you.

Your data will be treated confidentially and stored in accordance with Data Protection law and NHS Cheshire and Merseyside Privacy Notice. You can read NHS Cheshire and Merseyside Privacy Notice here

Q1 – Please tell us about your interest in this consultation (please tick as many as apply):

a)	I have coeliac disease.	
b)	I have another diagnosed condition which requires me to follow a gluten free diet.	
c)	I am a parent/guardian/carer of a child with coeliac disease, or another diagnosed condition which requires them to follow a gluten free diet.	
d)	I am a carer of an adult with coeliac disease, or another diagnosed condition which requires them to follow a gluten free diet.	
e)	I do not have or care for someone who has coeliac disease, or another diagnosed condition which requires me or they to follow a gluten free diet, but I'd like to share my views on this issue.	
f)	I am a health professional and would like to share my views in an individual professional capacity (move to question two)	
g)	I am responding on behalf of a group, charity or organisation (move to question two)	
h)	Other (please specify)	

Q2 – What type of organisation do you work in? (Only answer if you selected f) or g) for Q1)

NHS organisation (trust or ICB)	
General practice (GP)	
Pharmacy	
Local authority	
Voluntary, community, faith or social enterprise organisation (Please state)	
Patient group (please state)	
Other (Please state)	

Q3 - Where do you live (if you are responding in a professional capacity, please state the area you are based in)?

Cheshire East	
Cheshire West	
Halton	
Knowsley	
Liverpool	
Sefton	
St Helens	
Warrington	
Wirral	
Outside of Cheshire and Merseyside (please specify)	

Q4 (Only answer if you selected a) or b) for Q1) Please tell us, which of the following apply:

I pay for my prescriptions	
I don’t pay for my prescriptions	
Prefer not to say	

Q5 (Only answer if you selected c) or d) for Q1) Please tell us which of the following apply:

The person I care for pays for their prescriptions	
The person I care for doesn't pay for their prescriptions	
Prefer not to say	

Q6 (Only answer if you selected a) or b) for Q1) Do you get gluten-free bread or bread mixes on NHS prescription? Please tick one box only.

Yes	
No	
Prefer not to say	

Q7 (Only answer if you selected c) or d) for Q1) Does the person you care for get gluten-free bread or bread mixes on NHS prescription? Please tick one box only.

Yes	
No	
Prefer not to say	

Q8 – To what extent do you agree or disagree with the proposal to stop providing gluten free bread and bread mixes on prescription?

Strongly agree	
Agree	
Neither agree nor disagree	
Disagree	
Strongly disagree	

Q9 – Please use this space to provide any additional comments. For example, you can explain more about why you agree or disagree with the proposed changes to gluten free prescribing or let us know if the proposed changes could have a negative effect on you or would put you at a disadvantage compared to other people.

Q10 – How did you hear about this consultation? Please tick all the boxes that apply.

From my GP practice	
Local pharmacy	
I (or the person I care for) was sent an email from NHS Cheshire and Merseyside	
Social media e.g. Facebook	
NHS website (for example, NHS Cheshire and Merseyside or hospital trust website)	
Through a patient group and/or voluntary sector organisation I am connected to	
NHS staff communication	
Other, please tell us:	

Equality monitoring

We are asking these questions because we want to make sure that we have asked lots of different people for their views.

All the information that you give will be recorded and reported anonymously – it will never be used with your name or contact details. NHS Cheshire and Merseyside collect this as part of its duty under the Equality Act 2010.

Your data will be treated confidentially and stored in accordance with Data Protection law and NHS Cheshire and Merseyside's privacy policy.

You do not have to answer these questions if you do not want to

1. **What is your ethnic group?** Choose one option that best describes your ethnic group or background.

White: English/Welsh/Scottish/Northern Irish/British	
White: Irish	
White: Gypsy or Irish Traveller	
White: Any other White background (please specify below)	
Mixed/Multiple ethnic groups: White and Black Caribbean	
Mixed/Multiple ethnic groups: White and Black African	
Mixed/Multiple ethnic groups: White and Asian	
Mixed/Multiple ethnic groups: Any other Mixed/Multiple ethnic background (please specify below)	

Asian/Asian British: Indian	
Asian/Asian British: Pakistani	
Asian/Asian British: Bangladeshi	
Asian/Asian British: Chinese	
Asian/Asian British: Any other Asian background (please specify below)	
Black/African/Caribbean/Black British: African	
Black/African/Caribbean/Black British: Caribbean	
Black/African/Caribbean/Black British: Any other Black/African/Caribbean background (please specify below)	
Other ethnic group: Arab	
Prefer not to say	

Any other ethnic group (please specify below):

2. How old are you?

16 - 19		55 - 59	
20 - 24		60 - 64	
25 - 29		65 - 69	
30 - 34		70 - 74	
35 - 39		75 - 79	
40 - 44		80 and over	
45 - 49		Prefer not to say	
50 - 54			

3. What is your religion or belief?

No religion	
Christian (including Church of England, Catholic, Protestant and all other Christian denominations)	
Buddhist	
Hindu	

Muslim	
Sikh	
Prefer not to say	
Other (please specify):	

4. How do you identify?

Male	
Female	
Trans-Man	
Trans-Woman	
Non-binary	
Gender-non-conforming	

Non-binary	
Gender-non-conforming	
Prefer not to say	
Other (please specify):	

5. What is your sexual orientation?

Heterosexual	
Lesbian	
Gay	
Bisexual	
Asexual	

Prefer not to say	
Other (please specify):	

6. What is your relationship status?

Married	
In a civil partnership	
Single	
Divorced	
Living with partner	
Separated	

Widowed	
Prefer not to say	
Other (please specify)	

7. **The Equality Act 2010 protects people who are pregnant or have given birth within a 26-week period. Are you pregnant at this time?**

Yes	
No	
Prefer not to say	

8. **The Equality Act 2010 protects people who are pregnant or have given birth within a 26-week period. Have you recently given birth? (within the last six months)**

Yes	
No	
Prefer not to say	

9. **Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?**

Yes, limited a lot	
Yes, limited a little	
No	
Prefer not to say	

10. **Do you consider yourself to have a disability?** *(*The Equality Act 2010 states a person has a disability if they have a physical or mental impairment that has a 'substantial' and 'long-term' (more than 12 months) negative effect on your ability to do normal daily activities.

Physical disability			Prefer not to say	
Sensory disability (e.g., Deaf, hard of hearing, Blind, visually impaired)			Other (please specify):	
Mental health condition				
Learning disability or difficulty				
Long-term illness (e.g., cancer, diabetes, COPD)				
No, I do not consider myself to have a disability				

11. Do you provide care for someone? A carer is defined as anyone who cares, unpaid (or in receipt of Carer's Allowance, but not someone who is employed as a care professional), for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support.

Yes - Care for young person(s) aged 24 and under	
Yes - Care for adult(s) aged 25 to 49	
Care for older person(s) aged 50 and over	

No	
Prefer not to say	

12. Have you ever served in the armed services?

Yes	
No	
Prefer not to say	

Please return this form by Tuesday, 11 March to.

Email: engagement@cheshireandmerseyside.nhs.uk

Postal address: Communications and Engagement Team
NHS Cheshire and Merseyside
No 1 Lakeside
920 Centre Park Square
Warrington
WA1 1QY

Thank you.

Appendix Three

NHS
Cheshire and Merseyside

Equality Analysis Report
Post Consultation Full EA Report

Cheshire & Merseyside wide

Start Date:	October 2024	
Equality and Inclusion Service Signature and Date:	Nicky Griffiths Andy Woods	30 October 2024 April 2025 post consultation review 25/04/2025 final
Sign off should be in line with the relevant ICB's Operational Scheme of Delegation (*amend below as appropriate)		
***Place/ ICB Officer Signature and Date:**	Katie Bromley	30 October 2024
***Finish Date:**	25th April 2025.	
***Senior Manager Sign Off Signature and Date**		
***Committee Date:**		

1. Details of service / function:
Guidance Notes: Clearly identify the function & give details of relevant service provision and or commissioning milestones (review, specification change, consultation, procurement) and timescales.
This is the final post consultation Equality Assessment. This paper and its recommendations need to be considered by NHSC&M ICB decision makers prior to making a commissioning decision. Failure to 'pay due regard' is unlawful. This **Equality Impact Assessment (EIA)** relates to the proposed cessation of gluten-free bread and bread mixes on prescription and will examine the potential effects on various groups, particularly those protected under the Equality Act 2010. 1. **Impact on Patients**: Identify the change and impact of the proposed cessation of all gluten-free prescriptions on patients, (sections 2 & 3). 2. **Protected Characteristics**: The EIA considers how changes might disproportionately impact groups such as children, the elderly, and women, who are more likely to be diagnosed with coeliac disease. (Please see the initial assessment completed on 30th October 2024). (Sections 3)

3. **Public Sector Equality Duty (PSED)**- will the proposal meet section 149, Equality Act 2010. (Section 6), specifically to eliminate discrimination and Advance equality of opportunity.
4. **Socio economic factors and the ICB's duty (section 1) –** will the proposal widen or decrease health inequalities and disadvantage amongst social inclusion groups and people from low-income households.
5. **Consultation and Feedback**: Public consultation and feedback from stakeholders, including patients, is a cornerstone of the process. We have identified several equality and health inequality concerns and risks that need to be brought to the attention of decision makers. The equality analysis of the consultation can be viewed in section 5. Key issues are identified in section 5.

Background and context

In 2016 – 2017 the Department of Health and Social Care undertook a review of prescribing for gluten free products and following a public consultation recommended that prescribing was limited to bread and bread mixes only.

When gluten free prescribing was first introduced, the availability of these foods was limited, however, all major supermarkets and other retailers stock gluten free foods both in store and on-line. In addition, food labelling has improved, and awareness has increased which means people are able identify which foods contain gluten and choose healthy options.

Currently in Cheshire and Merseyside 7* out of 9 Places offer Gluten Free (GF) Prescribing for patients with diagnosed coeliac disease in line with DHSC guidelines (*St Helens CCG and part of Cheshire West CCG stopped prescribing around 5 years ago). Therefore, there is inequity across Cheshire and Merseyside.

NHS Cheshire and Merseyside was created in July 2022 and, as the statutory body, took over commissioning responsibilities from the 9 former CCGS. NHS C&M has to consider how to use the fixed resource allocation from NHS England to enable them to fulfil their duties and have to decide how and where to allocate resources to best meet the healthcare needs of the population they serve, and in light of the significant financial pressures the ICB face both locally and nationally.

Under the Policy Harmonisation programme, and based on the DHSC consultation and clinical opinion, the recommendation was to re-instate prescribing for bread and bread mixes however this would result in an estimated additional annual spend of £130k.

However, because of the need for NHS Cheshire and Merseyside to consider how they allocate funding to ensure it is being allocated to areas of highest risk and need, a review has been undertaken regarding the continuation of spend on gluten free prescribing and a recommendation to Board to stop gluten free prescribing is being presented. This would of course be subject to a public consultation exercise to inform the final decision.

Several other ICBs have stopped prescribing, one of our neighbouring ICBs Lancashire and South Cumbria do not offer this service, and as an ICB we do not prescribe other food products for patients with other food intolerances or allergies.

What is the **legitimate aim** of the proposal.

- To ensure a harmonised approach across Cheshire and Merseyside to prescribing food products for patients with coeliac disease and with other food intolerances / allergies.
- NICE guidelines do not stipulate prescribing gluten free products. (NG20) https://www.nice.org.uk/guidance/ng20/resources/2019-surveillance-of-coeliac-disease-recognition-assessment-and-management-nice-guideline-ng20-

7019441821/chapter/Surveillance-decision?tab=evidence#:~:text=However%2C%20the%20guideline%20does%20not,a%20local%20and%20regional%20level.

- The ICB must commission efficient, effective and economic services to meet the needs of the population and make financial savings, as well ensuring resources are directed to support high priority services. Stopping prescribing across 8 places which would offer an estimated saving of £525k per year.
- The increased availability of gluten free products in the marketplace.
- GF products are not an essential element of GF diet.
- NHS does not prescribe other food products for patients with other food intolerances or allergies e.g. diabetes and lactose intolerance.

2. Change to service. (Impact on patients and or carers).

Currently 7* out of 9 Places offer Gluten free prescribing for bread and bread mixes, St Helens and Cheshire West CCG opted to stop this prior to the DHSC consultation. *For Cheshire West Place, the area that was covered by the former Vale Royal CCG did not opt to withdraw prescribing, and as such there are still part of Cheshire West were prescribing can be undertaken (Winsford, Northwich, Middlewich and surrounding area).

The proposal would stop prescribing across all of Cheshire and Merseyside. This proposal is based on the much wider availability of gluten free goods, which has increased in the 6 years since the DHSC consultation, the clearer food labelling which makes healthy choices easier and whilst bread is still more expensive than non-gluten free options.

Change to patients includes:

- Patients would need to source GF bread and bread mixes. This would impact -disabled people, people with impairments, young people, people who live in geographical isolated, rural communities, people who experience digital exclusion.
- Patients would need to pay for Gluten Free bread and bread mixes. This would impact people who face significant financial constraints and would impact people with eligible free prescriptions, working poor, people on benefits, disabled people, single parent households, children and young people etc.
- Carers and parents would need to source and purchase GF bread and bread mixes on behalf of their children/ young people, this would impact sex (women – in have caring responsibility and single parent households).
- Carers for disabled people and elderly people would need to source and purchase GF bread and bread mixes. This would impact children and young people who live in low-income households, disabled people.
- Patients/ parents and carers would have to ensure they can plan a full gluten free diet. This would impact children and young people and disabled people.
- Consumers would need to check labels especially on processed foods (impact Disability, Age, language)
- Patients would continue to have access to advice and guidance appropriate to their needs via their GP in line with NG20.

3. Barriers relevant to the protected characteristics

Guidance note describe where there are potential disadvantages.

Headline barriers and issues at play.

Consultation feedback and additional research highlighted strong opposition to the proposal to stop prescribing GF bread and bread mixes.

4.11 94% of those with coeliac disease disagreed or strongly disagreed with the proposal to stop providing gluten free bread and bread mixes on prescription.

4.12 71% of those with another diagnosed condition requiring a gluten free diet disagreed or strongly disagreed with the proposal to stop providing gluten free bread and bread mixes on prescription.

Affordability/ costs

The ability to pay and increased costs of sourcing and buying GF products such as bread and bread mixes. Despite improved availability, the withdrawal of prescribed GF bread and bread mixes would mean that people would have to pay significantly more for these products.

- **Higher Costs**: Gluten-free bread and bread mixes cost more than their gluten-containing counterparts. Families with limited financial resources may struggle to afford these specialised products.
- **Limited Access**: In areas with high poverty rates or rural communities, stores may not stock a wide variety of gluten-free options, making it harder for families to find affordable choices.

According to a recent report by Coeliac UK:
Bread loaves are approximately 4.5 times more expensive.
Plain flour is about 2 times more expensive.
Bread rolls are around 3.1 times more expensive.
Crackers are 1.7 times more expensive.
Cereals are 2.1 times more expensive.
Home - Coeliac UK

Limited access to source GF bread and bread mixes

Accessing GF bread and bread mixes due to geographical location and access to supermarkets that supply GF bread and bread mixes. This could impact people who find it difficult to travel and for people with disabilities who experience barriers to access.

Whilst GF bread and bread mixes are available on-line, this will still impact people who are digitally excluded including older people, disabled people, and a range of social inclusion groups below.

Health literacy: Planning a GF diet.

This will disproportionally impact children and young people, vulnerable and disabled adults, women, older people, race, and people who live in low-income houses.

Non-adherence to diet and clinical risks of dietary neglect for children and young people and vulnerable adults.

Protected Characteristic	Issue	Remedy/Mitigation

Age	**Children and young people** C&M data shows that less than 12% of prescriptions are allocated on the basis of being under 18yo. Research and consultation feedback from primary stakeholders highlighted a range of key concerns. *(see section 5). **Consultation report Section 4.13** 90% of parents/guardians/carers of a child with coeliac disease, or another diagnosed condition requiring a gluten free diet disagreed or strongly disagreed with the proposal to stop providing gluten free bread and bread mixes on prescription. **Comments from parents and carers** Children and young people are reliant on their parents and carers to buy and source GF bread and bread mixes. Children and young people are reliant on their parents and carers to plan a GF diet. This issue will be expounded if the child or young person is part of a low-income household and experiences poverty. The financial burden will mean some people will not be able to afford more expensive GF bread and bread mixes, risking nonadherence to GF diet. Families with low health literacy skills, face significant challenges accessing and understanding health information and services, leading to poorer health outcomes, including increased rates of preventable diseases, reduced adherence to medication and treatment plans, and higher rates of hospitalisation. https://library.nhs.uk/addressing-low-levels-of-health-literacy-a-determinant-of-poor-health/#:~:text=Health%20illiteracy%20has%20a%20stronger%20correlation%20to,emergency%20services%2C%20thus%20incurring%20higher%20healthcare%20costs. Parents and carers expressed affordability and the fact that many institutions like schools do not provide GF foods. This means GF products such as bread and bread mixes are important for packed lunches. https://assets.publishing.service.gov.uk/media/5a8	**See recommendations below for decision makers to consider ongoing support and access to GF prescriptions for low-income families with children and young people.**

	0b62d40f0b62302695133/4b_Health_Literacy-Briefing.pdf **Stigma and Isolation**: Children may feel isolated or stigmatised if they cannot eat the same foods as their peers, which can affect their willingness to adhere to a gluten-free diet. **Children's Taste and Behaviours** Preference for familiar foods: children often prefer foods they are accustomed to. Introducing new gluten-free alternatives can be met with resistance, especially if the taste or texture differs significantly from what they are used to. Behavioural challenges: children may have strong food preferences and aversions, making dietary changes difficult. This can be exacerbated by sensory issues or developmental disorders, which are more prevalent in low-income populations. Preparing gluten-free meals often requires more cooking from scratch, which can be challenging for families who rely on convenience foods due to time constraints, affordability, lack of cooking skills, child's tastes and preferences. Developmental Needs: Children and young people are in critical stages of growth and development. Ensuring they have access to necessary gluten-free foods is essential for their physical and cognitive development, as in line with Cheshire and Merseyside, Starting Well priorities. Coeliac UK also support the argument to prioritise children and young people, so they can have the best start in life. Malnutrition or dietary deficiencies during these formative years can have long-lasting impacts on their health and well-being. **Working age / older citizens** **4.14** 87% of carers of an adult with coeliac disease, or other diagnosed condition disagreed or strongly disagreed with the proposal to stop providing gluten free bread and bread mixes on prescription. (consultation report). According to Coeliac UK, the majority of people are diagnosed from 50 years old, and it is most common in people aged between 50 – 69 years.	**Recommendations below for decision makers to consider prescriptions for low income/ vulnerable adult patients, at risk of dietary neglect or non-adherence to GF diet.**

	C&M data shows that 60% of GF prescriptions are allocated because patients are aged 60 and above and therefore our older age population may feel disadvantaged by stopping prescribing. This disadvantage will be compounded by older people who reside in low-income households as this creates issues around affordability. Families with low health literacy skills, face significant challenges accessing and understanding health information and services, leading to poorer health outcomes, including increased rates of preventable diseases, reduced adherence to medication and treatment plans, and higher rates of hospitalisation. In C&M the majority of patients receiving GF prescriptions are exempt from charges, with over 70% of this being due to age. Because this exemption does not take into account financial capacity it is difficult to evidence what the individual financial impact on the impacted patients would be. Consideration should also be given to older people (who tend to be less mobile) or less mobile people (e.g. due to physical disability) who are more likely to find it difficult to source gluten free bread and bread mixes. Continue to prescribe GF for children and vulnerable old people are supported by a number of organisations including: BSPGHAN Position Paper RCPCH Consultation Response BDA Policy Statement Digital exclusion and sourcing GF may prove difficult.	Support would need to be developed to support adults and older people. (Transition plan). **Recommendations below for decision makers to consider prescriptions for all children under 18 years / or just children from low income families / vulnerable adult patients, at risk of dietary neglect or non-adherence to GF diet.** Communications and resources developed for children, young people and parents. To improve access. GF products are much more widely available in supermarkets and other outlets both in store and on-line, and improved food labelling means that patients are able to make more informed decisions about a healthy diet. *dependent upon health literacy).
Disability (you may need to discern types)	**4.14** 87% of carers of an adult with coeliac disease, or other diagnosed condition disagreed or strongly disagreed with the proposal to stop providing gluten free bread and bread mixes on prescription. Coeliac disease is not automatically classified as a disability under UK law. However, it can be considered a disability if it meets certain criteria outlined in the Equality Act 2010. For coeliac disease to be classified as a disability, it must have substantial and long-term effects on the individual's ability to perform everyday tasks. This includes difficulties in managing the strict gluten-	**If people are vulnerable to dietary neglect, then patients should have access to GF bread and bread mixes.** Many supermarkets now have outlets on-line offering home deliveries which would support those with mobility issues to access GF bread and bread mixes. GPs could offer prescriptions through the Individual Funding

	free diet required to prevent symptoms and complications. This could be due to sensory impairments, physical disabilities, neuro diverse, learning disabilities, dementia, mental ill health. Currently, patients can get free NHS prescriptions if, at the time the prescription is dispensed, they: • have a continuing physical disability that prevents them from going out without help from another person and have a valid MedEx • hold a valid war pension exemption certificate and the prescription is for an accepted disability. People with coeliac disease, amongst these groups of people, are therefore be negatively impacted as a result of this proposal. People in this cohort may feel that this has a detrimental effect on their finances and so on their overall quality of life. • People with learning difficulties and mental ill health are significant risk of dietary non-adherence. • People with learning difficulties may find the GF labelling confusing and could be at greater risk of not adhering to a GF diet without these products being prescribed. • Patient with mobility issues may struggle to get to shops to buy GF foods. • Disabled people are more likely to live in low-income families and will be reliant on benefits **Mental Health**: The stress of living in poverty can impact mental health, making it harder to focus on and implement dietary changes. The emotional burden of managing a chronic condition like coeliac disease can be overwhelming. • significant impacts on various groups, including those with learning disabilities, sensory impairments, neurodiversity, and poor mental health. • Accessibility and Affordability Increased Financial Burden: Gluten-free bread and bread mixes are more expensive than their gluten-containing counterparts. Removing these products from prescription can place a financial strain on individuals who rely on them, particularly those from low-income backgrounds • Accessibility Issues: For individuals with sensory impairments or learning disabilities, navigating supermarkets and identifying gluten-free products can be challenging. Prescriptions simplify this process by ensuring they receive the necessary items without the need for extensive shopping.	Request (IFR) process if their patient could demonstrate exceptionality.(but this is extremely small numbers). GP would continue to monitor patients **If people are vulnerable to dietary neglect, then patients should have access to GF bread and bread mixes.** Need for Advocacy: There is a need for advocacy and support from healthcare providers and community organisations to ensure that individuals affected by these policy changes receive adequate support and resources

	• Health and Well-being Dietary Management: Inconsistent access to gluten-free foods can lead to accidental gluten consumption, resulting in health complications. Mental Health Impact: The stress of managing dietary restrictions without prescription support can exacerbate mental health issues. Anxiety and depression are common among individuals who struggle to maintain their diet due to financial or accessibility barriers. • Social and Psychological Effects Stigma and Self-Esteem: The removal of prescriptions can contribute to feelings of stigma and lower self-esteem, as individuals may feel neglected by the healthcare system • Policy and Community Support Community Impact: The removal of gluten-free prescriptions can disproportionately affect vulnerable populations, including those with neurodiversity and poor mental health, who may already face challenges in accessing healthcare and support.	
Gender reassignment	No greater impact	
Marriage and Civil Partnership	No greater impact	
Pregnancy and maternity	Poorly controlled coeliac disease in pregnancy can increase the risk of developing pregnancy-related complications, such as low-birth-weight. However, if pregnant women adhered to gluten free diet and their disease is under control then pregnancy related risk would be like pregnant women without coeliac disease. Pregnant women with coeliac disease get advice on managing their condition from both General Practitioners and hospital doctors. Only 0.15% of the prescription exemptions are because of maternity exemption which implies the number of patients impacted is minimal. The prescription exemption applies to pregnant women from the time they are pregnant to one year after either the due date or delivery date. This protected group will have short term effect, that may have along term impact and poorer outcomes.	If pregnant women adhered to gluten free diet and their disease is under control, then pregnancy related risk would be like pregnant women without coeliac disease. Pregnant women with coeliac disease get advice on managing their condition from both GPs and hospital doctors. prescription to be provided if there is a risk of dietary non adherence.
Race	While coeliac disease, an autoimmune disorder triggered by gluten, can affect anyone, research	

	suggests that BAME (Black, Asian, and Minority Ethnic) individuals may experience lower rates of diagnosis and potentially face unique challenges with adhering to a gluten-free diet. This is not to say coeliac disease is limited to any specific ethnicity, but rather that factors like awareness, cultural dietary habits, and potential biases in healthcare access may contribute to disparities in diagnosis and adherence. Key points about BAME individuals and coeliac disease: • **Lower Diagnosis Rates:** Some studies indicate that BAME individuals may be less likely to be diagnosed with coeliac disease compared to white populations, even though the disease can affect anyone. • **Challenges with Adherence:** Adhering to a gluten-free diet (GFD) can be particularly challenging for some BAME individuals due to cultural dietary preferences, limited access to gluten-free foods, and social situations that may make adhering to a GFD difficult, according to the British Dietetic Association (BDA) [3, 20]. Expounded by poverty and inequalities, research indicates that BAME (Black, Asian, and Minority Ethnic) communities in the UK are significantly more likely to experience poverty compared to white communities. Poverty rates are not uniform within BAME groups, and some ethnic groups experience particularly high levels of poverty. **Higher Poverty Rates:** Overall, BAME individuals are more likely to live in poverty than white individuals. • **Specific Ethnic Groups:** Bangladeshis, Black Africans, and Pakistanis are particularly vulnerable to persistent poverty. **Social and Cultural Factors** • **Cultural Food Practices**: Traditional and culturally significant foods may contain gluten, making dietary changes more complex. Families may struggle to find gluten-free alternatives that fit within their cultural practices. Language barriers **Stress and Mental Health**: The stress of living in poverty can impact mental health, making it	**If people are vulnerable to dietary neglect, then patients should have access to GF bread and bread mixes.** GF bread and bread mixes to be prescribed if at risk of dietary neglect Ensure communications are developed in alternative languages and align to cultural food differences.

	harder to focus on and implement dietary changes. The emotional burden of managing a chronic condition like coeliac disease can be overwhelming. Access to information and poorer health literacy amongst racialised communities who experience poverty.	
Religion and belief	No greater impact	
Sex	According to NICE the prevalence in females is higher than in males (60% compared to 40%). C&M data reflects this with 65% of patients being female. This could result in females being more impacted than men, and they may feel that this has a detrimental effect on their finances and so on their overall quality of life. **Stress and Mental Health**: The stress of living in poverty can impact mental health, making it harder to focus on and implement dietary changes. The emotional burden of managing a chronic condition like coeliac disease can be overwhelming. Preparing gluten-free meals often requires more cooking from scratch, which can be challenging for families who rely on convenience foods due to time constraints, affordability, lack of cooking skills, Childs tastes and preferences. Women in the UK are more likely to live in poverty than men, and austerity measures have disproportionately impacted their living standards, particularly for certain groups. Studies show that women have experienced a higher annual loss in living standards compared to men since 2010, with some groups, like **single mothers** and those from Black and Asian backgrounds, facing the most significant drops. Elaboration: • **Gender Pay Gap:** The persistent gender pay gap contributes to women having lower average incomes than men. • **Austerity Impact:** Austerity measures, including cuts to social security and public services, have disproportionately affected women, who are more likely to rely on these services and often	Food labelling is much improved and supports people to make healthy choices. In addition, bread is not necessary for a healthy diet as there are gluten free alternatives e.g. GF pasta, rice, potatoes etc. There are many websites with information on how to remain GF. GP would continue to monitor patients

	bear the brunt of unpaid caregiving responsibilities. • **Specific Groups:** Women with disabilities, single mothers, those from Black and Asian backgrounds, and those living in poverty are particularly vulnerable to the effects of austerity. • **Research Findings:** Studies by the Women's Budget Group and other organizations have documented the significant losses in living standards for women, with some groups experiencing reductions of over 20%. • **Intersectional Analysis:** The impact of austerity is not uniform; it intersects with other factors like ethnicity, disability, and income levels, exacerbating existing inequalities. • **Impact on Health:** Austerity has been linked to negative health outcomes for women, including reduced life expectancy and increased mortality rates, particularly in deprived areas. Single parent households, including men and women, will be more likely to experience lower income. (caring responsibility for children, young people or vulnerable adults).	
Sexual orientation	No greater impact	
Whilst currently out of scope of Equality legislation it is also important to consider issues relating to socioeconomic status to ensure that any change proposal does not widen health inequalities. Socioeconomic status includes factors such as social exclusion and deprivation, including those associated with geographical distinctions (e.g. the North/South divide, urban versus rural). *Examples of groups to consider include:* *refugees and asylum seekers, migrant, unaccompanied child asylum seekers, looked-after children/ care leavers, homeless people, prisoners and young offenders, veterans, people who live in deprived areas, People living in remote, and rural locations.* *Health inclusion groups* *https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/what-are-healthcare-inequalities/inclusion-health-groups/* *For a more in-depth assessment of health inequalities please use the HEAT toolkit* https://www.gov.uk/government/publications/health-equity-assessment-tool-heat		
refugees and asylum seekers	For people prescribed with GF prescriptions, adherence to a GF diet would prove extremely difficult due to financial constraints.	Provide for people at risk of dietary neglect.

Looked after children and care leavers	Children and young people in care are not financially independent and often rely on GF specific products. Children in care with coeliac disease or other dietary issues require careful management of their food and nutritional needs. Coeliac disease, an autoimmune disorder triggered by gluten, necessitates a lifelong gluten-free diet. Other dietary issues can arise from various factors and may require tailored plans. Open communication with caregivers, preparation of safe meals and snacks, and potentially consulting with a registered dietitian are crucial for ensuring adequate nutrition and preventing complications. More likely to non-adhere to a GF diet. (see Age above).	Provide for people at risk of dietary neglect. Open communication with caregivers, preparation of safe meals and snacks, and potentially consulting with a registered dietitian are crucial for ensuring adequate nutrition and preventing complications.
Homelessness	More likely to non-adhere to a GF diet.	Provide if at risk of dietary neglect. Homelessness support organisations to provide advice
Worklessness	Issues associated with poverty outlined above, will impact adherence to GF diet.	Provide if at risk of dietary neglect.
People who live in deprived areas	Issues associated with poverty outlined above, will impact adherence to GF diet.	Provide if at risk of dietary neglect.
Carers	See consultation section 5. Many parents and carers discussing their reliance on GF prescriptions and the associated disadvantages with poverty and low levels of health literacy.	
Young carers	See Children and young people above.	
People living in remote, rural and island locations	There is a risk that people in more remote areas will not have the same access to supermarkets with gluten free alternatives to bread or bread mixes. People in this cohort may feel that this has a detrimental effect on their finances and so on their overall quality of life.	Many supermarkets offer on-line shopping and deliver to homes, and bread is not necessary for a healthy diet as there are gluten free alternatives e.g. GF pasta, rice, potatoes etc. GP would continue to monitor patients
People with poor literacy or health Literacy	See section 3 above, Age, disability, sex, race	
People involved in the criminal justice system: offenders in prison/on probation, ex-offenders.	High likelihood of non-adherence to GF diet.	
Sex workers	High likelihood of non-adherence to GF diet.	

People or families on a low income	There is a risk that people or families on low income will not be able to adhere to a gluten free diet because the cost of GF bread and bread mixes compared to a standard loaf and flour is higher. People on low income who choose to purchase gluten free products because they can no longer obtain them on prescription may feel that this has a detrimental effect on their finances and so on their overall quality of life. The financial capacity of patients over 60 receiving prescription payment exemptions due to age is unknow and therefore there is a risk that they will be impacted because of low income. Children and young people are at risk from not being able to adhere to a GF diet if the cost is too expensive. According to Coeliac UK a weekly gluten free food shop can be as much as 20% more expensive than a standard weekly food shop	Recommendations to decision makers to provide GF prescriptions for children and young people from low income households. C&M data shows that less than 2% of the prescription exemptions are because the patient is in receipt of tax credit or income based job seekers allowance. Whilst the cost of bread and flour is more expensive, there are other GF products e.g. pasta which is the same price as standard, and there are other natural GF foods. There are websites with information on how to maintain a GF diet. GP would continue to monitor patients.
People with addictions and/or substance misuse issues	High likelihood of non-adherence to GF diet.	
SEND / LD	See disability and children and young people above	See disability above
Digital exclusion	Older People and access to products and information on line and social inclusion groups.	See above Older people /Age.

4. What data sources have you used and considered in developing the assessment?

NHS England Guidance: 'Prescribing Gluten-Free Foods in Primary Care: Guidance for CCGs' NICE guidance regarding coeliac disease: https://www.nice.org.uk/guidance/qs134, Department of Health & Social Care website, Coeliac UK website, C&M prescribing data.

5. Involvement: consultation/ engagement

Guidance note: How have the groups and individuals been consulted with? What level of engagement took place? (If you have a consultation plan insert link or cut/paste highlights)

A selection of comments reflecting a range of frequently occurring themes for those against the proposal – stop providing gluten free bread and bread mixes on prescription.

People don't choose to be born with a gluten intolerance and I think it is absolutely abhorrent to even think about taking this off prescription, as the cost of living rises so does the cost of food – and the cost for gluten free food is extortionate anyway so taking gluten free prescribing away from 30% of the population who have been clinically diagnosed with coeliac disease not counting people who medically need a gluten free diet I think is a crazy proposition to even think of.

A gluten free diet is the medical treatment for coeliac disease therefore it is not an optional dietary choice. Gluten free products are 4x more expensive than regular products so it would have a real impact on our family finances if gf prescribing was stopped.

Gluten free food is 35% more expensive without any additional help. There is very little available on prescription so stopping bread mixture and bread will impact further on people who already have ridiculous expensive food bills

These changes would be detrimental to the health of my daughter aged 11 yrs. She is Type 1 Diabetic as well and the gluten free products in the supermarkets are so expensive for us to buy that she wouldn't be able to eat a balanced diet as we can't afford the nicer gluten free bread

A food shop for a person with Coeliac disease costs 35% more. Bread is a staple, yet a gluten free loaf can cost £3.50 making it unaffordable for people on low incomes. Coeliac poverty makes people feel that they have no option but to eat food cheaper food containing gluten that then causes other health issues.

As a parent of a coeliac daughter, I'm struggling to pay for the essential foods that she needs. Like bread for her lunches.

The sheer overwhelming lack of most food choices already limits my child and what gluten free food we can buy is already so much more expensive. We have no other choice; the only medical advice is to not eat gluten. Having gf flour on prescription gives us the ability to cook a lot of items we simply cannot purchase in supermarkets or are often out of stock. Such as our own pastry, bread, other items. We already have to provide our child with packed lunches as school do not provide gf and any social outings or parties we need to take our own food. We simply cannot "go out" without gf food with us. Having gf flour on prescription means we can visit places and still go out with friends. The sheer amount of extra sugar and additives in gf food which can be purchased in shops is really high and if

we are forced to purchase gf bread from shops this will impact the health of our child giving longer term impact on medical requirements.
The cost of living plus the price of gluten free food in general is hitting our pockets hard. Having the free bread and bread mix helps.
I strongly believe that gluten-free bread should remain available on NHS prescription. For people with coeliac disease, a strict gluten-free diet is the only treatment, and gluten-free alternatives are often significantly more expensive and harder to access than standard bread. The NHS provides essential medications for chronic conditions and gluten-free prescriptions should be treated no differently. Maintaining access ensures equality in healthcare and prevents unnecessary strain on NHS resources from complications arising from poor dietary management. Not all supermarkets or local shops stock gluten free products. Without a prescription for gluten free products, we may have to travel further or go without for our daughter making it harder to follow a strict gluten free diet.
Gluten free food is unaffordable. We get the basic bread and /or flour on prescription. We are limited to 8 units. Schools cannot safely provide food for our children. This means I need bread products to cover breakfasts and lunches. We are a one earning household who take no benefits. The bread products required to provide even the basics like sandwiches and toast are so expensive we can't afford to pay for it on top of other ingredients we pay our selves like pasta. Either keep prescriptions or provide subsidies like in Wales in the form of food tokens. With children especially you can't just eat 100% naturally gluten free food. This proposal is a disgrace.
My child relies on the flour and bread on prescription. I cannot afford the increased cost in the supermarkets
I feel sick with worry about this. My child was diagnosed 6 months ago and getting her to eat gluten free has been a big struggle. The bread from the GP really helped and I don't know how I'm going to manage to buy the food I need for her if it's taken away.
I disagree with the proposal to withdraw gluten free bread mixes from prescriptions. I encounter a variety of people in their own homes every day. In many communities' families cannot afford sufficient nutrition to maintain their health. This is only exacerbated in those adhering to a gluten free diet and the removal of gluten free mixes from prescriptions would only worsen this issue for countless deprived families and individuals. The removal of gluten free bread mixes runs the risk of removing a staple macronutrient and energy source from these individuals and further exacerbates health inequality and increases malnutrition risk in a region where spending on oral nutritional supplements indicated for use on malnutrition far exceeds the national average. The removal of gluten free bread mixes would only be a false economy.

Risk	Required Action	By Who/ When
If the option to withdraw prescribing is accepted, there is a risk that patients who previously received prescriptions will not adhere to a GF diet which could have significant health implications for them and will potentially increase demand (& cost) on future NHS Services.	A published DHSC Impact Assessment examines the issue of adherence in detail and concludes that adherence to a GF diet cannot be isolated to any single cause. Evidence shows that many factors are at play including product labelling, cost and information when eating out and managing social occasions. Adherence requires a range of knowledge and skills to avoid all sources of gluten. Gluten free foods are now much more readily available in supermarkets, with clear gluten free labelling and greater awareness on healthy	Medical Directorate would ensure this happened following a decision

An example given by Coeliac UK states it costs £195 a year per patient to support GF on prescription, but the average cost to the NHS of an osteoporotic hip fracture is £27,000.	eating choices. Whilst bread and bread mixes are still more expensive that non GF products (according to Coeliac UK a gluten free loaf of bread is on average 4.3 times more expensive than a standard gluten containing loaf) it can be said that the cost of these products has been reducing over time and there are other GF products that are comparable prices to standard goods (e.g.500g of GF pasta is the same price as 500g of pasta containing gluten). In addition, there are naturally free gluten free products e.g. rice, potatoes. In C&M the majority of patients receiving GF prescriptions are exempt from charges, with over 70% of this being due to age. Because this exemption does not take into account financial capacity it is difficult to evidence what the individual financial impact on the impacted patients would be. It should be noted that there are less than 2% of prescription exemptions identified as being on tax credits or income support. If the option to stop prescribing was accepted, information on how to adhere to a gluten free diet would be made available and GPs would continue to monitor these patients as usual.	
There is a reputational risk to the ICB if the option to withdraw prescribing is accepted. Due to the current cost of living, there have been a number of national articles on the increased cost of "free from" foods despite them being much more available. In addition, 99% of the cohort of patients receiving prescriptions have an exemption in that they do not pay for prescriptions so could be seen that we are	See above regarding non-GF options. In addition, the ICB does not prescribe for other conditions that are associated with, or affected by the types of food they eat, so this would result in a fairer approach for these patients. A public consultation has been held to understand feedback from patients, carers and interested parties. This feedback will be considered by the ICB decision makers	n/a

disadvantaging our most vulnerable population.		

6. Is there evidence that the Public Sector Equality Duties will be met (give details) Section 149: Public Sector Equality Duty (review all objectives and relevant sub sections)
PSED Objective 1: Eliminate discrimination, victimisation, harassment and any unlawful conduct that is prohibited under this act: (check specifically sections 19, 20 and 29)
The proposal to cease funding for gluten free bread and bread mixes is not in of itself discriminatory as it is in line with NICE guidelines NG20, it is much more widely available in the marketplace; it is not an essential ingredient of maintaining a gluten free diet. GP services will continue to support in line with guidelines. However, accessing gluten free prescriptions engages with specific protected groups, social inclusion groups and communities impacted by socio-economic factors and deprivation (section 3- barriers and impact). Financial Burden: For individuals with coeliac disease, purchasing gluten-free bread and bread mixes can be expensive. Removing these items from prescription could impact those who do not have the ability to pay for these products in the marketplace. (women, single parents, disabled people (including frail elderly), children and young people and vulnerable adults). Health Equity: disproportionately affect low-income households who may struggle to afford gluten-free products, leading to health disparities. (women, single parents, disabled people (including frail elderly), children and young people and vulnerable adults).
PSED Objective 2: Advance Equality of opportunity. (check Objective 2 subsection 3 below and consider section 4)
Please refer to sections 3 and section 5 above (consultation feedback from primary stakeholders (parents / carers) and additional research. For people who have the ability to source and buy GF products and manage and plan a GF diet, the proposed cessation of GF products on prescription will be extremely inconvenient but the consultation feedback has outlined concerns that go significantly beyond inconvenience and support Coeliac UK argument to maintain GF prescriptions for under 18 years (25 for people with additional needs). For people with coeliac disease, a strict gluten-free diet is not a lifestyle choice but a medical necessity. Ensuring access to these products through prescriptions can help manage their condition effectively. The impact of removing GF bread and bread mixes would disadvantage children and vulnerable adults (disability) from low-income households, who are at risk of 'dietary neglect'. Children and young people have no agency to source and buy GF bread and bread mixes and plan a GF diet. This is further compounded by children who reside in low-income households or who are in care. This places significant financial constraints on families to purchase GF bread and bread mixes from the marketplace, as the costs are higher, this could impact the effective adherence to a GF diet. Furthermore, low-income families are more likely to have low levels of health literacy and could and therefore be more susceptible to not adhere to a GF diet and develop medical complications. It is also important to acknowledge children occupy a different space to adults, in terms of both their dietary behaviours and development. Although GF prescription bread and bread mixes are not essential for maintaining a GF diet, we have to recognise that for children and families are currently reliant on these. The bread mix is a versatile ingredient that can be used to make a range of foods, such as pancakes, which are particularly important for satisfying the dietary preferences of children and young people. Moving to other alternative products may prove very difficult. This is especially the case for children and young people with autism.

https://www.autism.org.uk/advice-and-guidance/professional-practice/gluten-casein-free#:~:text=There%20is%20a%20subset%20of%20autistic%20children,of%20a%20gluten%20and%20casein%20free%20diet.&text=A%20majority%20of%20these%20parents%20reported%20significant,health%2C%20sleeping%20patterns%2C%20concentration%20and%20social%20communication.

- Reducing Health Disparities: Ensuring these patients have access to necessary dietary products helps reduce health disparities and promotes better health outcomes.
- Widening health inequalities: Acknowledging that financial barriers and low levels of health literacy and vulnerability impact people's ability to maintain a GF diet.
- Advancing Equality of Opportunity: Supporting vulnerable children and adults in managing their health conditions effectively promotes equality of opportunity.
- Longer term resource issues: Supporting children and vulnerable individuals by providing gluten-free products on prescription can prevent further hospital admissions and poor patient outcomes and costs on NHS resources.

Providing free prescriptions to children and vulnerable people is also supported by the following key clinical organisations

British Society of Paediatric Gastroenterology, Hepatology and Nutrition (BSPGHAN): BSPGHAN supports the provision of gluten-free prescriptions for children diagnosed with coeliac disease. They highlight the clinical necessity and the role of these prescriptions in ensuring adherence to a strict gluten-free diet, which is crucial for managing the condition. BSPGHAN Position Paper

Royal College of Paediatrics and Child Health (RCPCH): The RCPCH advocates for the provision of gluten-free prescriptions for children with coeliac disease, stressing the importance of these prescriptions in preventing nutritional deficiencies and ensuring proper growth and development. RCPCH Consultation Response

British Dietetic Association (BDA): The BDA supports the continuation of gluten-free prescriptions for children, highlighting the role of dietitians in managing coeliac disease and the need for accessible gluten-free foods to ensure dietary compliance. BDA Policy Statement

PSED Objective 2: Section 3. sub-section a) remove or minimise disadvantages suffered by people who share a relevant protected characteristic that are connected to that characteristic.

See above

PSED Objective 2: Section 3. sub-section b) take steps to meet the needs of people who share a relevant protected characteristic that are different from the needs of people who do not share it

see PSED Objective 2: Section 3. sub-section c) encourage people who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such people is disproportionately low.

See above

PSED Objective 3: Foster good relations between persons who share a relevant protected characteristic and persons who do not share it. (Consider whether this is engaged. If engaged, consider how the project tackles prejudice and promotes understanding -between the protected characteristics)

Not engaged

Health Inequalities: Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (s.14T);

It is a core purpose of the ICB to tackle inequalities in outcomes, experience and access. ICB's are required to have regard to the need to a) reduce inequalities between persons with respect to their ability to access health services, and b) to reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

If the proposed cessation of GF prescriptions is agreed it will more likely widen health inequalities specifically for coeliacs, specifically for low-income households who face a significant financial burden, who are more likely to have low levels of health literacy and are vulnerable of dietary neglect or non-adherence to a GF diet.

Consultation feedback Section 5 has outlined significant concerns. These must be taken into account by decision makers.

PSED Section 2: Consider and make recommendation regards implementing PSED in to the commissioning process and service specification to any potential bidder/service provider (private/ public/charity sector)

Mitigations identified in section 3 include the following:

Depending on the decision maker consideration and due regard, GF prescribing guidelines will need to be changed. Cessation or restricting prescribing to specific groups identified above and in the consultation feedback.

Development of support materials for patients with information and communication needs.
Sign posting patients to resources and information.

- Coeliac UK – www.coeliac.org.uk
- NHS – www.nhs.uk/conditions/coeliac-disease/
- The Association of UK Dietitians – www.bda.uk.com/resource/coeliac-disease-and-gluten-free-diet.html

This ICB decision does not affect the provision by local authorities for children who require a gluten-free diet at school.

Specific communications will need to be adapted so they inclusive and meet the information, communication and language needs of patients.

7. Recommendation to Board

Guidance Note: will PSED be met?

1. The proposal to cease funding for gluten free bread and bread mixes is not in of itself discriminatory as it is in line with NICE guidelines NG20, they are much more widely available in the marketplace and they are not essential ingredients of maintaining a gluten free diet. GP services will continue to support in line with N20 guidelines.
2. However, with regard to Advancing Equality of Opportunity (PSED Objective 2, above) and 'due regard' it is important that decision makers consider the impact on children and young people, disabled/ vulnerable children and adults, women, and pregnancy. Children and young people are of significant concern, as affordability, children and young people's behaviours in relation to food, their inability to source and plan GF, the increased likelihood of nonadherence to a GF diet could result in poor outcomes.
3. Health Inequalities duty (s.14T); has identified that low income and low levels of health literacy will impact peoples ability to afford, source and plan GF diet. This will impact children and young people and vulnerable adults.
4. Take into account the consultation feedback, specifically from primary stakeholders who expressed overwhelming rejection of the proposal. Also consider the range of concerns on clinical needs and risks, affordability, access, health literacy and supporting their children or vulnerable adults to adhere to a GF diet who are risk of dietary neglect (including all pregnant women). The practicality of determining low income and poverty is challenging.

8. Actions that need to be taken

Dependent upon decision.

Mitigations will need to put in place for vulnerable adults and children at risk of dietary neglect.

QUALITY IMPACT ASSESSMENT					
Project Name	Gluten Free Prescribing – Option 3 All Places Withdraw Gluten Free Prescribing				
Verto/PMO reference		Date of QIA	10/07/24	Date QIA reviewed	Stage 1 (local) 21/08/2024 Stage 2 (regional) 06/09/24
Name of Project Manager	Katie Bromley	Name of Programme manager	Natalia Armes	Clinical Lead	Rowan Pritchard Jones
Confirm date discussed at PDG or appropriate Place forum.	n/a ICB Wide Recovery Programme	Is this QIA part of an options appraisal?	Yes	Is the place of care expected to change?	n/a
Is this a permanent or temporary change? (e.g., a GRANT or a PILOT scheme?)	Permanent	If temporary – what are the expected timescales?	n/a	What will happen to the cohort of patients in progress when the service ends?	They will have to fund their own Gluten Free products
It is a nationally, or regionally, mandated service?	No	Is it identified as clinically essential?	No	Is it a statutory service? Y/N and details	No
Confirm if a Digital Impact Assessment has been undertaken	n/a	Confirm if a DPIA is required. (Remember this on **all** the data involved – not just the data held by NHS C&M)	n/a	An EIA is advised. Confirm if it has been undertaken.	Yes
Number of patients affected	2570 (23/24 data)	**Mitigated quality risk if project progresses.**	Moderate - 4	**Mitigated Quality risk if project is NOT Progressed**	Low - 1
Current costs	£520,000	Proposed costs	£0	Does it impact on another C&M Place?	8 of 9 Places: Liverpool Wirral Sefton

					Knowsley Warrington Halton Cheshire East Cheshire West (excluding GP practices in Cheshire West CCG footprint)

Background and overview of the proposals *(can be copied from PID on Verto or from National/Regional commissioning guidance)*

In 2016 – 2017 the Department of Health and Social Care undertook a review of prescribing for gluten free products and following a public consultation recommended that prescribing was limited to bread and bread mixes only.
When gluten free prescribing was first introduced, the availability of these foods was limited, however, all major supermarkets and other retailers stock gluten free foods both in store and on-line. In addition, food labelling has improved, and awareness has increased which means people are able identify which foods contain gluten and choose healthy options.

Currently in Cheshire and Merseyside 7* out of 9 Places offer Gluten Free prescribing for patients with diagnosed coeliac disease in line with the national Department of Health and Social Care (DHSC) consultation the outcome of which was to reduce prescribing to bread and bread mixes only in 2018. It is of note that for the remaining 2 Places, St Helens CCG and Cheshire West CCG opted to withdraw prescribing completely (noting this was prior to the national Department of Health and Social Care (DHSC) consultation as detailed above).
*For Cheshire West Place, the area that was covered by the former Vale Royal CCG did not opt to withdraw prescribing, and as such there are still part of Cheshire West were prescribing can be undertaken (Winsford, Northwich, Middlewich and surrounding area. Therefore, there is inequity of access to these products across Cheshire and Merseyside.

NHS Cheshire and Merseyside was created in July 2022 and, as the statutory body, took over commissioning responsibilities from the 9 former CCGS. NHS C&M has to consider how to use the fixed resource allocation from NHS England to enable them to fulfil their duties and have to decide how and where to allocate resources to best meet the healthcare needs of the population they serve.

Under the Policy Harmonisation programme, and based on the DHSC consultation and clinical opinion, the recommendation was to re-instate prescribing for bread and bread mixes however this would result in an estimated additional annual spend of £130k. However, because of the need for NHS Cheshire and Merseyside to consider how they allocate funding to ensure it is being allocated to areas of highest risk, a review has been undertaken regarding the continuation of spend on gluten free prescribing and a recommendation to Board to stop gluten free prescribing is being presented. This would of course be subject to a public consultation exercise in order to inform the final decision.

The purpose of the QIA is to help articulate the risks to patients as it is hard to evidence the impact of withdrawing Gluten Free prescribing.

Risks if the project did not go ahead.

If this option was not supported, this would leave unwarranted variation in access to these services.

Patient safety

Please confirm the specific patient groups affected. Advise the impact on health inequalities	There are over 13,300 patients diagnosed with Coeliac Disease and other conditions which would deem them eligible for gluten free prescribing. Most patients choose to purchase their GF products themselves, however, 2,314 patients receive their GF bread and bread mixes through a prescription. Currently 99% of patients currently receiving Gluten Free prescriptions are exempt from charges. The highest categories are as follows: Aged 60 or over – 61% Under 18 – 12% Pre-payment certificate – 3% Medical Exemption – 3% Non specified Declaration – 19% The data shows the biggest impact would be to patients over 60.		
	Positive impact Improved patient safety, such as reducing the risk of adverse events is anticipated	Neutral Impact May have an adverse impact on patient safety. Mitigation is in place or planned to mitigate this impact to acceptable levels	Negative impact Increased risk to patient safety. Further mitigation needs to be put in place to manage risk to acceptable level
Explain how the project minimises the risk of harm and impacts patients. Include any risks	This would save the ICB over £500,000 per annum which could be spent on other priorities.	The majority of patients receiving prescriptions are exempt from charges, and this is mainly due to age. Because this exemption does not take into account financial capacity it is difficult to evidence that these patients would not be able to afford to purchase their own GF bread and mixes. The 2 CCGs that have withdrawn prescribing have advised that they have not experienced an increase in patients presenting with issues relating to not following a GF diet.	It is difficult to evidence the impact of Coeliac patients not being able to access Gluten Free (GF) bread and bread mixes, but there are known risks to not adhering to a GF diet which could have long term health impacts and lead to greater demand on wider health services. According to Coeliac UK, non-adherence to a gluten free diet puts patients at a higher at a higher risk of long-term complications, including osteoporosis, ulcerative jejunitis, intestinal malignancy, functional hyposplenism, vitamin D deficiency and iron deficiency. This could lead to patients requiring additional care and support from NHS.

Explain how the project may impact upon adults at risk and children and provide assurance that safeguarding process are in place with the provider		A gluten free diet may be maintained with items such as potatoes and rice, and bread is not essential	The patient groups that will be most impacted by this decision are older adults (over 60yo) and young people (under 18 & in full time education). These patient groups may potentially be at greater risk (incl. osteoporosis / long term conditions for younger patients) if they do not adhere to a GF diet. It is of note, however, this policy only relates to bread and bread mixes and bread is not an essential food item as there are gluten free alternatives e.g. GF pasta, rice, potatoes etc. and improved labelling on food and website with information on how to maintain a healthy GF diet. Due to the current cost of living, there have been a number of national articles on the cost of “free from” foods despite them being much more available. In addition, 99% of the cohort of patients receiving GF prescriptions have an exemption in that they do not pay for prescriptions so could be seen that we are disadvantaging our most vulnerable population. Because 73% of these exemptions are due to age, and this exemption does not take into account financial capacity, it is difficult to evidence that these patients would not be able to afford to purchase their own GF bread and mixes
Describe the impact on processes for reducing and	n/a	n/a	n/a

preventing patient harms and Healthcare Associated Infections? (e.g., falls, pressure ulcers, MRSA / CDI, VTE, etc)			

Clinical Effectiveness			
Please confirm how the project uses the best, knowledge based, research	The review of GF prescribing was carried out initially by Pharmacists and Dieticians, with support from other clinicians as part of the CPH Steering Group and was then continued under the ICB Unwarranted Variation Programme due to the financial constraints. Evidence from Dept. Health & Social Care, Coeliac UK was also reviewed. The recommendation from DH&SC is now to prescribe only bread and bread mixes, however, in the "Prescribing Gluten-Free Foods in Primary Care: Guidance for CCGs" document, published following the consultation in 2018 it does state "CCGs may further restrict the prescribing of GF foods by selecting bread only, mixes only or CCGs may choose to end prescribing of GF foods altogether".		
	Positive impact Clinical effectiveness will be improved resulting in better outcomes anticipated for patients	Neutral impact May have an adverse impact on clinical effectiveness. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	Negative impact Significant reduction in clinical effectiveness. Further mitigation needs to be put in place to manage risk to acceptable level
Explain if/how the project improves hospital flow or improves length of stay		These patients would not be treated in a hospital environment, so no impact on length of stay.	
Describe the impact on			It is difficult to evidence the impact of Coeliac patients not being able to access

clinical outcomes and how this will be monitored.			GF bread and bread mixes, but there are known risks to not adhering to a GF diet which could have long term health impacts (e.g. osteoporosis, ulcerative jejunitis, intestinal malignancy, functional hyposplenism, vitamin D deficiency and iron deficiency), and lead to greater demand on wider health services. However, availability of gf products has improved, as has food labelling. Patients would continue to be supported by their GPs as usual. Feedback from the 2 CCGs who have withdrawn prescribing have not reported any unforeseen consequences.
Does the project result in a higher likelihood of clinical recovery?			If patients cannot afford or cannot get to a supermarket to buy their own GF bread and bread mixes, there could be a negative impact on their long term health.
Does the project provide better access to wider care pathways?			No this would end prescribing
Does the project follow the latest NICE guidance/other relevant best practice evidence?			No. DH&SC and Coeliac UK guidance recommend prescribing bread and bread mixes
Describe the feedback of clinical leads	A number of clinicians have expressed support for the withdrawal, some noting that they have seen requests reduce over the last couple of years potentially due to wider availability of GF products in shops.	Where Clinical Leads support the withdrawal of prescribing, they have noted a potential financial impact to lower income patients.	The Dieticians who were part of the Clinical Policy Harmonisation programme did not support stopping prescribing through concern over those patients who may not follow a GF diet if not prescribed. However, feedback from those Places who have withdrawn

			prescribing is that they have not experienced unforeseen consequences. GPs would continue to support patients and information on how to maintain a GF diet is widely available

Patient Experience			
Please confirm the specific patient groups affected and how they are impacted.	A policy not to prescribe gluten free products may have an impact on vulnerable patients because gluten free products, while readily available in supermarkets, are more expensive that standard products, and some patients may not be able to access supermarkets easily.		
	Positive impact Improved patient and carer experience anticipated	Neutral impact May have an adverse impact on patient and carer experience. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	Negative impact Significant reduction in patient and carer experience. Further mitigation needs to be put in place to manage risk to acceptable levels
Explain how the project will impact on the experience of care and better access to services	Not prescribing GF products will save over £500k which can be invested in other services. In addition, GF products are also the only food product that is offered on prescription, but there are other food allergies that don't have this offer, so could argue that stopping prescribing further reduces unwarranted variation.	This option withdraws prescribing and therefore does not impact access to services, however for patients who currently receive prescriptions they may reflect that experience of care is impacted by this, but access to supporting services is unchanged.	

Describe any consultation or engagement with the population that has occurred or is planned.		Public consultation would take place following a decision from the ICB Board as to whether withdrawing prescriptions would be considered	
Describe any change of location or setting of care.	n/a	n/a	n/a

Have any risks been identified in the following areas? (please list risk and escalation process)				
Area	Risk identified	If escalated, identify where escalated to	Date escalated	Mitigations put in place
Staff Experience	no			
Service Delivery	no			
Disinvestment	no			
Contingency plans	no			
Interdependency	no			
Sustainability	no			

RISKS where the project is progressed				
	Comment to explain rationale (include mitigations where applicable)	Likelihood of risk (L) (see table below)	Risk Impact / Consequence (C) (see table below)	Multiplication Total L x C
Quality risk to progress project	If the option to withdraw prescribing is accepted, there is a risk that patients who previously received prescriptions will not adhere to a GF diet due to affordability of free from products, which could have significant health implications for them and will potentially increase demand on health services as a result. There is a risk that this will widen health inequalities in deprived areas.	2	3	6
MITIGATED RISK to progress project				
Quality risk to progress project	In line with Cheshire West CCG actions when they stopped prescribing, we would improve the information and advice available to patients with coeliac disease that will help them to have a healthy, nutritious and balanced diet with all the necessary vitamins and minerals. Coeliac patients can still eat all naturally gluten-free foods such as meat, fish, fruit, vegetables, rice, and potatoes. We will provide advice to the following: Coeliac UK website for guidance and advice NHS Choices Website BBC website on gluten free diet The Eatwell Guide - NHS). Engage with supermarkets within C&M footprint to advise of prescribing decision with ask of them to manage their stock levels.	2	2	4

RISKS if project is NOT progressed				
	Comment to explain rationale (include mitigations where applicable)	Likelihood of risk (L)	Risk Impact / Consequence (C)	Multiplication Total for not progressing project

		See table below	See table below	L x C
Quality risk if project does not proceed	If the option to withdraw prescribing is not supported, then C&M have unwarranted variation in access to these products. The alternative option is to re-instate prescribing, however, there is a financial risk to the ICB in that an additional £130k would be required to support this and a total estimated annual expenditure of £650k.	1	1	1
MITIGATED RISK if project is NOT progressed				
Mitigated quality risk to progress project	Place based Medicines Management teams would review prescribing quantities to ensure they are in line with Coeliac UK guidance. This may mitigate some of the cost.	1	1	1

Summary

Decision made	Score	Mitigated score	Impact
Progress	6	4	moderate
Not progress	1	1	Low
Score summary (add to front page)			
Negligible and Low risk	Moderate risk	Major risk	Catastrophic risk
1-3	4 to 6	8- 12	13- 25

Risk Impact Score Guidance

LEVEL	DESCRIPTOR	DESCRIPTION – ICB LEVEL
5	Catastrophic (>75%)	**Safety** - multiple deaths due to fault of ICB OR multiple permanent injuries or irreversible health effects OR an event affecting >50 people. **Quality** – totally unacceptable quality of clinical care OR gross failure to meet national standards. **Health Outcomes & Inequalities** – major reduction in health outcomes and/or life expectancy OR major increase in health inequality gap in deprived areas or socially excluded groups **Finance** – major financial loss - >1% of ICB budget OR 5% of delegated place budget **Reputation** – special measures, sustained adverse national media (3 days+), significant adverse public reaction / loss of public confidence major impact on trust and confidence of stakeholders
4	Major (50% > 75%)	**Safety** - individual death / permanent injury/ disability due to fault of ICB OR 14 days off work OR an event affecting 16 – 50 people. **Quality** – major effect on quality of clinical care OR non-compliance with national standards posing significant risk to patients. **Health Outcomes & Inequalities** – significant reduction in health outcomes and/or life expectancy OR significant increase in health inequality gap in deprived areas or socially excluded groups **Finance** - significant financial loss of 0.5-1% of ICB budget OR 2.5-5% of delegated place budget **Reputation** - criticism or intervention by NHSE/I, litigation, adverse national media, adverse public significant impact on trust and confidence of stakeholders
3	Moderate (25% > - 50%)	**Safety** - moderate injury or illness, requiring medical treatment e.g., fracture due to fault of ICB. RIDDOR/Agency reportable incident (4-14 days lost). **Quality** – significant effect on quality of clinical care OR repeated failure to meet standards **Health Outcomes & Inequalities** – moderate reduction in health outcomes and/or life expectancy OR moderate increase in health inequality gap in deprived areas or socially excluded groups **Finance** - moderate financial loss - less than 0.5% of ICB budget OR less than 2.5% of delegated place budget

		Reputation - conditions imposed by NHSE/I, litigation, local media coverage, patient and partner complaints & dissatisfaction moderate impact on trust and confidence of stakeholders
2	**Minor (<25%)**	**Safety** - minor injury or illness requiring first aid treatment **Quality** – noticeable effect on quality of clinical care OR single failure to meet standards **Health Outcomes & Inequalities** – minor reduction in health outcomes and/or life expectancy OR minor increase in health inequality gap in deprived areas or socially excluded groups **Finance** - minor financial loss less than 0.2% of ICB budget OR less than 1% of delegated place budget **Reputation** - some criticism slight possibility of complaint or litigation but minimum impact on ICB minor impact on trust and confidence of stakeholders
1	**Negligible (<5%)**	**Safety** - none or insignificant injury due to fault of ICB **Quality** – negligible effect on quality of clinical care **Health Outcomes & Inequalities** – marginal reduction in health outcomes and/or life expectancy OR marginal increase in health inequality gap in deprived areas or socially excluded groups **Finance** - no financial or very minor loss **Reputation** - no impact or loss of external reputation

The likelihood of the risk occurring must then be measured. Table 2 below should be used to assess the likelihood and obtain a likelihood score. When assessing the likelihood, it is important to take into consideration the existing controls (i.e. mitigating factors that may prevent the risk occurring) already in place.

Table 2 - Risk Likelihood Score Guidance

1	2	3	4	5
Rare The event could only occur in exceptional circumstances (<5%)	**Unlikely** The event could occur at some time (<25%)	**Possible** The event may well occur at some time (25%> -50%)	**Likely** The event will occur in most circumstances (50% > 75%)	**Almost certain** The event is almost certain to occur (>75%)

The impact and likelihood scores must then be multiplied and plotted on table 3 to establish the overall level of risk and necessary action.

Table 3 - Risk Assessment Matrix (level of risk)

LIKELIHOOD of risk being realised	**IMPACT (severity)** of risk being realised				
	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)	**1**	**2**	**3**	**4**	**5**
Unlikely (2)	**2**	**4**	**6**	**8**	**10**
Possible (3)	**3**	**6**	**9**	**12**	**15**
Likely (4)	**4**	**8**	**12**	**16**	**20**
Almost Certain (5)	**5**	**10**	**15**	**20**	**25**

Low Risk	**Moderate Risk**	**High Risk**	**Extreme Risk**	**Critical Risk**

Risk Proximity

A further element to be considered in the risk assessment process is risk proximity. Risk proximity provides an estimate of the timescale as to when the risk is likely to materialise. It supports the ability to prioritise risks and informs the appropriate response in the monitoring of controls and development of actions.

A pragmatic approach to the use of risk proximity which supports leadership, decision making and reporting is used and is therefore determined to be applied to all Risks.

The proximity scale used is below:

Proximity and timescale for dealing with the risk	Within the current quarter	Within the financial year	Beyond the financial year
Rating	**A**	**B**	**C**

Likelihood, impact and proximity are dynamic elements and consequently all three must be reviewed and reassessed frequently in order to prioritise the response.

Sign off process			
Name	Role	Signature	Date
Katie Bromley	Project lead		4/9/24
Sinead Clarke	Clinical lead		4/9/24
Natalia Armes	Programme manager		4/9/24
	PMO lead		
Once signed off by all above, then the QIA is submitted to QIA review group			

This section to be completed following review at the QIA review group					
Name	Role	Approved	Rejected	Signature	Date
ADs of Quality	QIA review group chair (after group meeting)	Yes			6/9/24
Denise Roberts (supported by Maxine Dickinson)	AD of Quality	Yes			21/08/24
	C&M ICB QIA lead (if necessary)				

NHS Cheshire and Merseyside

QUALITY IMPACT ASSESSMENT

Project/Proposal Name	Unwarranted Variation Recovery Programme – Gluten free prescribing for under 19yo only	Date of completion	14/05/2025
Programme Manager	Katie Bromley	Clinical Lead	Rowan Pritchard Jones

Background and overview of the proposals (can be copied from PID on Verto or from National/Regional commissioning guidance)

In 2016 – 2017 the Department of Health and Social Care undertook a review of prescribing for gluten free products and following a public consultation recommended that prescribing was limited to bread and bread mixes only.
When gluten free prescribing was first introduced, the availability of these foods was limited, however, all major supermarkets and other retailers stock gluten free foods both in store and on-line. In addition, food labelling has improved, and awareness has increased which means people are able identify which foods contain gluten and choose healthy options.

Currently in Cheshire and Merseyside 7* out of 9 Places offer Gluten Free prescribing for patients with diagnosed coeliac disease in line with the national Department of Health and Social Care (DHSC) consultation the outcome of which was to reduce prescribing to bread and bread mixes only in 2018. It is of note that for the remaining 2 Places, St Helens CCG and Cheshire West CCG opted to withdraw prescribing completely (noting this was prior to the national Department of Health and Social Care (DHSC) consultation as detailed above).
*For Cheshire West Place, the area that was covered by the former Vale Royal CCG did not opt to withdraw prescribing, and as such there are still part of Cheshire West were prescribing can be undertaken (Winsford, Northwich, Middlewich and surrounding area. Therefore, there is inequity of access to these products across Cheshire and Merseyside.

NHS Cheshire and Merseyside was created in July 2022 and, as the statutory body, took over commissioning responsibilities from the 9 former CCGS. NHS C&M has to consider how to use the fixed resource allocation from NHS England to enable them to fulfil their duties and have to decide how and where to allocate resources to best meet the healthcare needs of the population they serve.

Under the Policy Harmonisation programme, and based on the DHSC consultation and clinical opinion, the recommendation was to re-instate prescribing for bread and bread mixes however this would result in an estimated additional annual spend of £130k. However, because of the need for NHS Cheshire and Merseyside to consider how they allocate funding to ensure it is being allocated to areas of highest risk, a review has been undertaken regarding the continuation of spend on gluten free prescribing and a recommendation by Board to conduct a public consultation on ceasing prescribing was made in November 2024.

The feedback from the consultation exercise was reviewed and the EIA updated which identified greater risks to children and vulnerable adults, including those on a low income. Based on this feedback, 2 further options were considered: 1 – prescribe to under 19yo and 2 – to prescribe to under 19yo and adults on low income (based on income linked benefits)
On May 8th the ICB Executive Management Team reviewed the findings and asked that whilst they still support the option to cease prescribing that the Board are able to consider the option to prescribe to under 19yo.

The purpose of the QIA is to help articulate the risks to patients as it is hard to evidence the impact of withdrawing Gluten Free prescribing for all but the population of under 19yo.

Reason For Change/Proposal
Currently in Cheshire and Merseyside 7* out of 9 Places offer Gluten Free prescribing for patients with diagnosed coeliac disease in line with the national Department of Health and Social Care (DHSC) consultation the outcome of which was to reduce prescribing to bread and bread mixes only in 2018. It is of note that for the remaining 2 Places, St Helens CCG and Cheshire West CCG opted to withdraw prescribing completely (noting this was prior to the national Department of Health and Social Care (DHSC) consultation as detailed above). *For Cheshire West Place, the area that was covered by the former Vale Royal CCG did not opt to withdraw prescribing, and as such there are still part of Cheshire West were prescribing can be undertaken (Winsford, Northwich, Middlewich and surrounding area. Therefore, there is inequity of access to these products across Cheshire and Merseyside.

Who is likely to be Impacted?	Public	X	Patients	X	Workforce		Other parts of the system	X
Please provide additional details, including scale	There are over 13,300 patients diagnosed with Coeliac Disease and other conditions which would deem them eligible for gluten free prescribing. Most patients choose to purchase their GF products themselves, however, 2,314 patients receive their GF bread and bread mixes through a prescription. Currently 99% of patients currently receiving Gluten Free prescriptions are exempt from charges. The highest categories are as follows: Aged 60 or over – 61% Under 18 – 12% Pre-payment certificate – 3% Medical Exemption – 3% Non specified Declaration – 19%							
Who has been consulted with as part of the QIA development	A 6 week public consultation was held from 28th January to 11th March. 1064 people responded to the engagement questionnaire with 601 of these having coeliac disease and a further 57 had another diagnosed condition that requires them to follow a gf diet. 229 were a parent/guardian/carer of a child who required a gf diet. 78% of respondents disagreed or strongly disagreed with the proposal. This QIA has been developed based on the feedback from the consultation and the revised recommendations within the EIA							

Financial Considerations	Current Costs	£547k per year	Proposed Costs	£74.5k per year

Place/Local Sign off:						
Sign off group		Date of meeting	1	Post mitigation risk score *(Likelihood x Consequence)*	Safety	
					Effectiveness	
					Experience	
					Workforce/system	
Has an EIA been completed?	Y	Has a DPIA been completed?	Y – full DPIA not required	Have identified risks been added to risk register?	N	

Risk scores above 12 in any area of quality, including patient safety, clinical effectiveness or experience will be taken to QIA panel and must be included within the corporate risk register.

Patient safety						
Will the project or proposal impact on patient safety?	Positive impact Improved patient safety, such as reducing the risk of adverse events is anticipated	Neutral Impact May have an adverse impact on patient safety. Mitigation is in place or planned to mitigate this impact to acceptable levels	Negative impact Increased risk to patient safety. Further mitigation needs to be put in place to manage risk to acceptable level	Pre-mitigation Identified Risk Score (Prior to Mitigations)		
				L	C	Total L x C

Please consider… • Will this impact on the organisation's duty to protect children, young people and adults? • Impact on patient safety? • Impact on preventable harm? • Will it affect the reliability of safety systems? N/A • How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections to patients is reduced? N/A		If this option were to be supported, children would continue to receive gluten free bread and bread mixes on prescription and therefore there would be no detrimental impact. Vulnerable adults (those with a learning or physical disability that would mean they were at risk of not adhering to a gf diet) would be supported through a separate prior approval / IFR process.	Our data shows that the majority of patients receiving prescriptions for gf bread and bread mixes are over 60 and therefore this option does not support these adults. Whilst there is a greater risk that these patients might suffer dietary neglect and therefore at risk of e.g. osteoporosis, vitamin and nutrient deficiencies through not eating a gf diet, if should be noted that this proposal only concerns bread and bread mixes and patients can still access gf bread through supermarkets with even budget supermarkets now stocking these items.	3	1	3

Mitigations

Action	Owner	Expected date of completion	Date completed
Children under 19yo would be supported by this proposal, and for adults, it should be noted that this proposal is about bread and bread mixes and there is much wider availability of gf products in supermarkets. Also improvements in food labelling has improved so it is easier to understand which foods are gf		n/a	
Patients would continue to be supported by their GPs		n/a	

If the decision is made, we would inform supermarket regional offices of the decision with an ask to consider their stock levels	Katie Bromley	Post May 29th Board decision	End June 2025		
Vulnerable adults (those with a learning or physical disability that would mean they were at risk of not adhering to a gf diet) would be supported through a separate prior approval / IFR process.	Katie Bromley	Post May 29th Board decision	End June 2025 tbc		
Patients would continue to be supported by their GPs		**Post Mitigation Risk Score**	2	1	2

Clinical Effectiveness						
Please confirm how the project uses the best, knowledge based, research	The review of GF prescribing was carried out initially by Pharmacists and Dieticians, with support from other clinicians as part of the Clinical Policy Harmonisation Steering Group and was then continued under the ICB Unwarranted Variation Programme due to the financial constraints. Evidence from Dept. Health & Social Care, Coeliac UK was also reviewed. The recommendation from DH&SC is now to prescribe only bread and bread mixes, however, in the "Prescribing Gluten-Free Foods in Primary Care: Guidance for CCGs" document, published following the consultation in 2018 it does state "CCGs may further restrict the prescribing of GF foods by selecting bread only, mixes only or CCGs may choose to end prescribing of GF foods altogether".					
Will the project or proposal impact on Clinical effectiveness?	Positive impact Clinical effectiveness will be improved resulting in better outcomes anticipated for patients	Neutral Impact May have an adverse impact on clinical effectiveness. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	Negative impact Significant reduction in clinical effectiveness. Further mitigation needs to be put in place to manage risk to acceptable level	Identified Risk Score (Prior to Mitigations)		
				L	C	Total L x C

Please consider… • How does it impact on implementation of evidence based practice? • How will it impact on clinical leadership N/A • Does it reduce/impact on variation in care provision? • Does it affect supporting people to stay well? • Does it promote self-care for people with long term conditions? • Does it impact on ensuring that care is delivered in the most clinically and cost effecting setting? N/A • Does it eliminate inefficiency and waste by design? N/A • Does it lead to improvements in care pathways? N/A	This proposal would reduce the current levels of variation in C&M with regard to prescribing of gf bread and bread mixes	There is no NICE guidance on gluten free prescribing only management of coeliac disease. The DHSC recognised that individual organisations may choose to end prescribing.	Feedback from the public engagement exercise suggests that some people would find it difficult to source their own gf bread and bread mixes if prescriptions were withdrawn due to the overall cost of gf food and inconvenience of the sourcing of their own gf food. There is therefore a risk that these people will suffer from dietary neglect Those patients or families on low incomes would be most at risk from this.	2	3	6

Mitigations					
Action	**Owner**	**Expected date of completion**	**Date completed**		
Children from low income families would continue to be supported through this option. For adults, it should be noted that this proposal is about bread and bread mixes only, and there is a much wider availability of gf products (including bread and bread mixes in supermarkets).					
Patients would continue to be supported by their GPs and there is an IFR process if GPs felt a patient warranted clinical exceptionality.					
Vulnerable adults (those with a learning or physical disability that would mean they were at risk of not adhering to a gf diet) would be supported through a separate prior approval / IFR process.	Katie Bromley	Post May 29th Board decision	End June 2025 tbc		
		Post Mitigation Risk Score	2	2	4

Patient Experience						
Will the project or proposal impact on patient experience?	Positive impact Improved patient and carer experience anticipated	Neutral Impact May have an adverse impact on patient and carer experience. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	Negative impact Significant reduction in patient and carer experience. Further mitigation needs to be put in place to manage risk to acceptable levels	Identified Risk Score (Prior to Mitigations)		
				L	C	Total L x C
Please consider… • What is the impact on protected characteristics, such as race, gender, age, disability, sexual orientation, religion and belief for individual and community health, access to services and experience? • What impact is it likely to have on self-reported experience of patients and service users? (Responses to national/local surveys/complaints/PALS/incidents) • How will it impact on the choice agenda? N/A • How will it impact on the compassionate and personalised care agenda? N/A • How might it impact on access to care or treatment?			The revised EIA identifies the risk of dietary neglect for those patients who may be on low income and therefore struggle to buy the more expensive GF food, and those who live in rural areas where availability may be reduced. It also identified children and vulnerable adults as being high risk of dietary neglect. We would expect complaints and enquiries to increase even if this proposal to prescribe to under 19yos were implemented	2	3	6

Mitigations			
Action	**Owner**	**Expected date of completion**	**Date completed**
Children from low income families would continue to be supported through this option. For adults, it should be noted that this proposal is about bread and bread mixes only, and there is a much wider availability of gf products (including bread and bread mixes in supermarkets).			

Patients would continue to be supported by their GPs and there is an IFR process if GPs felt a patient warranted clinical exceptionality.					
Vulnerable adults (those with a learning or physical disability that would mean they were at risk of not adhering to a gf diet) would be supported through a separate prior approval / IFR process.	Katie Bromley	Post May 29th Board decision	End June 2025 tbc		
		Post Mitigation Risk Score	2	3	6

Workforce/System						
Will the project or proposal impact on the workforce or system delivery?	Positive impact Improved patient and carer experience anticipated	Neutral Impact May have an adverse impact on patient and carer experience. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	Negative impact Significant reduction in patient and carer experience. Further mitigation needs to be put in place to manage risk to acceptable levels	Identified Risk Score (Prior to Mitigations) L	C	Total L x C
Please consider… • Capacity and demand on services • Changes in roles N/A • Training requirements • Staff experience & morale • Redundancies N/A • Opportunities (including staff development) N/A • Impact on other parts of the system, including changes in pathways or access N/A • Increased demand • Financial stability • Safety N/A		It is not expected that we would see an increase in demand on services. Analysis of conditions associated with non-adherence to GF diet (osteoporosis, anaemia & other nutritional deficiencies) has shown that in the 2 areas that have previously withdrawn (St Helens Place & Cheshire West CCG) the prevalence of these conditions is no more prevalent than in the rest of C&M. Further analysis of those in the most deprived 20% of the population was also		1	1	1

		carried out and again prevalence was in line with C&M levels				

Mitigations					
Action	**Owner**	**Expected date of completion**	**Date completed**		
A comms exercise would be undertaken following the decision at Board to ensure all Providers and Pharmacies were aware of the outcome	Katie Bromley	Post Board decision 29th May	June 2025 tbc		
		Post Mitigation Risk Score	1	1	1

Summary

Decision made	Pre Mitigated Score	Mitigated score	Impact
Progress	6	4	Moderate
Not progress	6	4	Moderate
Score summary (add to front page)			
Negligible and Low risk	Moderate risk	Major risk	Catastrophic risk
1-3	4 - 7	8 - 12	13 - 25

Risk Impact Score Guidance

LEVEL	DESCRIPTOR	DESCRIPTION – ICB LEVEL
5	Catastrophic (>75%)	**Safety** - multiple deaths due to fault of ICB OR multiple permanent injuries or irreversible health effects OR an event affecting >50 people. **Quality** – totally unacceptable quality of clinical care OR gross failure to meet national standards. **Health Outcomes & Inequalities** – major reduction in health outcomes and/or life expectancy OR major increase in health inequality gap in deprived areas or socially excluded groups **Finance** – major financial loss - >1% of ICB budget OR 5% of delegated place budget **Reputation** – special measures, sustained adverse national media (3 days+), significant adverse public reaction / loss of public confidence major impact on trust and confidence of stakeholders
4	Major (50% > 75%)	**Safety** - individual death / permanent injury/ disability due to fault of ICB OR 14 days off work OR an event affecting 16 – 50 people. **Quality** – major effect on quality of clinical care OR non-compliance with national standards posing significant risk to patients. **Health Outcomes & Inequalities** – significant reduction in health outcomes and/or life expectancy OR significant increase in health inequality gap in deprived areas or socially excluded groups **Finance** - significant financial loss of 0.5-1% of ICB budget OR 2.5-5% of delegated place budget **Reputation** - criticism or intervention by NHSE/I, litigation, adverse national media, adverse public significant impact on trust and confidence of stakeholders
3	Moderate (25% > - 50%)	**Safety** - moderate injury or illness, requiring medical treatment e.g., fracture due to fault of ICB. RIDDOR/Agency reportable incident (4-14 days lost). **Quality** – significant effect on quality of clinical care OR repeated failure to meet standards **Health Outcomes & Inequalities** – moderate reduction in health outcomes and/or life expectancy OR moderate increase in health inequality gap in deprived areas or socially excluded groups **Finance** - moderate financial loss - less than 0.5% of ICB budget OR less than 2.5% of delegated place budget

		Reputation - conditions imposed by NHSE/I, litigation, local media coverage, patient and partner complaints & dissatisfaction moderate impact on trust and confidence of stakeholders
2	**Minor (<25%)**	**Safety** - minor injury or illness requiring first aid treatment **Quality** – noticeable effect on quality of clinical care OR single failure to meet standards **Health Outcomes & Inequalities** – minor reduction in health outcomes and/or life expectancy OR minor increase in health inequality gap in deprived areas or socially excluded groups **Finance** - minor financial loss less than 0.2% of ICB budget OR less than 1% of delegated place budget **Reputation** - some criticism slight possibility of complaint or litigation but minimum impact on ICB minor impact on trust and confidence of stakeholders
1	**Negligible (<5%)**	**Safety** - none or insignificant injury due to fault of ICB **Quality** – negligible effect on quality of clinical care **Health Outcomes & Inequalities** – marginal reduction in health outcomes and/or life expectancy OR marginal increase in health inequality gap in deprived areas or socially excluded groups **Finance** - no financial or very minor loss **Reputation** - no impact or loss of external reputation

The likelihood of the risk occurring must then be measured. Table 2 below should be used to assess the likelihood and obtain a likelihood score. When assessing the likelihood, it is important to take into consideration the existing controls (i.e. mitigating factors that may prevent the risk occurring) already in place.

Table 2 - Risk Likelihood Score Guidance

1	2	3	4	5
Rare The event could only occur in exceptional circumstances (<5%)	**Unlikely** The event could occur at some time (<25%)	**Possible** The event may well occur at some time (25%> -50%)	**Likely** The event will occur in most circumstances (50% > 75%)	**Almost certain** The event is almost certain to occur (>75%)

The impact and likelihood scores must then be multiplied and plotted on table 3 to establish the overall level of risk and necessary action.

Table 3 - Risk Assessment Matrix (level of risk)

LIKELIHOOD of risk being realised	**IMPACT (severity)** of risk being realised				
	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)	**1**	**2**	**3**	**4**	**5**
Unlikely (2)	**2**	**4**	**6**	**8**	**10**
Possible (3)	**3**	**6**	**9**	**12**	**15**
Likely (4)	**4**	**8**	**12**	**16**	**20**
Almost Certain (5)	**5**	**10**	**15**	**20**	**25**

Low Risk	**Moderate Risk**	**High Risk**	**Extreme Risk**	**Critical Risk**

Risk Proximity

A further element to be considered in the risk assessment process is risk proximity. Risk proximity provides an estimate of the timescale as to when the risk is likely to materialise. It supports the ability to prioritise risks and informs the appropriate response in the monitoring of controls and development of actions.

A pragmatic approach to the use of risk proximity which supports leadership, decision making and reporting is used and is therefore determined to be applied to all Risks.

The proximity scale used is below:

Proximity and timescale for dealing with the risk	Within the current quarter	Within the financial year	Beyond the financial year
Rating	**A**	**B**	**C**

Likelihood, impact and proximity are dynamic elements and consequently all three must be reviewed and reassessed frequently in order to prioritise the response.

Sign off process			
Name	Role	Signature	Date
Olivia Billington	Project lead	Olivia Billington	06/05/25
Rowan Pritchard Jones	Clinical lead		
Katie Bromley	Programme manager	Katie Bromley	06/05/25
	PMO lead		
Once signed off by all above, then the QIA is submitted via qia@cheshireandmerseyside.nhs.uk **to QIA review group**			

PMO receipt					
Verto/PMO reference	N/A	Date QIA reviewed PMO		Reviewed by	

This section to be completed following review at the QIA review group				
Meeting Chair	Date of Meeting	Approved	Rejected	Comments/feedback
Chris Douglas	12.05.2025	14.05.25		Recommendations made for amendments to QIA for panel to be reconsidered at a later date: 1) Psychological impact to the patient to be articulated in patient safety domain 2) Negative impact on clinical effectiveness is to be reworded and centred on evidence 3) Further work to be undertaken on the system/workforce domain 4) Clarification of scores across all domains required

NHS
Cheshire and Merseyside

Action responses following JOSC 16/04/25

Members requested further information on the impact of the decision to withdraw gluten-free bread prescribing in the two Places it has already been withdrawn within the ICB area, with a focus on the impact on low-income families

The two locations that have previously stopped gluten free prescribing are St Helens CCG and Cheshire West CCG. In order to understand any health impact, we have considered conditions that arise from not adhering to a gluten free diet – osteoporosis and anaemia.

While the Cheshire & Merseyside primary care record *does* contain details of changes in the recording of diagnoses of Osteoporosis and Anaemia over the past ten years which would have shown if there was an increase since the decisions, the tables which hold this data are currently undergoing essential maintenance which means the data is not currently available to analysts. This includes details of individuals presenting in primary care with either condition.

However, there are some things we can say about the prevalence of these conditions across C&M. Based on the primary care Electronic Frailty Index (EFI) on average, across Cheshire & Merseyside roughly 4.5% of the population have a recording of osteoporosis, which is in-line with the national average of 4.4%. Osteoporosis is no more prevalent in either Cheshire West or St Helens than in the rest of the C&M population, with prevalence of 4.5% and 4.4%, respectively.

Again, using the EFI to look at anaemia, but also including other haematinic (nutrients essential for the production of blood cells by the bone marrow) deficiencies, shows a prevalence of 14.1% across Cheshire & Merseyside. Both Cheshire West and St Helens have slightly lower prevalence rates than the C&M average, at 13.8% and 12.8%, respectively.

To try to provide an assessment of the impact on low-income families, we looked at the prevalence of osteoporosis and anaemia in Cheshire West and St Helens compared to the rest of C&M amongst the most deprived 20% of the population.
For osteoporosis the prevalence across the whole of C&M for the 20% most deprived is 3.6% with Cheshire West and St Helens being slightly lower 3.3% and 3.5% respectively.
For anaemia and haematinic deficiency, the C&M prevalence for the 20% most deprived is 15.9% with Cheshire West and St Helens being 15.4% and 13.1% respectively.

In conclusion, while detailed primary care data is not available to help us answer this question more definitively, the data we have available now does not suggest that either Osteoporosis or Anaemia is consistently more prevalent in the populations of Cheshire West and St Helens.

Members asked if any additional information could be provided on the number of current recipients who are also using food banks.

We do not have data on recipients of prescription gluten free bread and bread mixes who use foodbanks.

Members asked if a full equality impact assessment could be prepared, particularly with reference to Section 1 of the Equality Act 2010. The impact of the proposal on families in deprived areas needs to be considered as much as possible as they will be the families most financially impacted by the withdrawal of gluten-free bread prescriptions.

The EIA has been updated and will be made available once it's been through appropriate ICB governance.

Members enquired if there had been a take-up campaign given the low rate of uptake among people who are eligible for the gluten-free bread prescriptions. If so, Members would like information on when this was last done and what the impact of that campaign was.

Since the ICB was formed in July 2022 there has been no campaign relating to low uptake among people who are eligible.

Members requested additional information on the estimated diagnostic rate of coeliac disease, given that lower-income individuals are less likely to seek a diagnosis when they have symptoms. Members requested to receive information about the most recent coeliac awareness campaign and if there were plans to have an additional campaign to raise awareness and encourage people to get checked for coeliac disease.

Unfortunately, due to the primary care dataset not being available we cannot provide information on coeliac diagnosis per Place over the last 10 years.

The ICB have not run any campaign regarding raising coeliac disease awareness, however, nationally there is a Coeliac Awareness month in May each year which Coeliac UK support and they also have a self-assessment tool which helps patients understand whether they should be tested for coeliac disease https://isitcoeliacdisease.org.uk/

Joint OSC briefing provided by NHS Cheshire and Merseyside

Proposal regarding ICB funded Gluten Free Prescribing across Cheshire and Merseyside

Date: 25th May 2025

Responsible Directors: *Rowan Pritchard Jones*

Report Author*: Natalia Armes*

1. Purpose of the Report

1.1 The purpose of the paper is to provide members of the Joint OSC with updated information relating to the proposal of ICB funded Gluten Free Prescribing across Cheshire and Merseyside.

1.2 Following the Public Consultation process, a period of conscientious consideration to the feedback and post consultation EIA has been undertaken. This has led to the development of further options. This paper provides an overview of the options which will be considered by the Board of NHS Cheshire Merseyside on 29th May 2025 as part of their decision-making process.

2. Background

2.1 On formation of the Integrated Care Board (ICB), clinical policies were inherited from across the 9 places. This meant that patients had different access to services and care, based on their postcode. The Reducing Unwarranted Variation programme set out to harmonise this approach to ensure we work to address health inequalities and provide a consistent offer across Cheshire and Merseyside.

2.2 It is of note that since the start of this review the NHS financial challenges have significantly increased, necessitating careful balancing of population needs, clinical risk, and commissioning decisions to address health inequalities.

2.3 This paper is written in the context of ensuring commissioning decisions prioritise the most pressing needs of the population, recognising the potential for increased demand in areas like mental health, urgent care and community services, whilst addressing unwarranted variation and the need for a consistent offer.

3. Gluten Free Current Policy Position:

3.1 Across the 9 Places in Cheshire and Merseyside, there are GP Practices within 8 Places that currently offer gluten free prescribing in line with the 2018 national Department of Health and Social Care (DHSC) consultation outcome, which was to reduce prescribing to bread and bread mixes only. It is of note that St Helens CCG and NHS Cheshire West CCG opted to withdraw prescribing completely (noting this was prior to the national Department of Health and Social Care (DHSC) consultation as detailed above). For Cheshire West Place, the area that was covered by the former NHS Vale Royal CCG did not opt to withdraw prescribing, and as such there are still parts of Cheshire West were GF prescribing can be undertaken (Winsford, Northwich, Middlewich and surrounding area).

3.2 In Cheshire and Merseyside, over 13,300 patients have a diagnosis of coeliac disease or other conditions which requires management through a gluten free diet. Most people choose to purchase their gluten free foods at supermarkets or other retailers however 2,314 patients receive their gluten free bread and bread mixes via prescription. It should be noted that of the gluten free prescriptions issued, 99% are exempt from prescription charges, with 73% being due to age

(under 16 or 18 if in full time education, or over 60 years old) and over 60% of these being over the age of 60.

4. Options considered

4.1 Under the ICBs Unwarranted Variation Recovery programme, a number of options were considered to address the unwarranted variation. The option to maintain the current arrangements was not considered, due to the current unharmonised position, and the need to ensure equity across Cheshire and Merseyside. In order to achieve this, the two main options considered were to either fully prescribe across Cheshire and Merseyside at an estimated additional cost of £130k per year (increase annual spend on the service of c.£655k) or to withdraw prescribing completely, offering an estimated annual saving of £525k. (A copy of the original options appraisal has been provided).

4.2 In the context of NHS Cheshire and Merseyside needing to consider how and where to allocate the fixed resources allocated by NHS England to best meet the healthcare needs of the population they serve, the Unwarranted Variation programme has proposed that gluten free prescribing is stopped across Cheshire and Merseyside due to the following rationale:

- availability of gluten free foods is much greater than it was when the original policies were implemented, and in the six years since the DHSC consultation. It should also be noted that bread is not classed as an essential food item and people can maintain a healthy diet without bread through choosing naturally gluten free foods
- whilst the cost of gluten free bread is still more expensive than non-gluten free there are other gluten free products (e.g. pasta) which are the same price. In addition, improved food labelling and increased awareness enables people to make informed and healthy choices
- Coeliac UK now say that 40% of ICBs have stripped or reduced prescribing. Our research shows that 32% have stopped completely, 61% prescribe bread and bread mixes and 6% offer to under 18s only
- consideration was given to prescribing to under 18s only, however, Cheshire and Merseyside data shows that over 60% of gluten free prescriptions are for patients 60 years old, and therefore could be seen as discriminatory against the older population
- gluten free prescriptions are in the main received by patients who have exemptions from payment, with the majority of this being due to age (73%). Because age exemption does not take into account financial capacity, it is difficult to evidence the individual financial impact on the impacted patients.
- withdrawing prescribing has already been implemented in St Helens and part of Cheshire West and to date we are not aware of any unforeseen consequences
- ceasing ICB funded gluten free prescribing across Cheshire and Merseyside would enable achievement of a harmonised policy and remove existing unwarranted variation in access to these products based on the rationale set out in this document. In addition, it would harmonise the approach to prescribing other foods for conditions impacted by “standard” products e.g. lactose intolerance, as NHS Cheshire and Merseyside does not currently prescribe food alternatives for other food allergies / intolerances.

- a number of neighbouring ICBs including Lancashire and South Cumbria and Shropshire, Telford and Wrekin have already stopped prescribing

5. Public Consultation Process undertaken

5.1 At the meeting of the Board held in November 2024, it was approved to commence Public Consultation based on the preferred option to cease prescribing of Bread and Break mixes to all adults and children.

5.2 NHS Cheshire and Merseyside ran a six-week public consultation from 28 January to 11 March 2025 on a proposal to stop making gluten free bread and bread mixes available on prescription.

5.3 A questionnaire and supporting information were produced. These were available online, printed/in alternative formats/languages on request. People could provide their responses over the phone, if required. Information was shared across NHS Cheshire and Merseyside channels. Partners, including GP practices and pharmacies, were sent a toolkit to help promote the consultation.

5.4 In total 1,064 people responded to the engagement questionnaire. 601 indicated they had coeliac disease. A further 57 had another diagnosed condition which requires them to follow a gluten free diet, and 229 were the parent/guardian/carer of a child with either coeliac disease or another diagnosed condition. Responses were received from people in each of Cheshire and Merseyside's nine Places.

6. Key themes and conclusions from the Public Consultation Report

6.1 Feedback has been analysed and compiled into a report by an independent organisation.

6.2 Overall, 768 respondents (78%) of 1,064 people who responded disagreed or strongly disagreed with the proposal to stop providing gluten free bread and bread mixes on prescription, compared with 20% who agreed or strongly agreed.

6.3 The report provides further detail on people's level of agreement or disagreement, broken down by different groups within the respondents. For example, the majority of those who indicated that they had coeliac disease, or another diagnosed condition requiring a gluten free diet, or who were a parent/guardian/carer for someone who did, disagreed or strongly disagreed with the proposal.

6.4 However, those respondents who stated that they didn't have coeliac disease or another diagnosed condition, and who weren't a parent/guardian/carer of someone who did, were more likely to strongly agree or agree with the proposal.

6.5 A copy of the detailed Public Consultation Report has been provided.

7. Post Public Consultation Equality Impact Assessment (EIA)

7.1 Following a period of conscientious consideration to review the feedback received during the public consultation period, the EIA was revisited to ensure this examined some of the points raised during the process.

7.2 The EIA concluded that the proposal to cease funding for gluten free bread and bread mixes is not in itself discriminatory as it is in line with NICE guidelines NG20, it is much more widely available in the marketplace; it is not an essential ingredient of maintaining a gluten free diet. GP services will continue to support in line with guidelines.

7.3 In addition it drew particular attention to the impact on children and young people as they have no agency to source and buy GF bread and bread mixes or plan a GF diet. This is further compounded by children who reside in low-income households or who are in care. This places significant financial constraints on families to purchase GF bread and bread mixes from the marketplace, as the costs are higher, this could impact the effective adherence to a GF diet. Furthermore, low-income families are more likely to have low levels of health literacy and could and therefore be more susceptible to not adhere to a GF diet and develop medical complications.

7.4 It is also important to acknowledge children occupy a different space to adults, in terms of both their dietary behaviours and development. Providing free prescriptions to children and vulnerable people is also supported by the following key clinical organisations:

- **British Society of Paediatric Gastroenterology, Hepatology and Nutrition (BSPGHAN):** BSPGHAN supports the provision of gluten-free prescriptions for children diagnosed with coeliac disease. They highlight the clinical necessity and the role of these prescriptions in ensuring adherence to a strict gluten-free diet, which is crucial for managing the condition. BSPGHAN Position Paper
- **Royal College of Paediatrics and Child Health (RCPCH):** The RCPCH advocates for the provision of gluten-free prescriptions for children with coeliac disease, stressing the importance of these prescriptions in preventing nutritional deficiencies and ensuring proper growth and development. RCPCH Consultation Response
- **British Dietetic Association (BDA):** The BDA supports the continuation of gluten-free prescriptions for children, highlighting the role of dietitians in managing coeliac disease and the need for accessible gluten-free foods to ensure dietary compliance. *BDA Policy Statement*

7.5 In summary, the EIA taking account of the Public Consultation process highlighted the following recommendations for due consideration:

- The proposal to cease funding for gluten free bread and bread mixes is not in of itself discriminatory as it is in line with NICE guidelines NG20, they are much more widely available in the marketplace and they are not essential

ingredients of maintaining a gluten free diet. GP services will continue to support in line with N20 guidelines.

- However, with regard to Advancing Equality of Opportunity (PSED Objective 2, above) and 'due regard' it is important that decision makers consider the impact on children and young people, disabled/ vulnerable children and adults, women, and pregnancy. Children and young people are of significant concern, as affordability, children and young people's behaviours in relation to food, their inability to source and plan GF, the increased likelihood of nonadherence to a GF diet could result in poor outcomes.
- Health Inequalities duty (s.14T); has identified that low income and low levels of health literacy will impact peoples ability to afford, source and plan GF diet. This will impact children and young people and vulnerable adults.
- Take into account the consultation feedback, specifically from primary stakeholders who expressed overwhelming rejection of the proposal. Also consider the range of concerns on clinical needs and risks, affordability, access, health literacy and supporting their children or vulnerable adults to adhere to a GF diet who are risk of dietary neglect (including all pregnant women). The practicality of determining low income and poverty is challenging.

7.6 A copy of the revised EIA following Public Consultation period has been provided.

8. Further options for consideration following Public Consultation and revised EIA

8.1 In addition to the original options appraisal considered by the Board in November 2024 (**Appendix 1**), it is important that due consideration is now given as a result of the Public Consultation undertake and the revised EIA completed.

8.2 To support this, further options have been prepared **(see table 8.5)** to further mitigate the potential impact in relation to ceasing funding prescribing for gluten free bread and bread mixes.

8.3 Following review of the Public Consultation report, the revised EIA and further options provided, The Executive Committee still recommended Option 3 as the preferred option, with a view that Board should provide due consideration to Option 4 to Prescribe to Children.

8.4 It should be noted, that it is the intention within the new policy to have a process to enable GPs to recommend prescribing for those vulnerable adults particularly with learning difficulties and therefore may not be able to consistently source their own gluten free bread and bread mixes. In addition, any exceptional circumstances outside of the clinical policy once approved can apply for consideration within the Individual Funding Request (IFR) process.

Table 8.5 Further options for consideration following Public Consultation and revised EIA

No	Description	Outcome	EIA Feedback*	QIA Feedback*	Financial Impact
1	Do nothing ***-discounted option***	Inequity of prescribing for patients across C&M	No EIA completed	No change to current situation, but unwarranted variation across C&M	Current **annual spend of circa £547,000** will be maintained
2	NHS C&M adopt prescribing to national guidelines across all Places – ***-discounted option on the basis of affordability***	Harmonised C&M policy in line with evidence base.	In line with DHSC EIA guidance following extensive public consultation and EIA completion If not prescribed will be contrary to national published guidance, however, this EIA is now 8 years old. Minimal equality impact identified.	Equity across C&M and improves access to patients in the Places who do not currently receive prescribed gluten free goods. **Overall Risk rating: 1 Green – Low risk**	Estimated increase in spend of £130,000. **Estimated annual spend £677,000**
3	NHS C&M to withdraw prescribing across all Places **Option endorsed by Board November 2024 and consulted on.**	Harmonised C&M policy contrary to published guidance however, this is now 6 years old. This option does not consider the feedback from the consultation or the EIA, however, does support the ICB with the financial position.	Initial EIA identified a number of groups of patients who could be at risk of dietary neglect including children and vulnerable adults, females, pregnant women, families on low income Post consultation EIA: 90% of parents / guardians / carers of a child with coeliac disease or other diagnosed condition requiring a GF diet disagreed or strongly disagreed with the proposal – children & young people do not have agency to purchase or plan their own GF diet and noted the impact of malnutrition or dietary deficiencies during these formative years can have long lasting impact. In C&M the majority of patients receiving GF prescriptions are over 60yo, and consideration should also be given to these, and vulnerable adults (physical disabilities or learning difficulties / mental illness) Whilst it advised that the proposal was not discriminatory in itself, there would be a greater impact on patients due to financial burden and health equity (low income households who may struggle to afford gf products)	Withdrawal of prescribing would impact those patients who receive free prescriptions who are likely to be vulnerable due to low income, holding medical certificates which implies wider health needs and age. There is a risk in this current economic climate that people on low income would consume non-GF bread and bread mixes which could have longer term health impacts and therefore increase health inequalities. (see **Appendix 4** for QIA) **Overall Risk rating: 4 Amber – moderate**	Most current spend would cease leading to an estimated saving of £547,000 with further estimated cost avoidance of £130k **Estimated annual spend £0**

4	Prescribe to under 18s only – **Board are asked to consider this as an alternative option**	Harmonised policy but only for young people. This option does take into consideration much of the feedback from the consultation and the EIA, however, does reduce the savings which would be delivered from the programme.	Post EIA consultation: The consultation feedback has outlined concerns that go significantly beyond inconvenience and support Coeliac UK argument to maintain GF prescriptions for under 18 years (25 for people with additional needs). For people with coeliac disease, a strict gluten-free diet is not a lifestyle choice but a medical necessity. Ensuring access to these products through prescriptions can help manage their condition effectively. The impact of removing GF bread and bread mixes would disadvantage children and vulnerable adults (disability) from low-income households, who are at risk of 'dietary neglect'. Children and young people have no agency to source and buy GF bread and bread mixes and plan a GF diet. See **Appendix 3** for Post Consultation EIA and **Appendix 5** for revised QIA in relation to this option.	Withdrawal of prescribing would impact those patients who receive free prescriptions who are likely to be vulnerable due to low income, holding medical certificates which implies wider health needs and age. There is a risk in this current economic climate that people on low income would consume non-GF bread and bread mixes which could have longer term health impacts and therefore increase health inequalities. Whilst this option would support younger people, they make up less than 15% of the C&M population receiving GF prescriptions.	Based on 10% of current spend **estimated annual spend would be £74.5k**
5	Prescribe to under 18yo and adults receiving income-based benefits – **not supported due to challenge of identifying the adult cohort and practicalities to implement**	Harmonised policy but only for young people and adults receiving income based benefits. This option does take into consideration much of the feedback from the consultation and the EIA, however, does reduce the savings which would be delivered from the programme.	Initial EIA identified a number of groups of patients who could be at risk of dietary neglect including children and vulnerable adults, females, pregnant women, families on low income Post consultation EIA: 90% of parents / guardians / carers of a child with coeliac disease or other diagnosed condition requiring a GF diet disagreed or strongly disagreed with the proposal – children & young people do not have agency to purchase or plan their own GF diet and noted the impact of	Withdrawal of prescribing would impact those patients who receive free prescriptions who are likely to be vulnerable due to low income, holding medical certificates which implies wider health needs and age. There is a risk in this current economic climate that people on low income would consume non-GF bread and bread mixes	Based on 20% of current spend **estimated annual spend would be £108.5k**

			malnutrition or dietary deficiencies during these formative years can have long lasting impact. In C&M the majority of patients receiving GF prescriptions are over 60yo, and consideration should also be given to these, and vulnerable adults (physical disabilities or learning difficulties / mental illness) Whilst it advised that the proposal was not discriminatory in itself, there would be a greater impact on patients due to financial burden and health equity (low income households who may struggle to afford gf products)	which could have longer term health impacts and therefore increase health inequalities. Whilst this option would support younger people and those on income based benefits, they make up around 20% of the C&M population receiving GF prescriptions.	

NHS
Cheshire and Merseyside

Meeting of the ICB Board of NHS Cheshire and Merseyside

29 May 2025

Post COVID Syndrome Review & Options Development

Agenda Item No: ICB/05/25/14

Responsible Director: Dr Fiona Lemmens Deputy Medical Director

Post COVID Syndrome
Review & Options Development

1. Purpose of the Report

1.1 To update the Board on the progress made in the recent review of post Covid (Long COVID) support options following the cessation of the Place based hubs at the end of 2024-25.

1.2 This includes an update on the outcomes of the recent stakeholder, including public & patient, engagement which has been used to inform development of future options.

1.3 To outline the proposed future approach determined by the ICB Executive Committee based on the recommendations of the ICB Clinical Effectiveness Group.

2. Background

2.1 During the Covid-19 pandemic a nationally funded programme was established to implement post Covid clinics. In Cheshire and Merseyside, dedicated services were provided through Place-based hubs run by six Trusts. The 'hub' services varied by size, but the majority were small, often with two or three clinical staff in each hub. Delivery models in each 'hub' worked to a similar specification but were variable in the actual offer. Cheshire and Merseyside ICB also funded specialist capacity for specialist fatigue support, additional pulmonary rehabilitation capacity and a specialist service to support children and young people.

2.2 In 2024-25 the ICB spent circa £3.7m directly on these support services. From April 2025 the funding for post Covid services was no longer ring fenced and was incorporated into the ICB baseline funding allocation.

2.3 From the peak in 2022 to the end of 2024 referrals had fallen by over 60% with a remaining caseload of 1007 people in December 2024.

2.4 As a result of these factors, the current delivery model of local hubs was assessed as being unsustainable when considered alongside the difficult decision that would need to be made in relation to the wider financial context and impact on our ability to fund other services and the hub providers commenced close down of the hubs with patients discharged or referred to other existing services.

2.5 In making this decision the ICB committed to undertaking a review of future options for supporting people with post Covid syndrome.

2.6 There has been considerable interest and concern and formal complaints from service users, politicians, local and regional media, and other stakeholders in relation to the decision to close the hubs and in relation to how we will ensure appropriate future support for people with post Covid.

2.7 The public and stakeholder survey was very positively engaged with including 516[1] responses, alongside qualitive feedback from meetings with post Covid support groups, charities, providers and clinicians and dialogue with peer ICBs to learn from their approaches to redesigning post Covid support. Appendix One provides the findings from the engagement exercise.

2.8 In addition, a comprehensive review of evidence and research and clinical and care guidelines has taken place and can be shared with Board members available on your request.

3. Impact and prevalence of post Covid syndrome

3.1 Based on an average post Covid syndrome prevalence of 3% during this period, it is estimated the numbers of new cases of post Covid since 2022 in Cheshire and Merseyside as, approximately:

- 40,000 new cases
- 29,000 "*adversely*"
- 7,500 impacted "*a lot."*

Research shows that post Covid has/does disproportionately impact on some communities including links to ethnicity and deprivation.

3.2 Locally hospital admissions for Covid-19 have continued to reduce reflecting success of the local and national prevention initiatives including the vaccination programme.

3.3 Kingston *et al* 2020 and Mu *et al*, 2024, found that healthcare utilisation rates over the 2 years after initially contracting Covid-19, were raised for people with post Covid syndrome across GP consultations, outpatient appointments and emergency attendances. It is therefore recognised that without dedicated support there will be additional costs of supporting people with post Covid in these settings.

3.4 Many of these people will self-care or be treated within primary care. However, based on the referral trends into the hubs of more complex patients, we would expect at present there are up to 1,000 people who would seek more specialist support across Cheshire and Merseyside.

[1] https://www.cheshireandmerseyside.nhs.uk/get-involved/previous-consultations-and-engagements/long-covid-services/

4. Equality, Diversity, and Inclusion

4.1 An Equality Impact Assessment (Appendix Two) was developed as part of the process to determine the decision to stand down of the previous place-based hubs, and this has been updated to reflect the feedback received through patient engagement and will be maintained as we develop our final plans.

5. Finance

5.1 The ringfenced national allocation used to fund the service ended on the 31st of March 2025. The allocation for 2025-26 transferred from ring-fenced service development funding to the ICB core baseline was £4,492m for adults and £129k for Children & Young People provision.

5.2 It is recognised that in light of the current financial challenge in Cheshire and Merseyside that any investment in post Covid support needs to be balanced against the reality that this would need disinvestment in other services.

5.3 Even before consideration of the costs of the options in section 6 there will be some residual costs in 2025-26 related to completing the process of closing the Place based hubs, the resulting additional referrals and activity in our ME/CFS (Myalgic encephalomyelitis/chronic fatigue syndrome) service at Liverpool University Hospitals in supporting people with fatigue related symptoms and for ongoing support of children and young people in our specialist service at Alder Hey. A moderate financial reserve has been included in the ICB financial plan.

6. Options for future provision

6.1 The options outlined below are based on the findings from patient engagement 'themes' from visiting post Covid support groups, post Covid engagement survey result themes, and academic research into best practice, discussions with 'hub' and specialist providers, a discussion with the ME Association, information from colleagues from other ICBs undertaking similar reviews.

6.2 A "long list" of options were developed. These options outlined the outline clinical model and approximate costs based on up to 1000 patients seeking specialist support and were then considered alongside a detailed report outlining the findings of the review by the ICB Clinical Effectiveness Group who supported the Option numbered 3 below.

6.3 Whilst referrals into our specialist Children and Young Peoples' Post Covid Service are low there remains 40 children on caseload. This service operates alongside the ME/CFS service at Alder Hey.

6.4 Options were then considered at Executive Committee whereby based on the discussions and recommendations of the Clinical Effectiveness Group agreed to

discount a number of the "long list" options as either clinically, operationally or financially not viable. The Executive Committee asked that further work was needed to develop the impact and plans in relation to Option 3, whilst also retaining consideration to Options 1 and 2, before a final decision was made.

6.5 A group of members of the public who had been service users in our hub services alongside representatives from Healthwatch and two national charities have subsequently reviewed these three options and highlighted from their perspective the importance of a number of factors including;

- local face to face services being accessible,
- gaps in current provision and knowledge in local services e.g. access to local community therapies such as exercise physiology, meant that without support the attendees felt they weren't being supported,
- the use of exclusively self-help/online materials was not seen as adequate,
- there were a number of points raised in relation to access to medication and treatment interventions. It was noted that this would require a further review of clinical evidence as our research to date hadn't supported this position.

***Option 1* – Use of online support offer (online tools and links to self-care and advice), General Practice coordination with referral to existing community and specialist services.**

- Patient care is coordinated by their local GP Practice and onward referral to existing community and specialist services, where available.
- An enhanced set of support materials available to help people in self-care and sources of information.
- Whilst there are not direct additional costs of this option there will be significant levels of additional activity/expenditure in primary and community services as well as tariff-based specialist services.

Option 2 – Limited additional capacity in existing ME/CFS services

- In addition to option one but with additional investment into the ME/CFS service to reduce waiting lists for support with more timely fatigue and related conditions.
- For this option, there may be the opportunity of clinics being held in a variety of locations to reduce inequality of access, this would need to be discussed with the provider.
- The estimated costs of this approach (from within the reserve referenced in 5.3) would be up to:
  - £323k cost for adults
  - £128k cost for Children and Young People

Option 3– Development of an integrated Post Viral Fatigue Service

- Enhancing the current commissioned ME/CFS model into an integrated Post Viral Fatigue service that is symptom led.
- This option would offer enhanced psychology and therapy led support, wellbeing co-ordinators and would offer specialist services as 'outreach and/or satellites' into a variety of locations offering more equitable access as well as including include digital options in delivery.

- This option could reduce waiting times by addressing the demand and capacity gap for ME/CFS/post Covid referrals.
- With a lead provider model, this option could enable the lead provider to sub-contract elements i.e. wellbeing co-ordinators to the voluntary sector linking with current local community provision i.e. social prescribers.
- This option would include some 'system' education, including for primary care and other community services, in identifying and supporting people with post Covid.
- This option would also support future care integration through our provider sector e.g. with pain management services.
- The estimated costs of this approach (from within the reserve referenced in 5.3) would be up to:
  - £657k for Adults
  - £128k cost for Children and Young People

6.6 As stated earlier it is recognised that by not having appropriate support there are likely to be "hidden" costs in both Primary Care but also increased activity and costs in community and hospital services which impact on waiting times and additional tariff-based costs to the ICB from patients accessing specialist services.

6.7 **Recommendation.** The Executive Committee review gave support towards recommending Option 3 to the Board but requested that the commissioner leads for this programme should undertake further work to explore in more detail how the proposals effectively balances meeting the needs of patients alongside delivering the most cost-effective option.

7. Ask of the Board

7.1 The Board is asked to**:**

- **Note** the engagement and research process undertaken to date in developing the short list of options above.
- **Endorse** the recommendation of the Executive Committee to undertake further work to explore in more detail how the proposals in Option 3 effectively balances meeting the needs of patients alongside delivering the most cost-effective option.

8. Reasons for Recommendations

8.1 **Benefits** to supporting the recommended option:

- **Patient journey:** The pathway for post Covid syndrome services would enable conversations to begin with the ME/CFS service to enable a more consistent offer across the ICB footprint reduce the variation and inequality of access across C&M for post Covid syndrome.
- **Financial:** enables the ICB to work with the provider to provide a more equitable, long term, sustainable funding option across the ICB whilst still delivering significant savings to the ICB

- **Quality and safety:** quality standards would be the same across NHS Cheshire & Merseyside ICB with patients accessing the same offer and working to the same specification. This would further provide assurance to the commissioners that the quality standards of the service are aligned. This would also support providers and offer some continuity to patients. This option also aligns with NICE Guidance for post Covid and Fatigue.
- **Quality monitoring**: this option would also allow quality standards to be monitored via the post Covid syndrome dashboard allowing benchmarking locally and nationally, helping to improve the quality of services to post Covid syndrome patients.

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

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

Research shows Core 20 + 5 populations are disproportionately impacted by post Covid syndrome.

Objective Two: Improving Population Health and Healthcare

The preferred option has been based on best practice and thorough research of the latest evidence base.

Objective Three: Enhancing Productivity and Value for Money

All options presented deliver a significant saving against historical expenditure.

Objective Four: Helping to support broader social and economic growth

Providing support to people with post Covid syndrome is an enabler to support people staying in or returning to work.

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

10.1 The options are entirely consistent with the ICB Joint Forward Plan and Annual Delivery Plan.

11. Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety

Supporting people to live healthier lives, safe & effective staffing, equity in access & experience/outcomes.

Theme Two: Integration

Safe systems, pathways & transitions, continuity & integration.

11.1 **NICE Guidance:** Option 3 meets most key areas laid out in NICE COVID-19 rapid guideline: managing the long-term effects of COVID-19 – NICE guideline NG188, published: 18 December 2020, last updated: 25 January 2024

11.2 **NICE Guidance:** Options 3 meets most key areas laid out in Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management, NG206, published; 29th October 2021

12. Next Steps and Responsible Person to take forward

12.1 Further work will be undertaken with our local ME/CFS provider to develop a more detailed proposal that will be oversee by the Executive Committee and progress reported to the ICB Board as this work develops.

13. Officer contact details for more information

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

Alison Hudson, Liverpool Place Delivery Lead LTCs & VWs alison.hudson@cheshireandmerseyside.nhs.uk)

14. Appendices

THE APPENDIX CAN BE ACCESSSED BY CLICKING HERE

Appendix One - Independent analysis of the patient survey
Appendix Two - Equality Impact Assessment

This is also published at Long COVID services - NHS Cheshire and Merseyside

Long COVID support services across Cheshire and Merseyside

Report into patient questionnaire findings

Report Prepared for:
NHS Cheshire and Merseyside Integrated Care Board (ICB)
By:
Praxis Evaluation and Research Community Interest Company
April 2025.

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1.0 Introduction

NHS Cheshire and Merseyside Integrated Care Board (ICB) held a period of public engagement about long COVID Services in Cheshire and Merseyside. The main mechanism for collecting responses was a questionnaire, which opened on 14th February 2025 and closed on 16th March 2025.

Praxis Community Interest Company CIC was appointed to analyse the feedback from the questionnaire and produce a report which could be used to inform decision-making about future provision of long COVID support.

2.0 Public engagement

The following information outlines NHS Cheshire and Merseyside's approach to involving patients and the public in planning for future provision of long COVID services.

Introduction and background

Long COVID services launched in 2020, to support patients who were suffering ongoing effects of the virus months after being infected, with symptoms including breathlessness, poor sleep, fatigue, a cough, or anxiety and low mood.

Dedicated national funding was allocated to run these services. In Cheshire and Merseyside, they were accessed through a GP referral, and provided through a number of hubs, run by the following trusts:

- Warrington and Halton Hospitals NHS Foundation Trust
- Mid Cheshire Hospitals NHS Foundation Trust
- East Cheshire NHS Trust
- Cheshire and Wirral Partnership NHS Foundation Trust
- Wirral Community Health and Care NHS Foundation Trust
- Mersey Care NHS Foundation Trust

Due to the significant drop in referrals, and as national funding was no longer ring-fenced for these services from 1 April 2025, NHS Cheshire and Merseyside is reviewing how long COVID support is provided in the future.

As a result, the current long COVID hub arrangements have ended, meaning that these services are no longer taking referrals. While the wider review is underway, GPs will refer patients to alternative services, depending on their clinical needs.

NHS Cheshire and Merseyside wants to find the most effective way of supporting people with long COVID in the future, while ensuring that it makes the best use of NHS resources. By involving the public, patients and staff in the review process, it aimed to gather a wide range of views and insights to help inform next steps.

The involvement objectives for this work were:

- Communicate the fact that changes are being made to local NHS long COVID support services, and that there is an opportunity for people to share their views about how this care looks in the future.
- Gather feedback from patients, carers, the wider public, staff and key stakeholders to understand what the core components of any future long COVID support should consist of. This will include key areas of support required, and preferences for how this is delivered.
- To compile and analyse findings so that they can be used to develop a proposal for how services might look in the future.

Methods of engagement and materials

NHS Cheshire and Merseyside has published information about changes to long COVID services on its website. This includes links to support materials (including self-help information, and signposting to resources such as the ORCHA App library), and the intention is to continue building this content over time.

Between Friday 14th February and Sunday 16th March 2025, people were able to complete an engagement questionnaire, containing both qualitative and quantitative questions, designed to gather views and perspectives on long COVID support. The questionnaire is shown in appendix number twenty-two.

Printed copies of both the information and questionnaire were available on request, as were alternative formats and languages. People who were unable to complete the questionnaire were able to provide their feedback over the telephone.
Wider partners and stakeholders, including NHS providers, Healthwatch, and voluntary, community, faith and social enterprise (VCFSE) organisations were asked to share details of the engagement using their own channels.

NHS Cheshire and Merseyside also attended local long COVID support groups to discuss the changes and understand more about what patients need to support their ongoing and future recovery. Participants were encouraged to complete the main engagement questionnaire, but we also captured a summary of the key themes which arose during these sessions. While not covered in this report, the key themes which arose during these sessions were captured by NHS Cheshire and Merseyside to inform the development of potential service options for the future.

3.0 Analysis and reporting

NHS Cheshire and Merseyside ICB required support with the following:

a) Analysis and reporting of responses to the engagement questionnaire identifying different views/needs of particular groups, including differences by equalities groups, geographical area (the nine local authority footprints within Cheshire and Merseyside and a further category of “out of area”) or other groups defined by the data. Data was provided as a single data sheet. Closed questions were analysed descriptively and statistically where relevant and possible. Open questions were analysed qualitatively.

b) As part of this engagement there was need to understand any equalities implications by exploring information presented by groups with protected characteristics. This required responses to be cross tabulated with each protected characteristic to better understand any differences of view. This is clearly identified in the report of findings to inform development of a full Equalities Impact Assessment.

c) The profile of respondents indicating their interest in this engagement are shown in appendices one to three. Equality Monitoring profiles are also shown in the appendix.

4. Summary of findings

4.1 This engagement was based on a self-completed questionnaire by 516 respondents. Of these 353 respondents indicated that they currently have or have had long COVID in the past. A further 27 respondents were members of staff working in a long COVID service role.

4.2 Of the 353 long COVID patients and carers 22% are aged between 18 and 44, 60% are aged between 45 and 64 and 18% aged over 64. Again, based on more limited data 23% are male and 77% female. These percentages are based on those respondents who answered both the question about whether they currently have or had long COVID and the questions about their age and gender profile.

4.3 The two long COVID symptoms respondents most frequently cited as the reasons they sought support were 'fatigue' (91% of respondents) and 'problems with memory and concentration' (82% of respondents).

4.4 All six of the defined long COVID symptoms that prompted respondents or their carers to seek support were recognised by a minimum of 60% of those who reported having long COVID.

4.5 On average, each of the 353 respondents with long COVID had approximately 4 of the recognised symptoms prompting them to seek medical help.

4.6 59% of patients with 'fatigue' said they needed the 'highest level of support' to deal with this symptom. This compares with just 22% who identified 'shortness of breath' as the symptom needing the 'highest level of support'.

4.7 110 respondents between them added a whole range of other health symptoms that prompted them to seek support for long COVID. These are shown in appendix four.

4.8 When presented with different potential options set out in the questionnaire for managing long COVID symptoms only 31 respondents said they had not received any additional support. Of the remaining 322 long COVID patients, each had accessed, on average, three of the listed support routes or services.

4.9 Of the ten different support services to manage long COVID symptoms, the most popular were GP Practice (60% using), Talking Therapies (43% using) and Community Therapies (38% using).

4.10 The most important sources of help in accessing long COVID support were 'face to face' appointments (85% selecting) and 'telephone appointment' (70% selecting).

4.11 Respondents were asked for additional comments, and particularly how changes to NHS long COVID services might impact those with long COVID and their carers. 259 individual comments were received. A thematic analysis identified four broad categories of responses. These are described below together with the number of individual responses allocated to each category. It should be noted that many of the responses selected for each of the three categories were abbreviated to aid analysis and presentation.

- 26% of responses were critical of the service they had received or the lack of accessible services.
- 44% of responses were concerned about the withdrawal of long COVID services at a time many people were still suffering with the condition.
- 28% of responses were satisfied with the quality of service or the options available to people with long COVID.
- 2% of responses were classified as providing a statement with a neutral stance on how changes to the long COVD service might impact them.

MAIN FINDINGS

5. Profile of respondents with long COVID

5.1 The number of respondents identifying with long COVID is shown below in Table 1.

Table 1. Respondents with long COVID or carer of someone with long COVID.

Respondents long COVID profile	No.	%
I have long COVID and I am currently accessing an NHS long COVID service	209	59.2
I have/had long COVID and have previously accessed an NHS long COVID service	83	23.5
I have/had long COVID but haven't received support for my condition	39	11.1
I am a carer of someone with long COVID	22	6.2
Total	353	100

5.2 To provide a more detailed profile of long COVID respondents, an age and gender profile is shown below. Caution is needed in interpreting these profiles because respondents were not required to provide their gender and age and therefore the totals are less than those shown in Table 1.

Table 2. Respondents with long COVID or carer of someone with long COVID by age

Respondents long COVID profile by age	18-44	45 - 64	64 +	Total
I have long COVD and currently accessing NHS long COVID service	49	112	24	185
I have/had long COVID and previously accessed NHS long COVID service	9	48	18	75
I have/had long COVID but haven't received support for my condition	6	12	9	27
I am a carer of someone with long COVID	2	10	6	18
Total	66	182	57	305

Table 3. Respondents with long COVID or carer of someone with long COVID by gender

Respondents long COVID profile by gender	Male	Female	Total
I have long COVD and I am currently accessing NHS long COVID service	37	129	166
I have/had long COVID and have previously accessed NHS long COVID service	22	44	66
I have/had long COVID but haven't received support for my condition	4	23	27
I am a carer of someone with long COVID	2	16	18
Total	65	212	277

6. Symptom(s) which prompted respondent to seek support for long COVID

6.1 Respondents were required to describe the symptom, or symptoms that prompted them, or the person they care for, to seek support for long COVID. They could choose as many options as applied. The results are shown in Table 4 below.

Table 4: Symptom(s) Prompted Respondent to Seek Support for long COVID

Symptom	**No**	%
Shortness of breath	249	70.5
Fatigue	321	90.9
Problems with memory and concentration (“brain fog”)	289	81.9
Heart palpitations and dizziness	214	60.6
Joint pain and muscle aches	249	70.5
Depression, anxiety and mental health	215	60.9
Other (See 6.2 Below)	110	31.2

(n=353.) These are respondents who have/had long COVID or a carer of someone with long COVID.

6.2 The 110 respondents who answered ‘other’ provided an extensive list of symptoms associated with long COVID. These are listed in appendix four.

7. Level of support needed for different symptoms

7.1 Respondents were required to select from five options the level of support they needed to manage the following symptoms.

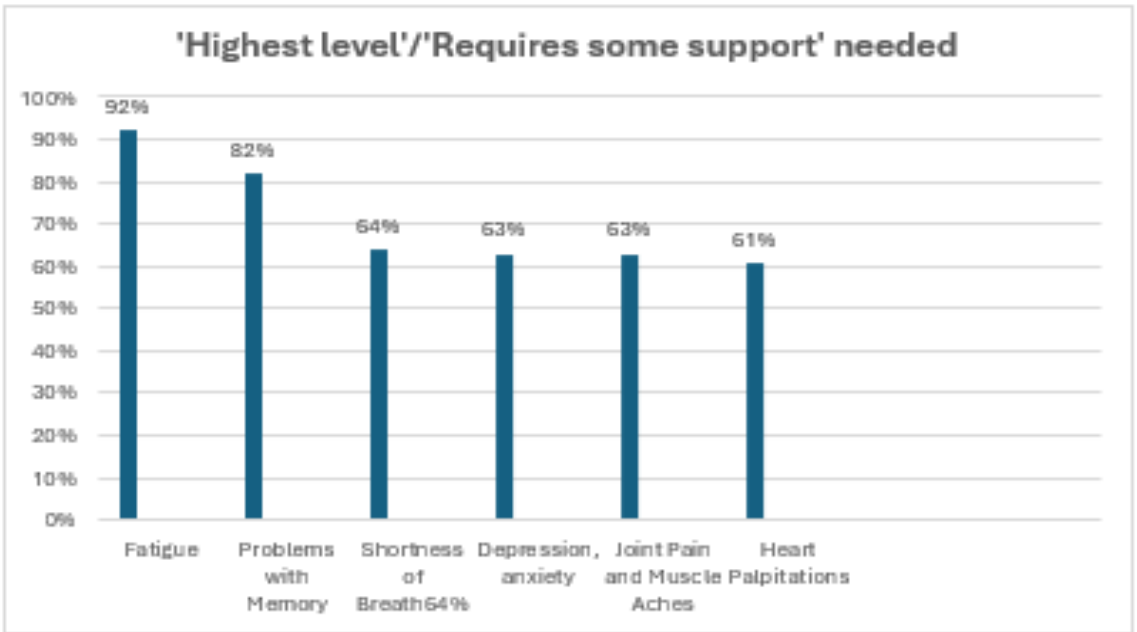
Table 5: Level of support needed for different symptoms

Symptom	Highest level of support	Requires some support	Lower level of support	Lowest level of support	No experience of this symptom
Shortness of breath (n = 303)	68 22%	127 42%	48 16%	33 11%	27 9%
Fatigue (n = 320)	188 59%	104 33%	20 6%	7 2%	1 -
Problems with memory and concentration (n = 313)	102 33%	153 49%	35 11%	14 4%	9 3%
Heart palpitations and dizziness (n = 298)	83 28%	97 33%	42 14%	30 10%	46 15%
Joint pain and muscle aches (n = 306)	117 38%	106 35%	38 12%	21 7%	24 8%
Depression, anxiety and mental health (n = 307))	98 32%	124 41%	29 9%	27 9%	29 9%
Other symptoms (n =196)	74 38%	49 25%	14 7%	7 4%	52 26%

N.B The total number of respondents answering this question were the 353 identified in Table 1. However not all respondents answered each section of the question. Therefore, the percentages are based on the number of respondents answering each individual question.

7.2 To identify the symptoms requiring most support Table 6 ranks them according to the level of support required.

Table 6: Long COVID symptoms requiring most support



8. Support received to manage long COVID

8.1 Respondents were asked to identify, from a range of different support services, the ones they had used to manage their long COVID symptoms. The results are shown below in Table 7.

Table 7: Support received to manage long COVID

Support services	No	%
Your GP practice	193	54.7
Talking therapies (Psychological treatments for mental and emotional problems)	138	39.1
Pain management	52	14.7
Respiratory/pulmonary rehabilitation	100	28.3
Community therapies (OT/Physio)	121	34.3
Chronic fatigue/ME (Regional service operated by Liverpool University Hospitals Foundation Trust)	62	17.6
Medical specialities relevant to individual clinical symptoms including Cardiology, Rheumatology, Gastroenterology, Neurology	98	27.8
Local wellbeing and support organisations e.g. wellbeing hubs, disability support.	102	28.9
Local social prescribing services e.g. in your GP practice	50	14.2
Online resources	103	29.2
I haven't received any additional support	31	8.9
Other	61	17.3

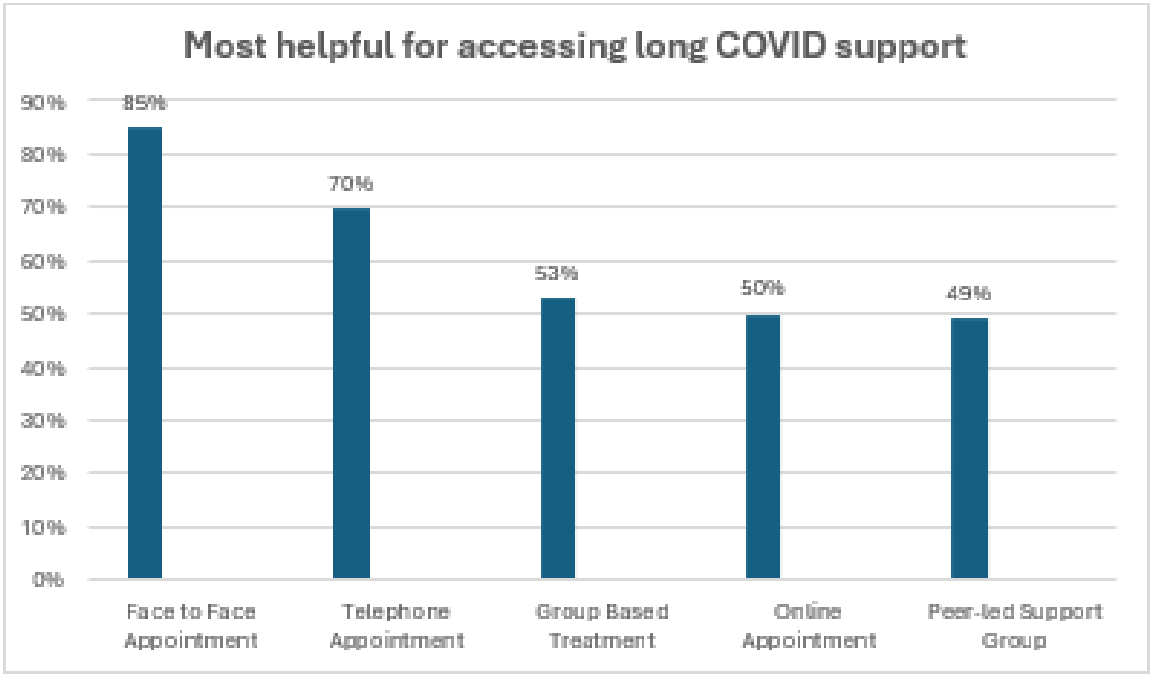
N.B. (Base = 353. These are respondents who have/had long COVID or a carer of someone with long COVID.)

8.2 Respondents were required to select from five options the level of help they received to access long COVID support.

Table 8: Long COVID support received

Symptom	Very helpful	Somewhat helpful	Somewhat unhelpful	Not very helpful	No experience of this symptom
Face to face appointment (n= 316)	228 72%	42 13%	8 3%	10 3%	28 9%
Online appointment (n = 305)	81 27%	69 23%	17 5%	26 8%	112 37%
Telephone appointment (n = 317)	110 34%	113 36%	19 6%	34 11%	41 13%
Group-based treatment (n = 307)	116 38%	47 15%	6 2%	18 6%	120 39%
Peer-led support group (n = 301)	107 36%	40 13%	11 4%	15 5%	128 42%

Table 9: Most helpful long COVID support



9. Opinions about long COVID support

9.1 Respondents were asked for additional comments, and particularly how changes to NHS long COVID services might impact those with long COVID and their carers.

9.2 259 individual comments were received. A thematic analysis identified four broad categories of responses. These are described below together with the number of individual responses we allocated to each category. It should be noted that many of the verbatim quotes selected for each of the four thematic categories have been abbreviated.

Table 10. Classification of responses about long COVID support

Classification of responses about long COVID support	No	%
Respondents who were critical of the service they had received or the lack of accessible services	67	26
Respondents concerned about the withdrawal of long COVID services at a time when many people were still suffering with the condition	114	44
Respondents who were satisfied with the quality of service or the options available to long COVID patients.	73	28
Statement with neither positive nor negative sentiment	5	2
Total	259	100

n=259: respondents who responded to the request for additional comments

9.3 The following is a random selection of comments from the three main classifications, and which provide deeper insights into the feelings of respondents.

Table 11. Respondents who were critical of the service they had received or the lack of accessible services

Respondents who were critical of the service they had received or the lack of accessible services
1.Feel symptoms are dismissed as being Long COVID and assumed to have other causes. I have had Covid 3 times and am very aware of how different symptoms are to other viruses.
2. I think the biggest issue with not having a dedicated portion of the NHS for long COVID is that some members of the individual departments don't have the belief that such a thing even exists, and you get fobbed off onto somewhere else. The only place where I have felt believed and supported is the long COVID dedicated department run by Warrington Disability Partnership, which I eventually got referred to via my GP.
3. Inaccurate information and derogatory comments were made about me from people who are supposed to be healthcare 'professionals', mocking my mental health and bowel issues. As a former nurse who caught Covid at work, I am disgusted and feel like I've just been dumped and my health needs, and that I, do not matter.
4. I don’t feel it was taken seriously enough by health care professionals plus no referral was made to Liverpool clinic.
5. I feel abandoned in the system, for 3 years the attitude has mainly been to get on with it and very little support has been signposted by health professionals apart from the long COVID service which is being discontinued.
6. I have been suffering, unknowingly, with Long COVID since 2022. In early 2024 I approached my GP 6 weeks after my second infection to discuss the crippling fatigue I was experiencing and my inability to return to work. I was told I hadn’t been unwell long enough to be referred to the long COVID clinic. By December 2024 I had become progressively more unwell and disabled by Long COVID symptoms.
7. There is nothing available to help support and prescribe for my symptoms of chronic fatigue and challenges with my immune system. it’s only ever been about respiratory issues.
8. Knowing how isolating a disease such as long COVID is, I fear for the lives of those severely affected. The lack of knowledgeable support I am sure will lead to tragic mental health consequences. I am also very aware of the gaslighting effect of the disjointed and uneducated effect of using the individual specialities.
9. Many people are alone with their symptoms and need positive reinforcement from others with similar long lasting and confusing symptoms. Most GPs are totally in the dark as to how to treat people with long COVID symptoms.
10. What long COVID patients most need is medication, not ‘support’. It is extremely difficult to access this via the NHS, in part due to prescribing guidelines, and in part due to lack of knowledge.

Table 12: Respondents concerned about the withdrawal of long COVID services at a time when many people were still suffering with the condition

Respondents concerned about the withdrawal of long COVID services at a time when many people were still suffering with the condition
1. I would like to see the service still going ahead they have been great support, got me through very dark days I still have these days, but I know I have got the support still where will we go for support; I would be lost without it
2. I'm sorry to hear the long COVID clinic is closing. I think the two biggest benefits for me were the recognition of long COVID as a condition. Secondly, the instructor led classes were great for leading me to peer support and almost incidentally the instructor identified Mast Cell Activation Syndrome as a condition I potentially had and was thus able to address with the clinic GP.
3. It's a shame the service is going to finish it has been very helpful not sure where to go now
4. I will struggle without the service; the service has gone above and beyond to help me. Assessing us, teaching and guiding us through talking and tools to help us manage long COVID.
5. It will be devastating to lose this invaluable provision - from the experts with answers to our questions and our peer group who support and help us.
6. I'm extremely concerned that without the long COVID service, not only will I not be able to access the level of support that I've received this far, but it will also leave me having to seek support from others who don't have the level of knowledge, understanding or expertise about the condition and what this means for us. This has been an absolute lifeline.
7. Please do not end the Liverpool long COVID service. As a thirty-four-year-old facing a potentially lifelong disabling condition, the support I have had from the service's GPS and nurses has been the lone light at the end of a very long and extremely exhausting tunnel. My GP practice does not provide any support for my long COVID aside from issuing medication prescribed by the long COVID service. I am extremely worried for myself and other patients if the service closes. It has been the only truly holistic care I have received since I was diagnosed in 2020. I feel extremely distressed and despairing since receiving the letter.
8.I will struggle without the service, the service has gone above and beyond to help me. Assessing us, teaching and guiding us through talking and tools to help us manage long COVID. They started a Peer Support Group so we could meet our patients. Had guest speakers to enlighten us with taster sessions.
9. The closure of the long COVID clinic will leave me vulnerable and open to falling through the cracks in the system, there will be no continuity of care. Our physical, mental and emotional wellbeing will be affected. We do not have the energy or capacity to co-ordinate multiple appts.
10. It's a smack in the teeth that valuable services are being withdrawn because there not popular. Already various agencies are saying goodbye so if like me you need multiple disciplines were screwed.

Table 13: Respondents who were satisfied with the quality of service or the options available to long COVID patients

Respondents who were satisfied with the quality of service or the options available to long COVID patients
1.Long COVID service is a vital part of ongoing support for so many of us, myself included. There is no known cure for us and no medication that can be prescribed so the help and support received from long COVID service is vital.
2.The long COVID clinic have been the only referral that have understood my conditions down to a T. For 3 years I had absolutely no support from GPs, or any referrals as they had no way of helping and no understanding. A lot of them treated me like an inconvenience and like I was overreacting or just needed therapy due to their complete lack of knowledge on the condition.
3.Meeting people who have suffered and sharing our experiences has been lifechanging! I don't feel so isolated and alone.
4. The holistic approach the clinic has provided has been most important. Advice given to GPs is also vital as they have very little knowledge of long COVID. The long-term cost of treating people living with long COVID will increase as we are passed from one specialist to the next, rather than being treated by one team.
5. The long COVID service have provided me with support and direction to help I did not find anywhere else nor did I know was available. I felt listened to and felt like the staff understood me and my condition.
6.NHS led support groups are very helpful. Long COVID clinic is the first medical place that looks at you as a whole person it's a crime to close these down. I assume referring us means putting us on a waiting list which is awful and once again each specialty will look at only that part of us and not the overall picture. The news that the clinics are closing has had a significant impact on my mental health and overall wellbeing it's an absolute disgrace.
7. The long COVID service had a huge impact on my life when I was deep in the midst of long COVID and was struggling to understand what was happening to me and how to move forward. The team were incredibly helpful when I was at the worst point in my life and helped find me the tools I needed to manage my condition.
8.The long COVID team got me from unable to work to returning part-time in a new career. Without them, I would be unemployed and claiming benefits with a very poor quality of life. They looked at my health holistically, which I have never experienced with the NHS before and this was key to getting me working again.
9. The long COVID Service provides me with invaluable support. I was seen within 3 months of GP referral. They immediately prescribed medication which improved my symptoms. They also provide excellent OT and physiotherapy support. They have provided these services in my home as I have been too exhausted to attend clinic. The level of advice, support and understanding of the condition is exceptional and I believe has helped me to cope with a profoundly disabling condition.
10. The long COVID Team have been an absolute lifeline to me. They are the only service to completely understand my condition, its symptoms, and how it impacts upon me, my life, family, and mental health. They are absolutely invaluable. I am absolutely desperate for the service to continue. Without it, I feel abandoned and like there will be no help for me, and not even any understanding from health professionals I see, and especially the Physio and OT are exceptional professionals and the best I have ever met in the NHS.

10. Views By health professionals not working in the long COVID service

10.1 Health professionals completing the questionnaire, were asked to share their views about long COVID in an individual capacity. There was a range of differing opinions, and which were classified as either scepticism towards the validity of long COVID or support for continued and accessible community and collaborative services. These are much abbreviated extracts from the comments made by health professionals but do represent the most frequently occurring themes.

Classification of responses about long COVID support
Scepticism towards the validity of long COVID services
Support for continued and accessible community and collaborative services

Table 14. Responses which show scepticism towards the validity of long COVID services

1. I think the support should be used elsewhere. The staff who carry out this service need to be back into the main hospitals help reducing patients waiting times, whether that be in clinic setting or A&E. Helping with the backlog of patients getting sicker because they are not getting seen quicker enough.
2. It is very clear that 'long COVID' is being used as an excuse for our patients who have actually being injured by the 'vaccinations'.
3. Long COVID is a poorly defined syndrome. Screening is poor. A diagnosis is typically given without properly excluding other causes. It is often diagnosed in individuals with no previous diagnosis of COVID.

Table 15. Support for continued and accessible community and collaborative services

1. As a clinical psychologist I am very aware of the multiple and wide-ranging health (physical, neurological, psychological and neuropsychological) and mental health effects that can be precipitated by long COVID - including many distressing medical symptoms that can further fuel dynamic cycles of mental and physical health symptoms.
2. As the long COVID service is winding down, we have several patients who are still very unwell and need ongoing specialist care.
3. Long COVID services need to be available for face-to-face engagements close to home.
4. The long COVID hubs must be accessible for patients who are navigating this condition and need good quality advice and guidance from professionals who are knowledgeable and willing to work collaboratively.
5. The long COVID service has been delivered out of my Health and Wellbeing proactive since 2022 and the team have built the service up with expertise and also resources in the form of workshops in the studio and rooms for clinic time. This has been very well attended and has provided a community hub for the community to get support from each other and from other specialist speakers.
6. The loss of a centralised service where patients can access all the support they need will be devastating and highly detrimental to these individuals

11. Views by members of staff working in long COVID services

11.1 Staff working in long COVID services completing the questionnaire, were asked to share their views about long COVID in an individual capacity. These respondents were all concerned about the negative consequences for patients created by the end of hub services for long COVID. They describe the most frequently occurring concerns for multi-disciplinary support and highlight the value of long-term support and understanding. These are a selection of abbreviated comments made by members of staff working in long COVID services.

Table 16: Comments by members of staff working in long COVID services

1.The loss of a centralised service where patients can access all the support they need will be devastating and highly detrimental to these individuals
2.Ending the long COVID services without first consulting with staff and patients and without assessing costs is wrong. Many patients will only have their GP surgery to turn to.
3. I believe that the current model is sufficient. Patients need access to a muti-disciplinary team. As most people do not understand the complexities of long COVID, it is hard for patients to receive the support they need from other practitioners.
4.I think the current model works well for patients and their families. I think the decision to close the service is short-sighted.
5. Long COVID support fundamentally needs not to be a year-on-year service provision.
6. No other services available for this cohort of patients to provide the holistic and timely approach that they need.
7. Patients need support for coping with their symptoms, from people who understand the condition and the impact it has on every aspect of their life. people are broken physically and mentally when they come to the service

Appendices

1. Profile of respondents indicating their interest in long COVID questionnaire

Personal interest of respondents	No.	%
I have long COVID and I am currently accessing an NHS long COVID service	209	40.4
I have/had long COVID and have previously accessed an NHS long COVID Service	83	16.1
I Have/had long COVID but haven't received support for my condition	39	7.6
I am a carer of someone with long COVID	22	4.3
I am a health professional working in another service and would like to share my views in an individual capacity.	24	4.7
I am a member of staff working in long COVID Service	27	5.2
None of the above apply to me but I would like to share my views	88	17.0
Other category.	24	4.7
Total	**516**	**100**

2. Home location of respondents

Home location of respondents	No.	%
Cheshire East	88	17.1
Cheshire West	123	23.8
Halton	33	6.4
Knowsley	17	3.3
Liverpool	54	10.5
Sefton	33	6.4
St Helens	35	6.8
Warrington	52	10.1
Wirral	56	10.9
Outside of Cheshire and Merseyside	25	4.8
Total	**516**	**100**

3. Where did you hear about this engagement

Where did you hear about this engagement	No	%
From GP practice	4	1.0
From local pharmacy	0	0
Sent a letter by an NHS long COVID service	115	27.6
Social media	71	17.0
NHS website	37	8.9
Patient group/Voluntary sector	49	11.8
NHS staff communication	38	9.1
Friend or family member	26	6.2
Other	77	18.5
Total	**417**	**100**

N.B. 99 Respondents did not answer this question.

4: Other symptom(s) prompted respondent to seek support for long COVID

Abnormal breathing pattern
Adrenaline rushes, tinnitus,
Affected senses e.g. auditory overload
Among others: tinnitus, noise sensitivity, light sensitivity, movement sensitivity, gastrointestinal issues, dizziness, light-headedness, derealisation, blood pooling, pins and needles, numbness, skin rashes, skin dryness, skin irritation, insomnia,
Asthma
Balance problems (4)
Blood pressure
Blurred vision, jerky movements of limbs, pins and needles, vertigo, loss of smell, change in taste, headaches, sensation to skin, intolerance to noise, light, busy areas, trouble swallowing, loss of appetite, nausea, gastrointestinal issues, poor balance/stability, peripheral neuropathy, sleep problems, clenching jaw, TMJ, spasms in hands /feet, cramps, rib pain, chest pain, tinnitus, overall body stiffness, fainting, abdominal pain/bloating, etc
CFS/PEM/Autonomic dysfunction – now registered disabled from COVID
Chronic migraines/Constant headaches
Constant headaches
Constipation, blackouts, sleep impact, no taste or smell (2)
Damaged nerves, weight and muscle lost, poor balance
Difficulty sleeping – short spells
Digestion issues, sinus issues, mouth issues
Digestion/histamine intolerance
Digestive/bowel issues along with nausea. (2)
Dizziness tinnitus and disorientation and dramatic changes in hr and bp (3)
Dryness mouth throat, sore lungs
Dysautonomia, ataxia, MECFS, MCAS
Electric shocks
Extreme Food/medication intolerance
Eye migraines. Double vision. Infected toes
Fibromyalgia
Gastrointestinal issues (4)
Hair loss
Headaches (4)
Hearing, eyesight, feet and skin problems
Heart pain, costochondritis, blood clots, Dysautonomia, fibromyalgia, chronic fatigue, ovarian failure and hormone problems
Hypertension, hot flushes, raised ALT levels, signs of nerve damage
Increase in blood pressure, cholesterol and breathing pattern disorder
Increased allergy symptoms
Inflammatory flare ups
Insomnia
Left side weakness, walking into walls,
Loss of appetite
Loss of smell and taste, confusion with coordinating, tinnitus, headaches, rashes, shakes in hands, tremors, light sensitivity, hair loss, brain fog, concentration problems,
Loss of smell and taste, tinnitus, digestive issues including diarrhoea, sleep issues, headaches, mental health (3)
Loss of voice
Lost all my teeth bar 2. Itchiness. Fluctuating blood pressure
Mast Cell Activation Syndrome
Mood swings and can't be bothered syndrome
Multiple new health conditions following covid – Raynaud's, High Blood Pressure, Eczema, Silent Reflux, Subclinical Hypothyroidism, Bell's Palsy and various AI markers (elevated inflammation, CRP, etc). Also, multiple new deficiencies (Vit D, Iron, B12 and Folate and others) and food intolerances.
Muscle tension and panic attacks
Neuropathic pain

Nose bleeds, pale/flushed, feeling ill, wheeze, recurrent viral illness, mood swings/violence, pins n needles, diarrhoea,
Not being able to walk, insomnia, voice dysphonia, sensory overload, headaches, severe memory loss, post exertional malaise, change of taste-smell, obesity, muscle weakness
Numerous ME/CFS symptoms (e.g. reduced exertion capacity, headaches, abdominal pain, disrupted sleep, PESE), POTS
Ongoing diarrhoea and bowel incontinence
Peripheral neuropathy, poor stamina, unpredictable low energy levels, need for a lot of sleep
Photophobie, vertigo, tinnitus
Pots, fainting, gastritis, chronic migraine, chronic fatigue (2)
Pots, heart damage
Prostatitis,
Pulsatile tinnitus.
Regular diarrhoea and sickness
Sensory overload, autism traits, extreme lethargy, neurological
Sensory symptoms
Skin condition
Sleep apnoea
Stomach pain and hair loss
Stutter. Don't always understand what is being said. Can get lost
Tinnitus (4)
Trouble walking, possible seizures, tachycardia, bradycardia, could feel temperature, felt euphoric for 14 months despite illness, strong chest pains, trouble sleeping, sudden high cholesterol, infections that won't clear up.
Urology issues, Vocal problems, social anxiety and agoraphobia
Vertigo
Vertigo and balance problems
Voice loss
Weakness, Facial Numbness, Stomach Pain, Altered proprioception
Weight gain, heart failure
Weight loss, loss of physical strength, cardiac.
Widespread pain, pins and needles, external tremors, internal tremors, PEM, imbalance, clumsiness
Worsening of CFS/Fibromyalgia symptoms after contracting COVID

N.B. The above is an extensive selection of symptoms from the 110 respondents selecting the option 'Other' in Table Four above.

5. Ethnic group of respondents

Ethnic group of respondents	No	%
White: English/Welsh/Scottish/Northern Irish/British	362	90.7
White: Irish	3	0.8
White: Gypsy or Irish Traveller	0	0
White: Any other White background	15	3.8
Mixed/Multiple Ethnic Groups: White and Black Caribbean.	0	0
Mixed/Multiple Ethnic Groups: White and Black African	2	0.5
Mixed/Multiple Ethnic Groups: White and Asian	3	0.8
Mixed/Multiple Ethnic Groups: Any other Mixed/Multiple Ethnic background	2	0.5
Asian/Asian British: Indian	2	0.5
Asian/Asian British: Pakistani	0	0
Asian/Asian British: Bangladeshi	0	0
Asian/Asian British: Chinese	2	0.5
Asian/Asian British. Any other Asian background	2	0.5
Black/African/Caribbean/Black British: African	0	0
Black/African/Caribbean/Black British: Caribbean	0	0
Black/African/Caribbean/Black British: Any other background	0	0
Other ethnic group: Arab	0	0
Prefer not to say	6	1.5
Total	399	100

6. Age group of respondents

Age group of respondents	No	%
Under 18	0	0
18 – 24	3	0.7
25 – 34	33	8.3
35 – 44	56	14.1
45 – 54	112	28.1
55 – 64	111	27.9
65 - 69	43	10.8
70 – 74	13	3.3
75 - 79	17	4.3
80 and over	6	1.5
Prefer not to say	4	1.0
Total	398	100

7. Religious belief of respondents

Religion or belief of respondents	No	%
No Religion	137	34.9
Christian	231	58.9
Buddhist	3	0.8
Hindu	1	0.3
Jewish	0	0
Muslim	0	0
Sikh	0	0
Other religion	0	0
Prefer not to say	20	5.1
Total	392	100

8. How respondents identify

How respondents identify	No	%
Male	94	23.8
Female	292	73.9
Trans-Man	0	0
Trans-Woman	1	0.3
Non-binary	2	0.5
Gender-Non-Conforming	0	0
Other	0	0
Prefer not to say	6	1.5
Total	395	100

9. Sexual orientation of respondents

Sexual orientation of respondents	No	%
Heterosexual	343	87.7
Lesbian	9	2.3
Gay	5	1.3
Bisexual	8	2.0
Asexual	3	0.8
Other	0	0
Prefer not to say	23	5.9
Total	391	100

10. Relationship status of respondents

Relationship status	No	%
Married	201	50.4
Civil partnership	5	1.3
Single	64	16.1
Lives with partner	42	10.6
Separated	11	2.8
Divorced	33	8.3
Widowed	18	4.5
Other	0	0
Prefer not to say	24	6.0
Total	398	100

11. Day to day activities limited because of health problem or disability which has lasted, or is expected to last, at least 12 months.

Day to day activities	No	%
Yes, limited a lot	261	65.9
Yes, limited a little	77	19.5
No	58	14.6
Total	396	100

12. Respondents consider themselves to have a disability (As defined by The Equality Act 2010)

Respondent considered to have a disability	No	%
Physical disability	105	27.6
Sensory disability	13	3.4
Mental health condition	34	8.9
Learning disability or difficulty	4	1.1
Long-term illness	116	30.6
Prefer not to say	18	4.7
Other	0	0
No, don't consider themselves to have disability	90	23.7
Total	380	100

13. Respondents providing care

Providing care for someone	No	%
Yes – For person aged 24 and under	42	10.6
Yes – For adults aged 25 to 49	18	4.5
Yes – For older person(s) aged 50+	43	10.8
Prefer not to say	18	4.5
No	276	69.6
Total	397	100

14. Respondent pregnant at time of questionnaire completion

Currently pregnant	No	%
Yes	2	0.5
No	386	97.2
Prefer not to say	9	2.3
Total	397	100

15. Respondent recently given birth

Recently given birth	No	%
Yes	0	0
No	388	97.7
Prefer not to say	9	2.3
	397	100

16. Respondent served in Armed Services

Served In Armed Services	No	%
Yes	11	2.8
No	383	95.7
Prefer not to say	6	1.5
Total	400	100

17. Those with long COVID by area

	I have long COVID and currently accessing NHS long COVID service	I have/had long COVID and previously accessed NHS long COVID service	I have/had long COVID but haven't received support for my condition
Cheshire East	**34**	**27**	**2**
Cheshire West	**52**	**13**	**16**
Halton	**7**	**6**	**2**
Knowsley	**4**	**4**	**1**
Liverpool	**21**	**5**	**4**
Sefton	**15**	**3**	**2**
St. Helens	**14**	**4**	**2**
Warrington	**22**	**10**	**5**
Wirral	**25**	**7**	**4**
Outside	**15**	**2**	**2**
Total	**209**	**81**	**40**

18. Those with long COVID by age

	I have long COVID and Currently Accessing NHS long COVID Service	I have/had long COVID and previously accessed NHS long COVID Service	I have/had long COVID but haven't received support for my condition
18-24	**2**	**1**	**0**
25-34	**19**	**2**	**2**
35-44	**28**	**6**	**4**
45-54	**47**	**27**	**7**
55-65	**65**	**21**	**5**
65-69	**13**	**11**	**4**
70-74	**5**	**3**	**1**
75-80	**3**	**3**	**2**
80+	**3**	**0**	**1**
Prefer not to say	**0**	**1**	**1**
	185	**75**	**27**

19. Those with long COVID by gender

	I have long COVID and currently accessing NHS long COVID service	I have/had long COVID and previously accessed NHS long COVID service	I have/had long COVID but haven't received support for my condition
Male	**37**	**22**	**4**
Female	**129**	**44**	**23**
Trans-woman	**1**	**-**	**-**
Non-binary	**1**	**-**	**-**
Prefer not to say	**1**	**-**	**-**
Total	**169**	**66**	**27**

20. Those with long COVID by relationship status

	I have long COVID and currently accessing NHS long COVID service	I have/had long COVID and previously accessed NHS long COVID service	I have/had long COVID but haven't received support for my condition
Married	**93**	**33**	**8**
Civil partnership	**1**	**2**	**1**
Single	**21**	**12**	**4**
Lives with partner	**16**	**10**	**6**
Separated	**5**	**2**	**3**
Divorced	**17**	**4**	**3**
Widower	**6**	**3**	**1**
Prefer not to say	**9**	**1**	**1**
Total	**168**	**67**	**27**

21. Those with long COVID by disability

	I have long COVID and currently accessing NHS long COVID service	I have/had long COVID and previously accessed NHS long COVID service	I have/had long COVID but haven't received support for my condition
Physical disability	**65**	**20**	**6**
Sensory disability	**4**	**4**	**1**
Mental health condition	**20**	**6**	**3**
Learning disability or difficulty	**2**	**2**	**-**
Long-term illness	**72**	**17**	**7**
Prefer not to say	**6**	**2**	**2**

N.B. Some respondents had more than one disability.

22. The survey

The survey was hosted online by Survey Monkey.

Survey questions:

Long COVID Services in Cheshire and Merseyside

Introduction and Privacy Statement

This questionnaire is for you to share your views on NHS long COVID support services in Cheshire and Merseyside. You can find background information about this on the NHS Cheshire and Merseyside website.

The questionnaire will close on Sunday 16th March 2025.

This questionnaire is for individual responses. If you would like to share views on behalf of a charity, support group or similar organisation, please email engagement@cheshireandmerseyside.nhs.uk

How will my information be used?

NHS Cheshire and Merseyside is coordinating responses for this engagement. Your responses to these questions are anonymous - we don't link this information with any that identifies you.

Your data will be treated confidentially and stored in accordance with Data Protection law and NHS Cheshire and Merseyside Privacy Notice. You can read NHS Cheshire and Merseyside Privacy Notice at Privacy Notice - NHS Cheshire and Merseyside

Questions marked with a * require an answer before you can move on.
Thank you.

1. Where do you live?

- ○ Cheshire East
- ○ Cheshire West
- ○ Halton
- ○ Knowsley
- ○ Liverpool
- ○ Sefton
- ○ St Helens
- ○ Warrington
- ○ Wirral
- ○ Outside of Cheshire and Merseyside (please specify)

*** 2.** Please tell us about your interest in this questionnaire (please tick as many as apply):

- ○ I have long COVID and I am currently accessing an NHS long COVID service
- ○ I have/had long COVID and have previously accessed an NHS long COVID service
- ○ I have/had long COVID but haven't received support for my condition
- ○ I am a carer of someone with long COVID
- ○ I am a health professional working in another service and would like to share my views in an individual
- ○ capacity
- ○ I am a member of Staff working in a long COVID Service
- ○ None of the above apply to me but I would like to share my views
- ○ Other (please specify)

My experience:

3. What symptom, or symptoms, prompted you, or the person you care for, to seek support for long COVID? Tick all that apply.

- ○ shortness of breath
- ○ fatigue
- ○ problems with your memory and concentration ("brain fog")
- ○ heart palpitations and dizziness
- ○ joint pain and muscle aches
- ○ depression, anxiety and mental health
- ○ Other (please specify)

4. What level of support do you feel you, or the person you care for, needs/needed for the following symptoms:

	Highest level of support	Requires some support	Lower level of support	Lowest level of support	I have no experience of this symptom
shortness of breath	○	○	○	○	○
fatigue	○	○	○	○	○
problems with your memory and concentration ("brain fog")	○	○	○	○	○
heart palpitations and dizziness	○	○	○	○	○
joint pain and muscle aches	○	○	○	○	○
depression, anxiety and mental health	○	○	○	○	○
Other, as stated in previous question	○	○	○	○	○

5. To help you manage your long COVID, have you received support from any of these other services?

- ○ Your GP practice
- ○ Talking Therapies (psychological treatments for mental and emotional problems)
- ○ Pain Management
- ○ Respiratory/Pulmonary Rehabilitation
- ○ Community Therapies (OT/Physio)
- ○ Chronic Fatigue/ME (regional service which is operated by Liverpool University Hospitals Foundation
- ○ Trust)
- ○ Medical Specialties relevant to your individual clinical symptoms including Cardiology, Rheumatology,
- ○ Gastroenterology, Neurology
- ○ Local wellbeing and support organisations e.g. wellbeing hubs, disability support
- ○ Local social prescribing services e.g. in your GP practice
- ○ Online resources
- ○ I haven't received any additional support
- ○ Other (please specify)

6. How do/did you find it most helpful to access long Covid support?

	Very helpful	Somewhat helpful	Somewhat unhelpful	Not very helpful	I have no experience of this kind of support
Face-to-face appointments	○	○	○	○	○
Online appointments (video)	○	○	○	○	○
Telephone appointments	○	○	○	○	○
Group-based treatment sessions	○	○	○	○	○
Peer-led support groups	○	○	○	○	○

7. Please use this space to provide any additional comments. For example, you could share details of how changes to NHS long COVID services might impact you/people you care for, or what wider support you feel is needed for people with long COVID.

Comments

8. Please use this space to share your views about how NHS long COVID support should look in the future. This could include how changes to NHS long COVID services might impact you or people you care for.

Equality monitoring questions

All the information that you give will be recorded and reported anonymously. NHS Cheshire and Merseyside collect this as part of its duty under the Equality Act 2010.

Your data will be treated confidentially and stored in accordance with Data Protection law and NHS Cheshire and Merseyside Privacy Notice.
You do not have to answer these questions if you do not want to.
Thank you.

*** 9.** Are you happy to complete this section to help us better understand who we are reaching? *

- ○ Yes
- ○ No

Equality monitoring questions

10. What is your ethnic group? Choose one option that best describes your ethnic group or background.

- ○ White: English/Welsh/Scottish/Northern Irish/British
- ○ White: Irish
- ○ White: Gypsy or Irish Traveller
- ○ White: Any other White background (please specify below)
- ○ Mixed/Multiple ethnic groups: White and Black Caribbean
- ○ Mixed/Multiple ethnic groups: White and Black African
- ○ Mixed/Multiple ethnic groups: White and Asian
- ○ Mixed/Multiple ethnic groups: Any other Mixed/Multiple ethnic background (please specify below)
- ○ Asian/Asian British: Indian
- ○ Asian/Asian British: Pakistani
- ○ Asian/Asian British: Bangladeshi
- ○ Asian/Asian British: Chinese
- ○ Asian/Asian British: Any other Asian background (please specify below)
- ○ Black/African/Caribbean/Black British: African
- ○ Black/African/Caribbean/Black British: Caribbean
- ○ Black/African/Caribbean/Black British: Any other Black/African/Caribbean background (please specify
- ○ below)
- ○ Other ethnic group: Arab
- ○ Prefer not to say
- ○ Any other ethnic group (please specify below)

11. How old are you?

- ○ Under 18
- ○ 18-24
- ○ 25-34
- ○ 35-44
- ○ 45-54
- ○ 55-64
- ○ 65-69
- ○ 70-74
- ○ 75-79
- ○ 80 and over
- ○ Prefer not to say.

12. What is your religion or belief?

- ○ No religion
- ○ Christian (including Church of England, Catholic, Protestant and all other Christian denominations)
- ○ Buddhist
- ○ Hindu
- ○ Jewish
- ○ Muslim
- ○ Sikh
- ○ Prefer not to say
- ○ Other (please specify)

13. How do you identify?

- ○ Male
- ○ Female
- ○ Trans-Man
- ○ Trans-Woman
- ○ Non-binary
- ○ Gender-non-conforming
- ○ Other (please specify)

14. What is your sexual orientation?

- ○ Heterosexual
- ○ Lesbian
- ○ Gay
- ○ Bisexual
- ○ Asexual
- ○ Prefer not to say
- ○ Other (please specify)

15. What is your relationship status?

- ○ Married
- ○ Civil Partnership
- ○ Single
- ○ Lives with Partner
- ○ Separated
- ○ Divorced
- ○ Widowed
- ○ Prefer not to say

16. The Equality Act 2010 protects people who are pregnant or have given birth within a 26-week period. Are you pregnant at this time?

- ○ Yes
- ○ No
- ○ Prefer not to say

17. Have you recently given birth? (Within the last 26-week period)

- ○ Yes
- ○ No
- ○ Prefer not to say

18. Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?

- ○ Yes, limited a lot
- ○ Yes, limited a little
- ○ No

19. Do you consider yourself to have a disability? (The Equality Act 2010 states a person has a disability if they have a physical or mental impairment which has a long-term (12month period or longer) or substantial adverse effects on their ability to carry out day-today activities).

- ○ Physical disability (please describe)
- ○ Sensory disability e.g., Deaf, hard of hearing, Blind, visually impaired (please describe below)
- ○ Mental health condition
- ○ Learning disability or difficulty
- ○ Long-term illness e.g., cancer, diabetes, COPD (please describe below)
- ○ Prefer not to say
- ○ No, I do not consider myself to have a disability
- ○ Other (please specify)

20. Do you provide care for someone? A carer is defined as anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support (Tick as many as appropriate)

- ○ Yes - Care for young person(s) aged 24 and under
- ○ Yes - Care for adult(s) aged 25 to 49
- ○ Yes - Care for older person(s) aged 50 and over
- ○ No
- ○ Prefer not to say

21. Have you ever served in the armed services?

- ○ Yes
- ○ No
- ○ Prefer not to say

Thank you - before you go.

22. Where did you hear about this questionnaire?

- ○ From my GP practice
- ○ From a local pharmacy
- ○ I was sent a letter by an NHS long COVID Service
- ○ Social media (Facebook etc.)
- ○ NHS website (for example, NHS Cheshire and Merseyside or hospital trust website)
- ○ Through a patient group and/or voluntary sector organisation I am connected to
- ○ NHS staff communication
- ○ Friend or family member
- ○ Other (please specify)

NHS
Cheshire and Merseyside

Equality Analysis Report

Pre-Consultation *(Use the same form but delete as applicable. If it is post-consultation it needs to include consultation feedback and results)*

Aggregated Long Covid Services Cheshire and Merseyside EIA

Start Date:	November 2024 (document refreshed following Executive Team decision on 19th December)	
Equality and Inclusion Service Signature and Date:	TCB	
Sign off should be in line with the relevant ICB's Operational Scheme of Delegation (*amend below as appropriate)		
***Place/ ICB Officer Signature and Date:**	Kath McEvoy	Updated
***Finish Date:**	Reviewed January 2024 and updated to reflect ICB decision at Executive Team on 19th December	
***Senior Manager Sign Off Signature and Date**	Neil Evans – Programme Lead 28th Jan 25	Sian Stokes – Clinical Lead 28th Jan 25
***Committee Date:**	Executive Committee December 19th 2024	

This document has been developed to incorporate feedback from Place based commissioners in dialogue with long covid hub providers.

1. Details of service / function:
Guidance Notes: Clearly identify the function & give details of relevant service provision and or commissioning milestones (review, specification change, consultation, procurement) and timescales.
This EIA has been produced in advance of the future commissioning review taking place to determine the 2025-26 onward commissioning arrangements for people with long covid, this document will be both considered as part of this review and the impact assessment updated to reflect the recommended options proposed by this review before final decisions are taken on future commissioning arrangements. At present the content of this document therefore is focused on the decision that the current local long Covid hubs will not be commissioned from 2025-26 and alternative provision will be used to support this population." **Background** There are six Long Covid commissioned local hubs across Cheshire and Merseyside with six different service providers. Current providers are:

Merseycare, CWP, East Cheshire Trust, CCICP, Wirral Community Health and Care, W&HH

At a clinic, patients may be seen by different members of the team depending on symptoms.

Members of the team may include:

- Care Coordinator
- Specialist GP
- Community Matron
- Occupational Therapist
- Physiotherapist
- Health Care Assistants
- Rehabilitation Assistants
- Social Prescribers
- Integrated Care Liaison Officer
- Administrators

The aim of the clinic is to identify what symptoms patients are experiencing and how this affects them on a day-to-day basis. The appropriate resources and treatments will be offered so patients can live the kind of life which matters to them and to offer both treatment and signposting to other services. There is a core service specification for all the Long Covid services across the region.

In addition, Liverpool University Hospitals FT provide a centralised chronic fatigue hub.

NHSE indicated through Northwest regional colleagues in late 2024 that it is highly unlikely that identified, ring fenced SDF monies for Long Covid specific services will continue into 25/26. Formal planning guidance released in January 2025 with confirmation was published and confirmed that all SDF monies are now in the ICB baseline and not ringfenced.

During 2024 there have been several meetings with providers and stakeholders from Cheshire and Merseyside where the status, capacity and outcomes for patients accessing the six separate Long Covid services have been discussed.

Providers of the Cheshire and Merseyside current services and the Place leads for Long Covid have held regular Long Covid Steering group meetings this year where the current impact, performance, referral and capacity of the existing commissioned services have been explored.

Reduction in referrals into Services in 2024

The BI team in the ICB manage a dashboard of performance data for the current services which is reported regularly to the regional and national teams. This data shows the number of referrals into the service and other KPI metrics such as numbers on caseload and time taken from referral to assessment.

The table below is a snapshot of referrals into services over the course of 12 months which shows overall that referral numbers into the services have reduced significantly. This is most likely due to the fact that there has been no formal requirement for people to test for COVID 19 for almost two years and as such it is much more difficult to evidence that persistent symptoms are a result of Long Covid and not any other Chronic Viral illness. It is predicted that during 2024 the full 12 months referrals across all services, based on the lowering demand, will be approximately 1000. At the end of December 2024 referral numbers into the services were 860 (before rejections)

	CM ICS	
	No.	Trend
Sep-23	135	
Oct-23	136	
Nov-23	117	
Dec-23	117	
Jan-24	133	
Feb-24	146	
Mar-24	110	
Apr-24	142	
May-24	125	
Jun-24	75	
Jul-24	73	
Aug-24	54	

Some further information regarding referrals into the current services are:

- In August 2022 there were 252 referrals into Adult services, in August 2023 there were 148 and 54 in August 2024.
- Some services are currently taking referrals from outside their local area and for other post viral symptoms/conditions as they have capacity as referral numbers have been low.
- Reducing number of referrals in 2024 is replicated across the NW- overall region saw **43.8%** lower referrals at the end of the reporting period (August 24)
- For adults the budget for Long Covid Services has remained stable (slightly increased) since 22/23 but numbers of referrals have reduced significantly.

This has meant that for the first 5 months of 24/25 the average cost per referral (before rejections into the service) is £2767.14.

EIA/QIA Process

In November 2024 all Place leads were asked to complete a draft EIA and QIA for their specific place based service outlining the key risks and impact if the Long Covid services were de-commissioned or significantly reduced. The points below are some of the issues raised as part of this exercise:

- Referral numbers in 24/25 have decreased significantly. COVID testing is no longer required so service providers cannot be sure that they are meeting specific needs arising from Long Covid or treating people with similar post viral presentations.
- Some services are currently taking referrals from outside their local area and for other post viral symptoms/conditions as they have capacity as referral numbers have been low.
- Potential redundancies for LC service specific posts have been identified and providers will need to validate this risk internally.
- The current caseloads will need to be clinically reviewed, and a decision taken whether to safely discharge or refer to alternative core services.
- Outcomes for patients attending services have not been consistently evidenced or monitored across the different services.
- Reduction in provision is likely to increase demand in Primary Care and secondary care services such as A and E or other post viral services.

Current Service Information -Activity and Performance

There is still a national specification in operation for all Long Covid services but the reality in 2024 is that current services in Cheshire and Merseyside have evolved locally in isolation to each other with variation in models. There is a lack of clarity across our region about what the shared expectations, objectives and outcomes for patients entering and exiting the services should be and each service is delivering variability in the clinical and social model offered.

Some of the smaller local hubs are also operating very small services with limited staffing numbers and referrals and are therefore very fragile operationally; one person leaving/being ill could potentially destabilise the whole service offer across a 12-month period.

The lack of economies of scale across the region plus reducing numbers of referrals and rejection rates in all services is also creating a significant increase in the “cost per case” in 2024. This makes it difficult to build an ongoing viable

business case for the continuation of these services when the ICB is managing significant financial challenges.

It has also been noted that these services tend to hold a high number of patients on their case load for up to a year or more. There is also a percentage of patients going back into the service using PIFU (Patient Initiated Follow Up)

The six services have not consistently maximised the use of digital and online communication and contacts are mostly face to face, this has also meant that there are a high number of physical clinical spaces being used across the region over the working week which adds to the overall service costs and restricts the number of patients who can be seen in an average working day.

Patient peer support groups and networks are also not being used in a consistent manner across all the services and the current models of care focus heavily on a medicalised model for patients which involves numerous clinical staff support. There are a range of clinical roles within these services consisting of a mix of:

- Specialist GP sessional support
- Matron/ANP/ Respiratory Nurses
- Physiotherapists
- Occupational Therapists
- Health Care Assistants

Referrals to the Long COVID hub services have decreased significantly. In 2022/23 there were 2910 referrals and in 2024/25 between April and December there have been 860 referrals.

Currently funded arrangements for the local hub model are not sustainable in the absence of ongoing national funding to support the service and as referral levels continue to stay on the current trajectory the ongoing viability of services as currently established is not possible. The Executive Team Meeting (December 19th, 2024) decided that the ongoing operation of local hubs by 6 providers isn't seen as viable and referrals should cease.

The ICB Executive Team agreed to undertake a commissioning process to determine what ongoing support arrangements are required in the medium to longer term by reviewing the needs and presenting symptoms of patients Long COVID and other similar conditions to assess if there is a commissioning gap or if existing commissioned services can support the needs of this population within a more affordable financial envelope and balanced and aligned with other comparable services.

2. Change to service.

It is intended that the clinical needs and other requirements of patients accessing Long COVID and other similar services, such as chronic fatigue/ CFS and other post viral services will be reviewed by their current provider. NHS Cheshire and Merseyside will undertake a commissioning review to identify and agree the best way of supporting people with Long Covid symptoms to ensure they continue to receive the appropriate care and support in the future.

In the interim period whilst a review is carried out patients will be either discharged from their current service (if clinically safe to do so) or referred or signposted to a suitable alternative service. Examples can be seen on some existing provider websites of useful information which will be developed further to include additional NHS resources relevant to the local population.

Currently Place Leads are working with providers to support them with the development of plans and to understand in more detail the impact on patients and the current staffing of these services.

LongCovidUsefullinksandinformation.pdf

Support and resources - Wirral Community Health and Care NHS Foundation Trust

Long COVID service: Mersey Care NHS Foundation Trust

Generic Services include:

- IAPT (Talking Therapies)
- Pain Management
- Respiratory/Pulmonary Rehab
- Community Therapies (OT/Physio)
- Chronic Fatigue/ME (regional service at present run by LUHFT at Broad Green),
- Secondary Care Medical Specialties include Cardiology, Rheumatology, Gastroenterology, Neurology
- Local wellbeing and support organisations e.g. wellbeing hubs, disability partnerships
- Local social prescribing services (noting availability will vary by Place)
- National charity and support offers (see links above)

3. Barriers relevant to the protected characteristics

Long COVID and other viral illnesses can have a wide spectrum of effects on multiple body systems and variable presentation in different individuals.

It is also of paramount importance that during this transition and service change patients do not ‘slip through the net’ and that all patients (including/especially

vulnerable) patients are offered choice and support to secure alternative GP or secondary care provision if appropriate. Patients at greater risk of slipping through the net have been identified in APPENDIX A.

Officers leading any transition need to ensure that this list is used to identify people who may need support with the transition or require adaptations to the information and communications.

Guidance note: describe where there are potential disadvantages.

Each of the above scenarios are not envisaged to impact disproportionately on patients with protected characteristics.

Protected Characteristic	Issue	Remedy/Mitigation
Age	Children and young people will need to be informed of the proposed changes. Working age- long Covid could impact a person's ability to maintain work or college Older citizens- Long COVID is of particular concern among older people (i.e., aged 65 years or older), who are at greater risk than younger people of persisting symptoms associated with COVID-19 In addition, COVID-19 might trigger or exacerbate chronic conditions that occur commonly in older people, such as cardiovascular diseases, respiratory diseases, neurodegenerative conditions, and functional decline.	Work with carers, parents for younger people and children. Ensure appropriate referrals to other clinically appropriate core services. Understand potential prevalence of age ranges across current cohort, to support clinical review. Ensuring g older citizens are supported to access a range of services
Disability (you may need to discern types)	Long COVID-19 depending on individual could equate to a disability There may be an impact on people with a disability because of increased distance to travel to alternative services.	A digital or virtual consultation offer could be made in future service design, or patients could be seen at home. Signposting to relevant local disability support organisations or other agencies e.g.

	Information and communication needs are not met. (reasonable adjustments and AIS NHS England » Accessible Information Standard) Home visits (people with physical of mobility Acrophobia / house bound It is recognised that removing a service can be a disheartening process for the people use the service.	Dept Work and Pensions Review current patients lists and identify patients who have additional communication and information needs See Appendix A A digital offer or virtual consultation could be made, or the patient could be seen at home Ensure review and consultation is thorough robust and sensitive to peoples needs.,
Gender reassignment	No specific impact anticipated	N/A
Marriage and Civil Partnership	No specific impact anticipated	N/A
Pregnancy and maternity	this may impact on women who are pregnant because of increased distance to travel.	A digital offer or virtual consultation could be made, or the patient could be seen at home.
Race	There are currently gaps in the ethnicity data for patients. Covid-19 had a disproportionate impact from people from global majority. People whose first language is not English may need support to understand the proposed change.	Ensure patients are not lost in the system and review findings to support new approach Discuss any gaps in provision and possible mitigations
Religion and belief	No specific impact anticipated	N/A
Sex	No specific impact anticipated	N/A

Sexual orientation	No specific impact anticipated	N/A
Whilst currently out of scope of Equality legislation it is also important to consider issues relating to socioeconomic status to ensure that any change proposal does not widen health inequalities. Socioeconomic status includes factors such as social exclusion and deprivation, including those associated with geographical distinctions (e.g. the North/South divide, urban versus rural). *Examples of groups to consider include: refugees and asylum seekers, migrant, unaccompanied child asylum seekers, looked-after children/ care leavers, homeless people, prisoners and young offenders, veterans, people who live in deprived areas, People living in remote, and rural locations.* *Health inclusion groups* *https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/what-are-healthcare-inequalities/inclusion-health-groups/* *For a more in-depth assessment of health inequalities please use the HEAT toolkit* https://www.gov.uk/government/publications/health-equity-assessment-tool-heat		
Refugees and asylum seekers	Being unable to speak English as a first language, may have an impact on specific offers, such as digital provision.	all offers for refugees and asylum seekers, would have to be language appropriate.
Looked after children and care leavers	No specific impact anticipated	N/A
Homelessness	Being homeless, may have an impact on specific offers, such as digital provision.	all offers for homeless people would have to access digital applicability.
Worklessness	Long Covid could lead to an inability to fulfil work duties	Signposting to relevant alternative organisations e.g. ACAS, Local Authority Skills and Employment, GOV.UK
People who live in deprived areas	It is accepted that Long Covid can impact on people in deprived populations more, especially on those with other co morbidities and social deprivation	Ensure appropriate signposting is developed
Carers	No specific impact anticipated	N/A
Young carers	No specific impact anticipated	N/A
People living in remote, rural and island locations	No specific impact anticipated	N/A
People with poor literacy or health Literacy	Having poor literacy or health literacy, may have an impact on specific offers, such as digital provision.	The patient could be seen at home. Alternative Services expected to support health literacy in how they communicate.

People involved in the criminal justice system: offenders in prison/on probation, ex-offenders.	No specific impact anticipated	N/A
Sex workers	No specific impact anticipated	N/A
People or families on a low income	Limited impact on potential increased cost of travel to another location in C&M	Potential offer of digital support or virtual consultation support for these patients. Signposting to relevant agencies e.g. citizens advice
People with addictions and/or substance misuse issues	No specific impact anticipated	N/A
SEND / LD	No specific impact anticipated	N/A
Digital exclusion	Limited impact on patients who may benefit from digital support who do not have access to digital support.	Potential offer of face-to-face support for these patients in alternative or future services

4. What data sources have you used and considered in developing the assessment?
The monthly Long Covid data completed by providers has been analysed and shows a downward trajectory in referrals of @ 60%. National referral data mirrors this finding
5. Involvement: consultation/ engagement
Guidance note: How have the groups and individuals been consulted with? What level of engagement took place? (If you have a consultation plan insert link or cut/paste highlights)
A steering group containing service leads, clinical leads and members of support groups has met frequently during the creation of the long covid services including the local hubs and feedback fed into planning for the future. It is recognised that as the providers of these services most will reflect a preference for the status quo. In deciding to cease referrals into the current local hubs the ICB Executive have asked for a full commissioning review of the current services. The Executive Team have made a commitment to assess our future commissioning plans. The services are currently in the process of developing wind down plans and engaging with patients and staff. Comms have been developed for Primary Care, Politicians and wider stakeholders and information for the public has been added to the ICB website. A further comms and engagement plan will be developed as part of the de commissioning process. The ICB decommissioning policy is being followed as part of this process.

It is recognised formal consultation requirements need to be followed and will take place when the future planning of commissioning arrangements are known. Involvement and consultation with patients and stakeholders will also need to incorporate recommendations from this report and from the Quality impact assessment.
6. Have you identified any key gaps in service or potential risks that need to be mitigated
Guidance note: Ensure you have action for who will monitor progress. Ensure smart action plan embeds recommendations and actions in Consultation, review, specification, inform provider, procurement activity, future consultation activity, inform other relevant organisations (NHS England, Local Authority).
. As part of the decision to close the hub-based services to new referrals, we have asked providers to review all patients on their current caseload. Those patients currently seen within the service who require ongoing care and support and those on the waiting list for assessment, will be advised of alternative suitable provision from within other 'core' services.

Risk	Required Action	By Who/ When
Patients currently seen within the service and those on the waiting list for assessment would need to be advised of alternative provision from within 'core' services. (Need to have an understanding as to the impact on these core services (such as COPD or respiratory) from impact deflection)	ICB place leads will develop a Directory of alternative services	February 7th 2024
Patients currently seen by the service have no clear pathway for onwards support	C&M ICB provide clarity on pathways into core service offers for patients currently seen within the service or on the waiting list for assessment.	Existing providers to liaise with C&M ICB and Place commissioners list of local service offers whereby patients are currently onwards referred to by end November 2024
Financial challenge by existing providers/ potential redundancy cost pressures	Providers to quantify the specific redundancy cost relating only to substantively employed posts employed specifically to Long COVID	Mersey Care Trust and other providers to provide full transparency on staffing by end January 2025 and to consider posts that can be

	services (not those in place prior to service establishment). Provider to consider redeployment to avoid redundancy costs.	redeployed to avoid potential redundancy costs)
Potential impact of extending the contract due to contractual obligations	To clarify duration of contract	By Place commissioners/contracts team by end of January 2025

7. Is there evidence that the Public Sector Equality Duties will be met (give details) Section 149: Public Sector Equality Duty (review all objectives and relevant sub sections)
PSED Objective 1: Eliminate discrimination, victimisation, harassment and any unlawful conduct that is prohibited under this act: (check specifically sections 19, 20 and 29)
The decommissioning of this service will be carried out ensuring equity of access for all patients across the ICB. Alternative services to meet clinical requirements, when necessary, will be offered to those patients with ongoing care and support needs into core services. In addition, a thorough review of patients will take place to understand clinical needs of patients and their needs (based also on their characteristics and socio-economic status). To support consultation, section 3 above has highlighted a range of people accessing services who may need further and additional support, for example older citizens, disabled people and people from specific ethnic groups who first language is not English.
PSED Objective 2: Advance Equality of opportunity. (check Objective 2 subsection 3 below and consider section 4)
The service decommissioning and review of alternative provision will be equitable and accessible across the ICB A review will take place to ensure patients are supported and referred as appropriate.
PSED Objective 2: Section 3. sub-section a) remove or minimise disadvantages suffered by people who share a relevant protected characteristic that are connected to that characteristic.
The service decommissioning and review of alternative provision will be equitable and accessible across the ICB Alternative services to meet clinical requirements will be offered to those patients with ongoing care and support needs into core services. In addition, a thorough review of patients will take place to understand clinical needs of patients, their needs (based also on their characteristics and socio-economic status). To support consultation, section 3 above has highlighted a range of people who may need further and additional support, for example older citizens, disabled people and people from specific ethnic groups who first language is not English.
PSED Objective 2: Section 3. sub-section b) take steps to meet the needs of people who share a relevant protected characteristic that are different from the needs of people who do not share it
The service decommissioning and review of alternative provision will be equitable and accessible across the ICB

Alternative services to meet clinical requirements will be offered to those patients with ongoing care and support needs into core services. In addition, a thorough review of patients will take place to understand clinical needs of patients, their needs (based also on their characteristics and socio-economic status). To support consultation, section 3 above has highlighted a range of people who may need further and additional support, for example older citizens, disabled people and people from specific ethnic groups who first language is not English.
PSED Objective 2: Section 3. sub-section c) encourage people who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such people is disproportionately low.
The service decommissioning and review of alternative provision will be equitable and accessible across the ICB, and any consultation or engagement will encourage involvement from protected groups. Alternative services to meet clinical requirements, if required, will be offered to those patients with ongoing care and support needs into core services. In addition, a thorough review of patients will take place to understand clinical needs of patients, their needs (based also on their characteristics and socio-economic status). To support consultation, section 3 above has highlighted a range of people who may need further and additional support, for example older citizens, disabled people and people from specific ethnic groups who first language is not English.
PSED Objective 3: Foster good relations between persons who share a relevant protected characteristic and persons who do not share it. (Consider whether this is engaged. If engaged, consider how the project tackles prejudice and promotes understanding -between the protected characteristics)
Not relevant
Health Inequalities: Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (s.14T);
The service decommissioning and review of alternative provision will be equitable and accessible across the ICB Alternative services to meet clinical requirements will be offered to those patients with ongoing care and support needs into core services. In addition, a thorough review of patients will take place to understand clinical needs of patients, their needs (based also on their characteristics and socio-economic status). To support consultation, section 3 above has highlighted a range of people who may need further and additional support, for example people who experience poverty, worklessness etc.
PSED Section 2: Consider and make recommendation regards implementing PSED into the commissioning process and service specification to any potential bidder/service provider (private/ public/charity sector)
All commissioned services are subject to contractual PSED requirements.
8. Recommendation to Board
Guidance Note: will PSED be met?
Yes, PSED is met provided that the recommendations are approved and form a part of the exit plan, transition and review.

9. Actions that need to be taken
Analysis post consultation • Inform people of the cessation of the service, providing the reasons behind the decision. • Inform people is accessible and inclusive methods so patients understand next steps. • Undertake a thorough review of clinical need and ensure patients are moved to appropriate services when necessary • Ensure the review considers people relevant socio – economic status and impacts and their protected characteristics including Age, Disability and race. **10.** Ensure any new approach is fit for purpose.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

Cheshire and Merseyside Sub Fertility Clinical Policy Status and Options for consideration

29 May 2025

Agenda Item No: ICB/05/25/15

Responsible Directors: Prof. Rowan Pritchard Jones, Medical Director

Dr Fiona Lemmens, Deputy Medical Director

Cheshire and Merseyside Sub Fertility Clinical Policy Status and Options for consideration

1. Purpose of the Report

1.1 This document provides background information and considerations for Board members on the proposal to harmonise access to Sub-fertility services across Cheshire and Merseyside.

1.2 This paper provides an update on the work undertaken to date, the current position and options for consideration, taking into account the clinical view, use of resources, the latest evidence base including NICE guidance and the policy positions of neighbouring and national Integrated Care Boards (ICBs).

1.3 In addition, this paper requests approval by Board to commence a consultation exercise with the public and stakeholders regarding the proposed preferred option.

2. Background

2.1 On formation of the Integrated Care Board (ICB), clinical policies were inherited from the 9 predecessor CCGs which covered patients registered with a GP Practice within the geographic areas of the nine Cheshire and Merseyside local authority area places. This meant that patients had different access to services and care, based on their postcode/where they were registered with a GP Practice. The ICBs Reducing Unwarranted Variation programme set out to harmonise this approach to ensure we work to address health inequalities and provide a consistent offer across Cheshire and Merseyside.

2.2 The NHS faces significant financial challenges, necessitating careful balancing of population needs, clinical risk and commissioning decisions to address health inequalities. This paper is written in the context of ensuring commissioning decisions prioritise the most pressing needs of the population, recognising the potential for increased demand in areas like mental health, urgent care and community services, whilst addressing unwarranted variation and the need for a consistent offer.

3. Sub Fertility Current Policy Position:

3.1 At present each Local Authority within NHS Cheshire and Merseyside (C&M) ICB has a separate unharmonised fertility policy and therefore unwarranted variation in access to these services exists.

3.2 The main area of variation within the policies is the number of In vitro fertilisation (IVF) cycles offered which ranges from 1 to 3 cycles. This document

focuses on the options to harmonise IVF cycles. As part of the review a full options appraisal has been undertaken, which can be found within **Appendix 1**.

3.3 It is of note that other aspects within the policy are proposed to be harmonised in accordance with the latest available NICE guidance and local clinical and operational knowledge. Further details of this can be found within **Appendix 1.1**. The scope of this policy is for patients with health-related fertility issues, who are struggling to have a live birth and require fertility treatments. This policy has been reviewed in line with the latest evidence base and NICE guideline CG156; it is important to note that this will be an interim policy until the new NICE guidance is published when a broader review of subfertility and assisted conception will be undertaken.

3.4 NICE recommends offering patients with infertility 3 cycles of IVF. The cost of this would equate to a total spend for the ICB of £5.78m. (The current spend is £5.043m so there would be an additional annual spend of circa £734k).

3.5 Due to the financial constraints of the ICB and the need to prioritise commissioning decisions and funding against the most critical needs, it is important that all options are considered which may not always result in adherence to guidance including NICE recommendations.

4. National Policy Position:

4.1 The table below shows the number of ICBs offering 1, 2 or 3 cycles excluding Cheshire and Merseyside:

CYCLES	No. ICBs	%
1	27	66%
2	7	17%
3	3	7%
Currently unharmonised position under review	4	10%

4.2 It is important to note that the majority of neighbouring ICBs offer 1 IVF cycle, with the only exception being Greater Manchester. Following a similar review undertaken, colleagues in Greater Manchester are working up a proposal and plan for Public Consultation following discussion planned at their Board meeting in May.

- Lancashire and South Cumbria offer 1 IVF cycle.
- Greater Manchester is currently under review - varies from 1 to 3.
- West Yorkshire offer 1 IVF cycle.
- Staffordshire and Stoke-on-Trent offer 1 IVF cycle.

5. Current Cheshire and Merseyside Position

5.1 There are currently 10 subfertility policies across C&M. Depending on where the patient lives, will determine the number of IVF cycles that they are eligible for. Below is the current offer:

Local Authority / Legacy CCG area	Offer
Liverpool	2 cycles (additional cycle available via an IFR)
St Helens	2 cycles
Warrington	3 cycles
Southport & Formby	3 cycles
South Sefton	3 cycles
Halton	3 cycles
Knowsley	3 cycles
Wirral	2 cycles
Cheshire East	1 cycle
Cheshire West	2 cycles (Unless IUI has been undertaken, then 1 cycle)*

*This document discusses IVF cycles; it does not include IUI cycles as activity is minimal.

5.2 Within Cheshire and Merseyside, we only have one provider for IVF, The Hewitt Fertility Centre at Liverpool Women's Hospital. Previously and until September 2023, Care Fertility provided fertility treatment for some of our Cheshire based patients at the Countess of Chester Hospital. Historic activity data from both sites has been used to model the proposal.

6. Clinical effectiveness of IVF cycles

6.1 NICE Health Economics analysis describes the effectiveness of each cycle with regard to cumulative live birth rate and shows that whilst the chances of having a live birth increase with each cycle, the effectiveness and cost effectiveness of each cycle is reduced.

6.2 For example in the case of an average 34-year-old, the 1st cycle is c 30% effective, the 2nd cycle is c 15% and the 3rd cycle is less than 10% effective.

7. Activity data and options modelling

7.1 To determine the average number of cycles and frozen embryo transfers (FET) each patient receives, historical data from Care Fertility and LWH has been used. This data along with outcome information and Tariff detail (as described in the table below) has been used to model the options with validation undertaken by LWH operational and finance teams.

7.2 An IVF cycle is deemed complete when all quality embryos have been transferred. The IVF cycle tariff allows for one fresh and one frozen embryo

transfer, with any remaining required FET being charged at the subsequent FET tariff.

	IVF cycles	Subsequent FETs
Number (average)	1.36	1.88 (All frozen transfers)
Tariff	£4,862.34	£1,210.80

7.3 Based on the 2024/25 actuals and forecast, data has been extrapolated from those Cheshire and Merseyside areas already providing 3 cycles to enable options to be modelled across all Cheshire and Merseyside area based on %s of activity for each cycle:

- Percentage of patients receiving 1 cycle: 64%
- Percentage of patients receiving 2 cycles: 23%
- Percentage of patients receiving 3 cycles: 13%

8. Options for consideration

Option	Description	Outcome	EIA feedback	QIA feedback	Financial impact
1	Do nothing. • ***Discounted option***	This is not a viable option as this would leave the ICB and its patients with an unharmonised position and therefore unwarranted variation in access to fertility services.	Not completed	Not completed	**£5,043,081 per year**
2	NHS C&M offers patients 1 round of IVF treatment. • ***Executive Committee preferred option***	This option would disadvantage a cohort of patients who require additional cycles to have a live birth, as the average number of cycles that our patients have is 1.36. Clinically this is not supported due to the benefits in being able to take the learnings from an unsuccessful first cycle to improve chances of success in a second cycle. Whilst this option will reduce the cost of this service to the ICB, it is not supportive of NICE recommendation and would attract negative publicity.	The number of cycles does not affect protected characteristics. This option will affect those patients and families who are on a low income, if the patient does not have a successful live birth following a single round of IVF, they would have to self-fund to try again. This may mean they cannot have a biological child. Appendix E covers the full policy EIA.	There would be a negative impact for patients who are currently eligible for either 2 or 3 cycles. Without additional attempts at subsequent IVF cycles, there is a risk that patients would be detrimentally impacted and may not be able to have a biological child if they cannot afford to privately fund. Data shows the average number of IVF cycles that our patients have is 1.36. Therefore, there is a risk that if those patients are not successful in the first IVF round, they would be disadvantaged by not being able to try a different approach in the second cycle. Knowledge is gained from the first cycle such as optimum dose of stimulation and best methods used for fertilisation.	This would result in an estimated cost of **£3,728,347 per year.** Comparing this to the current position, this would result in estimated **savings of £1,315,732 per year.** (This cost includes the modelled cost of additional FETs – on average patients have an additional 1.88 FETs)

Option	Description	Outcome	EIA feedback	QIA feedback	Financial impact
		A public consultation exercise would be required in 8 Places.		These are then implemented for subsequent attempts. **Overall risk rating: 16 (High)**	
3	NHS C&M offer patients 2 rounds of IVF treatment. • ***Clinical Working Group Preferred Option***	This option is the preferred clinical option and is supported by the data that patients are having an average of 1.36 IVF cycles. Knowledge is gained from the first cycle such as optimum dose of stimulation and best methods used for fertilisation. These are then implemented for subsequent attempts. A public consultation would be required in 4 Places.	The number of cycles does not affect protected characteristics. Appendix C covers the full policy EIA.	According to the data analysis allowing 2 cycles of IVF would benefit the majority of patients, with the average number of IVF cycles being 1.36. Because the estimated number of 2nd IVF cycles for Cheshire East is equal to the existing number of 3rd cycles in Sefton, Knowsley, Warrington and Halton, the number of FETs is assumed to be the same based on this average. Once harmonised, this will mean that there is a consistent equitable offer for patients accessing subfertility treatments. **Overall risk rating: 4 (Moderate)**	This would result in an estimated cost of **£5,084,437.** Comparing this to the current position, this would result in an estimated **cost increase of £40,357 per year.** (This cost includes the modelled cost of additional FETs – on average patients have an additional 1.88 FETs)
4	NHS C&M offer patients 3 rounds of IVF treatment. • ***Unsupported option***	This option is not supported because data suggests that the average number of IVF rounds is 1.36.	The number of cycles does not affect protected characteristics.	Not completed as not supported.	This would result in an estimated cost of **£5,778,295.** Comparing this to the current position, this would result in an

Option	Description	Outcome	EIA feedback	QIA feedback	Financial impact
		Also, this option would require additional funding of over c.£734k pa and therefore does not support the ICB to meet its financial objectives.			estimated **cost increase of £734,217 per year.**

Please refer to Appendix 1 for the full options appraisal document and appendices 1.2 to 1.5 for EQIA documents.

9. Pros and cons of Options

Option 1: Do nothing (Option discounted)

Pros	Cons
• There would be no change in the ICB financial position.	• This would leave NHS C&M with an unharmonised position, patients would continue to have unequal access to IVF rounds. • There is an increased risk of challenge by Equalities and Human Rights commission re inequality in service access.

Option 2: Offer patients 1 cycle of IVF

Pros	Cons
• This offer is in line with most of our neighbouring ICBs offer. • Offering 1 cycle provides the greatest financial savings opportunity. • 66% of ICBs across the country offer 1 cycle.	Data shows that the average number of cycles patients require is 1.36. Therefore offering 1 cycle would disadvantage patients who require an additional cycle. If the first cycle is not successful, observation and learnings are used to inform the second cycle in order to increase the potential for a successful live birth. This is especially relevant as patients are becoming more complex, are older, have comorbidities which affect their fertility or are under time pressure (e.g. fertility preservation). Although it is of note that patients could choose to fund this privately. • Risk of negative publicity for the ICB in those places that currently offer 2 or 3 cycles - patients will be generally dissatisfied, and this may result in an increase of complaints, therefore more time will need to be allocated to respond to these. • Patients on low income in 8 Places could be disadvantaged as they either receive 2 or 3 cycles currently, and if they fail to have a live birth in the first cycle, they would be required to self-fund which may not be financially possible.

Pros	Cons
	• A public consultation exercise would need to be held which would impact the time taken to implement and could be costly. • Does not match current NICE guidance of three cycles. • There is a sustained decline in birth rates across Cheshire and Merseyside. The OECD identifies a replacement fertility rate of 2.1 children per woman as necessary to maintain population levels. ONS data shows that the total fertility rate in C&M has been in consistence decline since 2021, falling to 1.49 in 2022. This trend presents significant long-term risks to the region's workforce and the sustainability of health and social services. Therefore, a reduction in cycles will undermine efforts to support population health and long-term system planning. • There is a risk on the mental health impact that childlessness has on couples, research shows that this is coupled with grief, depression and emotional stress which can impact on quality of life, this can be expected to increase. • Reducing NHS IVF cycles will potentially increase cost elsewhere as more patients will turn to cheaper IVF options in other countries with less regulation and potentially increasing the rates of multiple pregnancies, leading to maternal and neonatal morbidity and placing a greater financial and clinical burden on the NHS services downstream. • Data shows that 1 cycle of treatment (with subsequent FET's) gives a 56% chance of a live birth whereas with 2 cycles couples have a cumulative 68% chance of a live birth.

Option 3: Offer patients 2 cycles of IVF

Pros	Cons
• The average number of cycles patients currently have is 1.36, therefore the proposal of 2 cycles of IVF would support these findings and would enable learning to be taken from the first cycle and a different approach to be used for the second cycle with an aim to improving success. • Offering 2 cycles would be a positive for Cheshire East patients, as currently they are eligible for 1 cycle. • This option is supported by all clinicians including the Obs & Gynae clinical network and LWH Finance and Operational teams who will deliver the service.	• Patients in the 4 Places who offer 3 cycles, particularly if on low income, may feel they are disadvantaged by a reduction in the IVF cycle offer and this may generate negative publicity for the ICB. • A public consultation exercise would need to be held which would impact the time taken to implement. • Does not match current NICE guidance of three cycles, (NICE data shows that whilst the effectiveness of each cycle with regard to cumulative live birth rate increases with each cycle the effectiveness of each cycle is reduced). Our data modelling showing the average number of cycles per patient is 1.36. • This offer is higher than the national average (66% offering 1 cycle), our neighbouring ICB Cumbria and Lancashire offer patients 1 cycle of IVF. (Greater Manchester are in the

Pros	Cons
	process of harmonising their cycles offer). This would mean there is continued variation in access to subfertility services within the Northwest region and surrounding areas.

Option 4: Offer patients 3 cycles of IVF (Option discounted)

Pros	Cons
• Often if the first cycles are not successful, learnings are taken from this, and a different approach is used for the second and third cycles with an aim to improving success. • Offering 3 cycles would be a positive for Cheshire East, Cheshire West, Liverpool, St Helens and Wirral patients, currently they are eligible for 1 or 2 cycles. • A public involvement exercise could be a light touch communication approach. • Meets current NICE guidance, NICE data shows that whilst the effectiveness of each cycle with regard to cumulative live birth rate increases with each cycle, the effectiveness of each cycle is reduced.	• This offer is higher than our neighbouring ICB, Cumbria and Lancashire who offer 1 cycle. (Greater Manchester are in the process of harmonising their cycles offer). • This offer is higher than the country average, with 66% of ICBs offering 1 cycle. • This results in estimated additional cost to the ICB of £734k pa • The average number of cycles patients currently have is 1.36, therefore this option does not support data findings.

10. Recommendations

10.1 As described within the options table presented, the Executive team have selected Option 2 as their preferred option based on the need to carefully balance the needs of the population, clinical risk, and commissioning decisions to address health inequalities in the context of the significant financial challenges. In addition, this Policy stance would be consistent with the majority of ICBs nationally (66%) and within the Northwest region.

10.2 Based on clinical effectiveness, the clinical working group selected Option 3 as the preferred option based on the average IVF cycles required for a positive outcome being 1.36.

10.3 Board members are asked to consider the options set out, the considerations raised within the Quality and Equality impact assessment to determine to determine the preferred option to progress forward to Public Consultation.

11. Next steps

11.1 The intention is to seek the preferred option of the Board in order to consult the public on the proposed change. Subject to approval of this plan, a six-week consultation would start on Tuesday 3 June and run until Tuesday 15 July.

11.2 Please see ***Appendix 2*** for the Public Consultation Plan.

11.3 Following the close of consultation, responses will be analysed and compiled into a report, and engagement will take place with Health Oversight & Scrutiny Committee.

11.4 The intention would be for a paper to return to Board for final decision-making, either at an extra ordinary board in August (if possible) or September, with the policy launch once any final decisions are made taking account of the public consultation are made.

12. Ask of the Board:

12.1 **The Board are asked to:**

- **note** the work undertaken to date.
- **consider** the options and recommendations of the Executive Committee and the Clinical Working group.
- **consider** the items raised within the Quality and Equality impact assessment, and to **determine** the preferred option to progress to Public Consultation.

- **approve** commencement of Public Consultation based upon the preferred option determined.

- **note** the risks set out in relation to the approach and timescales.

13. Appendices

ALL APPENDICES CAN BE ACCESSSED BY CLICKING HERE

Appendix 1: Options Appraisal document

Appendix 1.1: Proposed other changes within policy document

Appendix 1.2: EIA for 1 IVF Cycle option

Appendix 1.3: QIA for 1 IVF Cycle option (post panel review)

Appendix 1.4: EIA for 2 IVF Cycles option

Appendix 1.5: QIA for 2 Cycles option

Appendix 2: Public Consultation Plan

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NHS
Cheshire and Merseyside

Appendix One

Subfertility Clinical Policy

Options Appraisal for harmonisation of

In vitro fertilisation (IVF) cycles

Glossary

Term	Definition
In vitro fertilisation (IVF)	A full cycle of IVF (with or without ICSI) is defined as one episode of ovarian stimulation and the transfer of all resultant fresh and/or frozen embryo(s). If there are any remaining frozen embryos, the cycle is only deemed to have ended when all these embryos have been used up or if a pregnancy leading to a live birth occurs or the patient adopts a child (i.e. in accordance with the ICB's policy on "Childlessness").
Embryo	A fertilised egg.
Egg collection	As part of the IVF cycle, eggs are collected from the womb. The collection involves attempts to retrieve all eggs within the stimulated follicles in the ovary.
Embryo transfer	After egg collection, the embryos are transferred into the womb. The best quality embryo available is transferred.
Frozen embryo transfer (FET)	Treatment involves freezing and storing embryos, the embryo(s) is warmed and transferred into the womb.
Intra-cytoplasmic sperm injections (ICSI)	Intra-cytoplasmic sperm injection. A common treatment for sperm-related male infertility. It is performed as part of IVF and involves the sperm being injected directly into the egg.
Intrauterine insemination (IUI)	Sperm is put directly into the womb when the female is ovulating. This can also be called artificial insemination.

1. Background

On formation of the Integrated Care Board (ICB), clinical policies were inherited from across the 9 places. This meant that patients had different access to services and care, based on their postcode. The Reducing Unwarranted Variation programme set out to harmonise this approach to ensure we work to address health inequalities and provide a consistent offer across Cheshire and Merseyside.

The NHS faces significant financial challenges, necessitating careful balancing of population needs, clinical risk, and commissioning decisions to address health inequalities. This paper is written in the context of ensuring commissioning decisions prioritise the most pressing needs of the population, recognising the potential for increased demand in areas like mental health, urgent care and community services, whilst addressing unwarranted variation and the need for a consistent offer.

At present each Place within NHS Cheshire and Merseyside (C&M) ICB has a separate unharmonised fertility policy and therefore unwarranted variation in access to these services exists.

The main area of variation within the policies is the number of In vitro fertilisation (IVF) cycles offered which ranges from 1 to 3 cycles. This document focuses on the options to harmonise IVF cycles. It is of note that other aspects within the policy are proposed to be harmonised in accordance with the latest available NICE guidance and local clinical and operational knowledge.

The scope of this policy is for patients with health-related fertility issues, who are struggling to have a live birth and require fertility treatments. This policy has been reviewed in line with the latest evidence base and NICE guideline CG156; it is important to note that this will be an interim policy until the new NICE guidance is published when a broader review of subfertility and assisted conception will be undertaken.

NICE recommends offering patients with infertility 3 cycles of IVF. The cost of this would equate to a total spend for the ICB of £5.78m. (The current spend is £5.043m so there would be an additional annual spend of circa £734k).

Due to the financial constraints of the ICB and the need to prioritise commissioning decisions and funding against the most critical needs, it is important that all options are considered which may not always result in adherence to guidance including NICE recommendations.

1.1 National Policy Position:

Nationally there is variation in the number of IVF rounds offered.

The table below shows the number of ICBs offering 1, 2 or 3 cycles excluding C&M:

CYCLES	No. ICBs	%
1	27	66%
2	7	17%
3	3	7%
Currently unharmonised position under review	4	10%

Source: ICB websites (March 2025)

It is important to note that the majority of neighbouring ICBs offer 1 IVF cycle, with the only exception Greater Manchester. Following a similar review undertaken, colleagues in GM are working up a proposal and plan for Public Consultation following discussion planned at their Board meeting in May.

- Lancashire and South Cumbria offer 1 IVF cycle.
- Greater Manchester is currently under review - varies from 1 to 3.
- West Yorkshire offer 1 IVF cycle.
- Staffordshire and Stoke-on-Trent offer 1 IVF cycle.

1.2 Current C&M Position

There are currently 10 subfertility policies across C&M. Depending on where the patient lives, will determine the number of IVF cycles that they are eligible for, the number of cycles range from 1 – 3. Below is the current offer:

Place / Legacy CCG	Offer
Liverpool	2 cycles (additional cycle available via an IFR)
St Helens	2 cycles
Warrington	3 cycles
Southport & Formby	3 cycles

South Sefton	3 cycles
Halton	3 cycles
Knowsley	3 cycles
Wirral	2 cycles
Cheshire East	1 cycle
Cheshire West	2 cycles (Unless IUI has been undertaken, then 1 cycle)*

*This document discusses IVF cycles; it does not include IUI cycles as activity is minimal.

Within Cheshire and Merseyside, we only have one provider for IVF, The Hewitt Fertility Centre at Liverpool Women's Hospital. Previously and until September 2023, Care Fertility provided fertility treatment for some of our Cheshire based patients at the Countess of Chester Hospital. Historic activity data from both sites has been used to model the proposal.

1.3 Current activity levels with cost to NHS C&M

This table below shows the month 7 activity and the forecast outturn for 2024/2025 activity.

		Based on LWH's Month 7 2024/25 actual position, forecasted to year-end using agreed					
	IVF		FET		Total		
Sub ICB Location	Actvity	Spend	Activity	Spend	Activity	Spend	
Southport & Formby	48	£ 231,494	5	£ 6,227	53	£ 237,721	
South Sefton	87	£ 415,617	9	£ 10,378	96	£ 425,995	
Liverpool	322	£ 1,559,470	56	£ 68,497	378	£ 1,627,967	
Knowsley	72	£ 350,088	14	£ 16,605	86	£ 366,694	
Halton	39	£ 189,913	9	£ 10,378	48	£ 200,291	
St Helens	46	£ 225,057	8	£ 10,378	54	£ 235,435	
Warrington	51	£ 242,471	12	£ 14,530	63	£ 257,001	
Cheshire E	101	£ 492,606	27	£ 32,185	128	£ 524,792	
Cheshire W	115	£ 555,761	30	£ 36,311	145	£ 592,073	
Wirral	117	£ 566,810	7	£ 8,303	124	£ 575,113	
TOTAL	**998**	**£ 4,829,289**	**177**	**£ 213,793**	**1175**	**£ 5,043,081**	

(Please note BI data still represents former CCG allocations and therefore Cheshire data is not split out into Cheshire East and Cheshire West. In the above table this split has been modelled based on previous years' activity as provided by LWH and Care Fertility).

2. Approach

As part of the CPH programme, a subfertility working group was convened to review the current policies and support the harmonisation. This multi-disciplinary working group included Secondary care local fertility specialists, GPs, health watch colleagues, commissioners, Equality & Diversity colleague and policy development specialists. The group reviewed each of the policy positions within the current policies and made recommendations in line with evidence base to shape the proposed policy, the policy has also been reviewed by the Clinical Network and feedback has been considered. A summary of these and the changes can be found in **Appendix 1.1**.

The data used is the 2024/25-month 7 activity reported by SLAM and the remainder of the year forecast outturn. The reason for using this data set is because the month 7 position will be used as the basis for the 2025/26 forecast and activity plan for LWH. The data provided is non patient identifiable, therefore, modelling has been carried out by C&M BI Team to determine the current allocation of first, and where applicable second and third cycles with the support and validation from operational and finance staff at LWH. The data modelling is available upon request by the Board.

Based on the data modelling an options appraisal process considered a do-nothing option, 1 cycle, 2 cycle and 3 cycle options. A do-nothing option was not supported by the group, this is because this would leave C&M in an unharmonised position and unwarranted variation would remain.

A 3-cycle option was also not supported by the group, this is because our data shows that 2 cycles would support majority of patients, and harmonising to 2 cycles would enable equity of access whilst maintaining current activity levels; a 3-cycle option would increase activity levels and which would impact LWH capacity to deliver and increase the annual cost of funding this service.

An Equality Impact Assessment and Quality Impact Assessment have been completed for the recommended option of 2 cycles and a 1 cycle option. This is to consider the impact on patients with protected characteristics and patient safety and experience.

2.1 Clinical effectiveness of IVF cycles

NICE Health Economics analysis describes the effectiveness of each cycle with regard to cumulative live birth rate and shows that whilst the chances of having a live birth increase with each cycle, the effectiveness and cost effectiveness of each cycle is reduced.

For example, in the case of an average 34-year-old, the 1st cycle is c 30% effective, the 2nd cycle is c 15% and the 3rd cycle is less than 10% effective.

2.2 Activity data and options modelling

To determine the average number of cycles and frozen embryo transfers (FET) each patient receives, historical data from Care Fertility and LWH has been used. This data along with outcome information and Tariff detail (as described in the table below) has been used to model the options with validation undertaken by LWH operational and finance teams.

An IVF cycle is deemed complete when all quality embryos have been transferred. The IVF cycle tariff allows for one fresh and one frozen embryo transfer, with any remaining required FET being charged at the subsequent FET tariff.

	IVF cycles	**Subsequent FETs**
Number (average)	1.36	1.88 (All frozen transfers)
Tariff	£4,862.34	£1,210.80

Based on the 2024/25 actuals and forecast, data has been extrapolated from those Places already providing 3 cycles to enable options to be modelled across all C&M Places based on %s of activity for each cycle:

- Percentage of patients receiving 1 cycle: 64%
- Percentage of patients receiving 2 cycles: 23%
- Percentage of patients receiving 3 cycles: 13%

2.3 Modelling of IVF cycles and FETs

Baseline – current unharmonised position

Sub ICB Location	1 cycle		2 cycle		3 cycle		Total	
	IVF	FET	IVF	FET	IVF	FET	IVF	FET
Southport & Formby	31	3	11	1	6	1	48	5
South Sefton	56	6	21	2	11	1	88	9
Liverpool	236	41	86	15	0	0	322	57
Knowsley	46	9	17	3	9	2	72	14
Halton	25	6	9	2	5	1	39	9
St Helens	34	6	12	2	0	0	46	8
Warrington	33	8	12	3	6	1	51	12
Cheshire E	101	27	0	0	0	0	101	27
Cheshire W	84	22	31	8	0	0	115	30
Wirral	85	5	31	2	0	0	116	7
TOTAL	**731**	**133**	**230**	**38**	**37**	**6**	**998**	**178**

1 cycle

The table below shows the modelled activity data if NHS C&M were to offer 1 cycle of IVF.

Sub ICB Location	1 Cycle		2 cycle		3 Cycle		Total	
	IVF	FET	IVF	FET	IVF	FET	IVF	FET
Southport & Formby	31	3	0	0	0	0	31	3
South Sefton	56	6	0	0	0	0	56	6
Liverpool	236	41	0	0	0	0	236	41
Knowsley	46	9	0	0	0	0	46	9
Halton	25	6	0	0	0	0	25	6
St Helens	34	6	0	0	0	0	34	6
Warrington	33	8	0	0	0	0	33	8
Cheshire E	101	27	0	0	0	0	101	27
Cheshire W	84	22	0	0	0	0	84	22
Wirral	85	5	0	0	0	0	85	5
TOTAL	**731**	**132**	**0**	**0**	**0**	**0**	**731**	**132**
Difference in activity (to baseline)							**-267**	**-46**

2 cycles

The table below shows the modelled activity data if NHS C&M were to offer 2 cycles of IVF.

Sub ICB Location	1 Cycle		2 cycle		3 Cycle		Total	
	IVF	FET	IVF	FET	IVF	FET	IVF	FET
Southport & Formby	31	3	11	2	0	0	42	5
South Sefton	56	6	21	2	0	0	77	8
Liverpool	236	41	86	16	0	0	322	57
Knowsley	46	9	17	3	0	0	63	12
Halton	25	6	10	2	0	0	35	8
St Helens	34	6	12	3	0	0	46	9
Warrington	33	8	12	3	0	0	45	11
Cheshire E	101	27	37	9	0	0	138	36
Cheshire W	84	22	31	8	0	0	115	30
Wirral	85	5	32	2	0	0	117	7
TOTAL	**731**	**132**	**269**	**50**	**0**	**0**	**1000**	**182**
Difference in activity (to baseline)							**2**	**4**

3 cycles

The table below shows the modelled activity data if NHS C&M were to offer 3 cycles of IVF.

	1 Cycle		2 cycle		3 Cycle		Total	
Sub ICB Location	**IVF**	**FET**	**IVF**	**FET**	**IVF**	**FET**	**IVF**	**FET**
Southport & Formby	31	3	11	2	6	0	48	5
South Sefton	56	6	21	2	10	1	87	9
Liverpool	236	41	86	16	44	7	366	64
Knowsley	46	9	17	3	9	2	72	14
Halton	25	6	10	2	4	1	39	9
St Helens	34	6	12	3	7	1	53	10
Warrington	33	8	12	3	6	1	51	12
Cheshire E	101	27	37	9	19	5	157	41
Cheshire W	84	22	31	8	15	4	130	34
Wirral	85	5	32	2	15	1	132	8
TOTAL	**731**	**132**	**269**	**50**	**135**	**23**	**1135**	**205**
Difference in activity (to baseline)							**137**	**27**

2.4 Guiding Principles

- To reduce unwarranted variation and harmonise access to services across Cheshire and Merseyside.
- Use the latest evidence base to develop harmonised policies.
- Consider sustainability of Cheshire and Merseyside ICB in context of financial requirements.

2.5 Strategic Context

The harmonisation of the policies and in particular IVF cycles meets the “Tackling health inequality, improving outcomes and access to services” and ‘Enhancing productivity and value for money’ strategic objectives:

Objective 1	
Objective	Tackling health inequality, improving outcomes and access to services
Current Arrangement	Inequity in the number of IVF cycles offered across C&M. Places currently offer either 1, 2 or 3 cycles and therefore there is unwarranted variation. There is a reputational risk, as we are one organisation, but patients are not being treated equitably, which is a risk to quality.
Gap/Business Needs	To harmonise the IVF rounds offered within the NHS C&M subfertility policy.

Objective 2	
Objective	Enhancing Productivity and Value for Money
Current Arrangement	Inequity in the number of IVF cycles offered across C&M. Places currently offer either 1, 2 or 3 cycles and therefore there is unwarranted variation.
Gap/Business Needs	To harmonise the IVF rounds offered within the NHS C&M subfertility policy whilst maintaining existing levels of activity and cost to support our Providers to continue to deliver against their operational plans.

3 Options and considerations:

Option	Description	Outcome	EIA feedback	QIA feedback	Financial impact
1	Do nothing • ***Discounted option***	This is not a viable option as this would leave the ICB and its patients with an unharmonised position and therefore unwarranted variation in access to fertility services.	Not completed	Not completed	**£5,043,081 per year**
2	NHS C&M offer patients 1 round of IVF treatment. • ***Executive Committee preferred option***	This option would disadvantage a cohort of patients who require additional cycles to have a live birth, as the average number of cycles that our patients have is 1.36. Clinically this is not supported due to the benefits in being able to take the learnings from an unsuccessful first cycle to improve chances of success in a second cycle. Whilst this option will reduce the cost of this service to the ICB, it is not supportive of NICE recommendation and would attract negative publicity. A public consultation exercise would be required in 8 Places.	The number of cycles does not affect protected characteristics. This option will affect those patients and families who are on a low income, if the patient does not have a successful live birth following a single round of IVF, they would have to self-fund to try again. This may mean they cannot have a biological child. **See Appendix 1.2 for EIA.**	There would be a negative impact for patients who are currently eligible for either 2 or 3 cycles. Without additional attempts at subsequent IVF cycles, there is a risk that patients would be detrimentally impacted and may not be able to have a biological child if they cannot afford to privately fund. Data shows the average number of IVF cycles that our patients are having is 1.36. Therefore, there is a risk that if those patients are not successful in the first IVF round, they would be disadvantaged by not being able to try a different approach in the second cycle. Knowledge is gained from the first cycle such as optimum dose of stimulation and best methods used for fertilisation. These are then implemented for subsequent attempts. **See Appendix 1.3 for QIA** **Overall risk rating: 16 (High)**	This would result in an estimated cost of **£3,728,347 per year.** Comparing this to the current position, this would result in estimated **savings of £1,315,732 per year.** (This cost includes the modelled cost of additional FETs – on average patients have an additional 1.88 FETs)

3	NHS C&M offer patients 2 rounds of IVF treatment. • ***Clinical Working Group Preferred Option***	This option is the preferred clinical option and is supported by the data that patients are having an average of 1.36 IVF cycles. Knowledge is gained from the first cycle such as optimum dose of stimulation and best methods used for fertilisation. These are then implemented for subsequent attempts. A public consultation would be required in 4 Places.	The number of cycles does not affect protected characteristics. **See Appendix 1.4 for EIA.**	According to the data analysis allowing 2 cycles of IVF would benefit the majority of patients, with the average number of IVF cycles being 1.36. Because the estimated number of 2nd IVF cycles for Cheshire East is equal to the existing number of 3rd cycles in Sefton, Knowsley, Warrington and Halton, the number of FETs is assumed to be the same based on this average. Once harmonised, this will mean that there is a consistent equitable offer for patients accessing subfertility treatments. See **Appendix 1.5** for QIA **Overall risk rating: 4 (Moderate)**	This would result in an estimated cost of **£5,084,437.** Comparing this to the current position, this would result in an estimated **cost increase of £40,357 per year.** (This cost includes the modelled cost of additional FETs – on average patients have an additional 1.88 FETs)
4	NHS C&M offer patients 3 rounds of IVF treatment. • ***Unsupported option***	This option is not supported because data suggests that the average number of IVF rounds is 1.36. Also, this option would require additional funding of over c.£734k pa and therefore does not support the ICB to meet its financial objectives.	The number of cycles does not affect protected characteristics.	Not completed as not supported.	This would result in an estimated cost of **£5,778,295.** Comparing this to the current position, this would result in an estimated **cost increase of £734,217 per year.**

3.4 Risks, Constraints & Dependencies

The following risks, constraints and dependencies have been highlighted as part of the development of the case for change.

Risks

The following risks have been identified:

Risk	Mitigating actions
Option 2: There is a risk of challenge during the public consultation from those patients in Knowsley, Halton, Warrington, Southport & Formby and South Sefton where currently 3 cycles are offered, and Liverpool, Wirral, Cheshire West and St Helens where currently 2 cycles are offered. If we reduce the number of cycles to 1, patients living in these Places may feel disadvantaged	There is an option to submit an Individual Funding Request if the patient could demonstrate clinical exceptionality. It should be noted however, that Liverpool Place have a policy of 2 cycles and 3 if clinical exceptionality is evidenced and there have been no instances of a 3rd IVF round approved. Whilst not a mitigation for these patients, reducing the IVF offer to 1 cycle would support the ICB to deliver savings in support of the financial challenge, and ensure that we can continue to provide this treatment across the whole of Cheshire and Merseyside
Option 2: If C&M ICB offers patients 1 cycle of IVF there is a risk that LWH would not receive enough income and therefore would not be sustainable as a Provider	This option would reduce LWH income by between £1m - £1.5m. A small element of this may be mitigated by planned productivity initiatives but would leave a deficit.
Option 3: There is a risk of challenge during the public consultation from those patients in Knowsley, Halton, Warrington, Southport & Formby and South Sefton where currently 3 cycles are offered, If we reduce the number of cycles to 2, patients living in these Places may feel disadvantaged.	C&M data shows that the average number of cycles patients have is 1.36, so the option to move to 2 cycles would support the majority of our patients. There is an option to submit an Individual Funding Request if the patient could demonstrate clinical exceptionality. It should be noted however, that Liverpool Place have a policy of 2 cycles and 3 if clinical exceptionality is evidenced and there have been no instances of a 3rd IVF round approved.
Option 3: There is a risk that unknown activity in non C&M Providers may mean that there is a significant number of CE patients having treatment out of area, due to geographical location.	Because of historic data reporting, we know that under £70,000 was spent in Cheshire with Greater Manchester providers. Assuming all of these are Cheshire E patients, there would be an estimated number of 4 patients requiring a 2nd cycle – Which would cost around £20k.
Option 3: If C&M ICB offers patients 2 IVF cycles, there is a risk that there will be increased activity levels for our provider Liverpool Women's Hospital. This increase will come from patients in Cheshire East who currently are eligible to 1 cycle. This would potentially increase waiting lists for treatment and will have a negative effect on women aged 40 and over, who are eligible for 1 cycle and may miss out on treatment due to a longer wait.	Offering 2 cycles of IVF for C&M patients will mean reducing the offer in Warrington, Halton, Sefton and Knowsley where patients are currently eligible for 3 cycles. Our data shows that the number of patients having 3 cycles per year and the estimated number of Cheshire East patients having a second cycle would result in minimal change to the activity levels and therefore minimal risk of introducing patient waiting lists. Patients in Cheshire East will sometimes choose to have their treatment in one of the Greater Manchester Trusts due to locality, so it is not expected that all of the estimated increased activity fall wholly on LWH.
All Options: Data from our providers has been used to inform the recommendations regarding the number of IVF cycles. There is a risk that this data may not be accurate as it is not patient identifiable – and is therefore based on averages.	To make for a richer data set, data has been collated and validated with LWH and Care Fertility. This will give a more accurate understanding of both Cheshire patients and Mersey patients. The options have been modelled using month 7 actuals with forecast end of year outturn for 2024/25 using SLAM data and verified by LWH finance and operational team.

Constraints

- The review is being undertaken in context of the reducing unwarranted variation recovery programme and the current financial climate.
- Due to the significance of the change, a public consultation exercise would be required in Cheshire and Merseyside to support either proposal to harmonise to one or two IVF cycles. In addition, it would be necessary to engage and consult with the Health Oversight and Scrutiny Committees in all affected Places for them to determine if this proposal is a significant development or variation. If so, a joint OSC would need to be formed. The availability and timing would largely be dictated by the Local Authorities, this would impact the timing of benefits delivery.
- Engagement/communication would also be required with local MPs.
- Consideration is needed regarding any delays to benefits delivery caused by the potential for 'call in' to the Secretary of State for Health & Care of any proposed service change – members of the public or organisations can write to the Secretary of State at any stage of the process.

Dependencies

- NHS C&M's communications and engagement team are currently focused on a number of pieces of public involvement work. Any public involvement requirements around IVF cycles will need to be considered alongside existing work plans.

4 Options Appraisal

For completeness, a range of options have been considered as part of the case for change, a brief description of the options, including subsequent actions required for Options 2, 3 or 4 is below:

Option 1: Do nothing (Option discounted)

Pros	Cons
• There would be no change in the ICB financial position.	• This would leave NHS C&M with an unharmonised position, patients would continue to have unequal access to IVF rounds. • There is an increased risk of challenge by Equalities and Human Rights commission re inequality in service access.

Option 2: Offer patients 1 cycle of IVF

Pros	Cons
• This offer is in line with most of our neighbouring ICBs offer. • Offering 1 cycle provides the greatest financial savings opportunity. • 661% of ICBs across the country offer 1 cycle.	• Data shows that the average number of cycles patients require is 1.36. Therefore offering 1 cycle would disadvantage patients who require an additional cycle. If the first cycle is not successful, observation and learnings are used to inform the second cycle in order to increase the potential for a successful live birth. This is especially relevant as patients are becoming more complex, are older, have comorbidities which affect their fertility or are under time pressure (e.g. fertility preservation). Although it is of note that patients could choose to fund this privately.

	• Risk of negative publicity for the ICB in those places that currently offer 2 or 3 cycles - patients will be generally dissatisfied, and this may result in an increase of complaints, therefore more time will need to be allocated to respond to these. • Patients on low income in 8 Places could be disadvantaged as they either receive 2 or 3 cycles currently, and if they fail to have a live birth in the first cycle, they would be required to self-fund which may not be financially possible. • A public consultation exercise would need to be held within 8 Places which would impact the time taken to implement and could be costly. • Does not match current NICE guidance of three cycles. • There is a sustained decline in birth rates across Cheshire and Merseyside. The OECD identifies a replacement fertility rate of 2.1 children per woman as necessary to maintain population levels. ONS data shows that the total fertility rate in C&M has been in consistence decline since 2021, falling to 1.49 in 2022. This trend presents significant long-term risks to the region's workforce and the sustainability of health and social services. Therefore, a reduction in cycles will undermine efforts to support population health and long-term system planning. • There is a risk on the mental health impact that childlessness has on couples, research shows that this is coupled with grief, depression and emotional stress which can impact on quality of life, this can be expected to increase. • Reducing NHS IVF cycles will potentially increase cost elsewhere as more patients will turn to cheaper IVF options in other countries with less regulation and potentially increasing the rates of multiple pregnancies, leading to maternal and neonatal morbidity and placing a greater financial and clinical burden on the NHS services downstream. • Data shows that 1 cycle of treatment (with subsequent FET's) gives a 56% chance of a live birth whereas with 2 cycles couples have a cumulative 68% chance of a live birth.

Option 3: Offer patients 2 cycles of IVF

Pros	Cons
• The average number of cycles patients currently have is 1.36, therefore the proposal of 2 cycles of IVF would support these findings and would enable learning to be taken from the first cycle and a different approach to be used for the second cycle with an aim to improving success. • Offering 2 cycles would be a positive for Cheshire East patients, as currently they are eligible for 1 cycle. • This option is supported by all clinicians including the Obs & Gynae clinical network and LWH Finance and Operational teams who will deliver the service.	• Patients in the 4 Places who offer 3 cycles, particularly if on low income, may feel they are disadvantaged by a reduction in the IVF cycle offer and this may generate negative publicity for the ICB. • A public consultation exercise would need to be held within 4 Places which would impact the time taken to implement. • Does not match current NICE guidance of three cycles, (NICE data shows that whilst the effectiveness of each cycle with regard to cumulative live birth rate increases with each cycle the effectiveness of each cycle is reduced). Our data modelling showing the average number of cycles per patient is 1.36. • This offer is higher than the national average (71% offering 1 cycle), our neighbouring ICB Cumbria and Lancashire offer patients 1 cycle of IVF. (Greater Manchester are in the process of harmonising their cycles offer). This would mean there is continued variation in access to subfertility services within the Northwest region and surrounding areas.

Option 4: Offer patients 3 cycles of IVF (Option discounted)

Pros	Cons
• Often if the first cycles are not successful, learnings are taken from this, and a different approach is used for the second and third cycles with an aim to improving success. • Offering 3 cycles would be a positive for Cheshire East, Cheshire West, Liverpool, St Helens and Wirral patients, currently they are eligible for 1 or 2 cycles. • A public involvement exercise could be a light touch communication approach. • Meets current NICE guidance, NICE data shows that whilst the effectiveness of each cycle with regard to cumulative live birth rate increases with each cycle, the effectiveness of each cycle is reduced.	• This offer is higher than our neighbouring ICB, Cumbria and Lancashire who offer 1 cycle. (Greater Manchester are in the process of harmonising their cycles offer). • This offer is higher than the country average, with 71% of ICBs offering 1 cycle. • This results in estimated additional cost to the ICB of £734k pa • The average number of cycles patients currently have is 1.36, therefore this option does not support data findings.

5.1 Financial Case

Options	Description (*Committed costs)	Recurrent cost annual	Comments
Option 1: Do nothing – Variation would remain in the number of IVF cycles offered across C&M	£5,043,081	£5,043,081	
Option 2: Offer patients 1 cycle of IVF across C&M	N/A	£3,728,347	This would result in estimated savings of £1,315,732 per year.
Option 3: Offer patients 2 cycles of IVF across C&M	N/A	£5,084,437	This would result in an estimated cost increase of £40,357 per year**.**
Option 3: Offer patients 3 cycles of IVF across C&M	N/A	£5,778,295	This would result in an estimated cost increase of £734,217 per year.

Appendices

Appendix 1.1 proposed other changes within policy document

Appendix 1.2 EIA for 1 IVF Cycle option

Appendix 1.3 QIA for 1 IVF Cycle option (post panel review)

Appendix 1.4 EIA for 2 IVF Cycles option

Appendix 1.5 QIA for 2 Cycles option

Appendix 1.1 - Other proposed changes to NHS C&M Subfertility policy

Section	Current CCG policies	Evidence-based policy suggestion & proposed policy section	Major changes and Rationale	Impact
3. Definition of Subfertility, Timing of Access to Treatment & Age Range	3.1 Fertility problems are common in the UK, and it is estimated that they affect one in seven couples. 84% of couples in the general population will conceive within one year if they do not use contraception and have regular sexual intercourse. Of those who do not conceive in the first year, about half will do so in the second year (cumulative pregnancy rate 92%). In 25% of infertility cases the cause cannot be identified. 3.2 Where a woman is of reproductive age and having regular unprotected vaginal intercourse two to three times per week, failure to conceive within twelve months should be taken as an indication for further assessment and possible treatment. In the following circumstances an earlier assessment should be considered: • If the woman is aged 36 or over, then such assessment should be considered after 6 months of unprotected regular intercourse since her chances of successful conception are lower and the window of opportunity for intervention is less. • If there is a known clinical cause of infertility or a history of predisposing factors for infertility. 3.3 Women should be offered access to investigations if they have subfertility of at least 1 year duration (6 months for women aged 36 and over) and offered IVF if they have had subfertility of at least 2 years duration (12 months for women aged 36 and over) Additional criteria apply for IVF in women aged 40 – 42 (see paragraph 12.4). 3.4 If, as a result of investigations, a cause for the infertility is found, the patient should be referred for appropriate treatment without further delay.	4.1 Fertility problems are common in the UK and it is estimated that they affect one in seven couples. Eighty four percent of women in the general population will conceive within one year if they have regular, unprotected sexual intercourse. Of those who do not conceive in the first year, about half will do so in the second year (cumulative pregnancy rate 92%). In 25% of infertility cases the cause cannot be identified. 4.2 Where a woman is of reproductive age and having regular unprotected vaginal intercourse two to three times per week, failure to conceive within twelve months should be taken as an indication for further assessment and possible treatment. 4.3 In the following circumstances an earlier assessment should be considered: • If the woman is aged 36 or over, then such assessment should be considered after 6 months of unprotected regular intercourse since her chances of successful conception are lower and the window of opportunity for intervention is less. • If there is a known clinical cause of infertility or a history of predisposing factors for infertility. 4.4 Women should be offered MAR treatments if they have had subfertility of at least 2 years duration (12 months for women aged 36 and over) – this includes the initial 12-month period before the initial assessment. Additional criteria apply for IVF in women aged 40–42 (see paragraph 12.6). 4.5 This policy adopts NICE guidance that access to high level treatments including IVF should be offered to women up to the age of 42 years. First treatment cycles must be commenced before the woman's 43rd birthday. 4.6 Women will be offered treatment provided their hormonal profile is satisfactory i.e. in line with NICE CG156.	1. The minimum age (23 years) has been removed as this is no longer supported by NICE. 2. "Before the woman's 42nd birthday" has been changed to "before the woman's 43rd birthday" because this is consistent with NICE. 3. Additional Mersey paragraph (in green) has been deleted – the statements are not supported by the cited references. However, this topic is covered later in section 11. 4. Paragraph 3.3 rewritten to improve clarity/accuracy.	1. NICE withdrew the recommendation for minimum age (23 years) in 2004. 2. Together with the "increase" in upper age from before the woman's 42nd birthday to 43rd birthday, these changes in age limits are unlikely to have a significant impact. 3. The impact on additional costs with increasing this upper age limit has been detailed below **

Section	Current CCG policies	Evidence-based policy suggestion & proposed policy section	Major changes and Rationale	Impact
	Additional text in Mersey only The CCG will offer access to intra-uterine insemination (IUI) or donor insemination-(DI) services where appropriate after subfertility of at least 12 months duration. See Section 11. NICE guidance recommendations 117 – 119. P223 http://www.nice.org.uk/guidance/cg156/resources/cg156-fertility-full-guideline3 Fertility | Guidance and guidelines | NICE section 1.91 p31 This policy adopts NICE guidance that access to high level treatments including IVF should be offered to women between the ages of 23 – 42 years. First treatment cycles must be commenced before the woman's 42nd birthday (See section 12.4 for further details). Women will be offered treatment provided their hormonal profile is satisfactory i.e. in line with NICE CG156 section 6.3 guidance recommendations.	https://www.nice.org.uk/guidance/cg156 https://www.nice.org.uk/guidance/cg156/evidence/full-guideline-pdf-188539453		

Section	Current CCG policies	Evidence-based policy suggestion & proposed policy section	Major changes and Rationale	Impact
4. Definition of Childlessness	4.1 Funding will be made available where a couple have no living children from a current or any previous relationship i.e. if previous living child from current or previous relationship then excluded from subfertility treatment. 4.2 A child adopted by a patient or adopted in a previous relationship is considered to have the same status as a biological child. 4.3 Once a patient is accepted for subfertility treatment they will no longer be eligible for further treatment if a pregnancy leading to a live birth occurs or the patient adopts a child. Alternative text in E & W Cheshire only 4.3 Where a patient has started a cycle of IVF treatment and they have a pregnancy leading to a live birth, or the patient adopts a child, they can continue to complete this cycle but would not be eligible to start a further new cycle. (E Cheshire / W Cheshire)	7.1 Funding will be made available where a couple have no living children from a current or any previous relationship i.e. if there is a previous living child from a current or previous relationship, then patients are excluded from subfertility treatment. 7.2 A child adopted by a patient or adopted in a previous relationship is considered to have the same status as a biological child. 7.3 Once a patient is accepted for subfertility treatment, they will no longer be eligible for any other MAR treatment or procedures if a pregnancy leading to a live birth has occurred or the patient has adopted a child.	1. Around 75% of ICBs in England and 87% of the former CCGs concur with the evidence-based policy definition of childlessness related to living/adopted children. This definition is not covered by NICE because (presumably) this is a "non-clinical" factor. 2. All 4 current policies carry this same definition in 4.1 & 4.2 and thus are "harmonised". 3. The E & W Cheshire's modified version of paragraph 4.3 suggests that once a pregnancy occurs, the patient can continue using the frozen embryos from the existing cycle. This is unusual, and most policies state that once a woman is pregnant (or adopts a child), the NHS is no longer liable for further treatment. It is also inequitable that some women may receive treatment for more than one child, whereas others are ineligible for any NHS treatment at all.	1. The current and evidence-based policies are in broad agreement with each other and are consistent with the rest of the country. 2. There is unlikely to be a significant impact with regard to the cost to this policy. This will result in reduced activity and therefore a small financial saving. 3. The subject of storage of any remaining embryos following a live birth is covered in section 16.
8. Female and Male Body Mass Index (BMI)	8.1 Women Male and female partners will be required to achieve a BMI of 19-29.9 before subfertility treatment begins. Women outside this range can still undergo investigations, but subfertility treatment will not commence until their BMI is within this range. Alternative text in Wirral only Additional text in green. N.B. Although Wirral is the only CCG which specifies *male and female* patients , E & W Cheshire and Mersey CCGs cite women only in their statements. However, it has to be emphasised that the title in the Cheshire policies is "Female and Male BMI". This could leave the reader in some confusion as to whether the policy applies to men or women.	8.1 The woman intending to carry the pregnancy, will be required to achieve a BMI of 19-29.9 kg/m² before subfertility treatment begins. Women outside this range can still undergo investigations, but subfertility treatment will not commence until their BMI is within this range. 8.2 Men who have a BMI of 30 or over should be informed that they are likely to have reduced fertility, and they should be strongly encouraged to lose weight as this will improve their chances of a successful conception.	1. According to NICE, a BMI which is >30 in females has a negative impact on fertility. The chance of a live birth following IVF treatment falls with a female BMI outside the range 19-30. 2. Therefore, it is not unreasonable to withhold treatment until the female BMI is <30. 3. In men, a high BMI may become a consideration especially if male factor infertility is a problem. 4. NICE recommendation of "informing" men that their obesity is likely to have an impact on their fertility was based on the best available evidence at that time (2013).	1. It could be argued that the current CCG policies are so ambiguous that readers will be uncertain whether the BMI restrictions apply to both men and women. Therefore, the proposed policy brings greater clarity.

Section	Current CCG policies	Evidence-based policy suggestion & proposed policy section	Major changes and Rationale	Impact
9. Female and Male Smoking[1] Status	9.1 Patients (Male and female partners) should be confirmed non-smokers in order to access any subfertility treatment and must continue to be non-smoking throughout treatment. Providers should seek evidence from referrers and confirmation from patients. Providers should also include this undertaking on the consent form and ask patients to acknowledge that smoking could result in cessation of treatment. 9.2 It is preferable that couples are not using any nicotine products but if nicotine replacement therapy or e-cigarettes are being used by either person in the couple, this would not exclude fertility treatment. (Wirral, E Cheshire and W Cheshire) Alternative text in Mersey only Additional text in green. Additional paragraph in E & W Cheshire only Text in blue Mersey and Wirral contain paragraph 9.1 only.	**Female and Male Smoking * Status** 9.1 Both partners (i.e. female and/or male) should be confirmed non-smokers in order to access any subfertility treatment and must continue to be non-smoking throughout treatment. Providers should seek evidence from referrers and confirmation from patients. Providers should also include this undertaking on the consent form and ask patients to acknowledge that smoking could result in cessation of treatment. *Smoking increases the risk of infertility in women and men. Nicotine alone is known to affect development of the foetus and long-term safety data on e-cigarettes are unknown. Because of these concerns and issues, all forms of smoking (which includes cigarettes, e-cigarettes or NRT) are not permitted.	1. The Mersey policy refers to "patients" (as opposed to *male and female partners*) which suggests that smoking restrictions apply only to the person receiving treatment i.e. the "patient". This ignores the impact of second-hand smoke on the on the offspring and if the partner is also a smoker, the impact of smoking on their fertility. 2. Paragraph 9.2 (in blue) appears in E & W Cheshire policies only and this exempts couples using e-cigarettes and/or nicotine therapy. 3. According to NICE CG156, smoking can adversely affect fertility and the success rates of assisted reproductive techniques (in both men and women). 4. There are significant associations between maternal cigarette smoking in pregnancy and increased risks of small-for-gestational-age infants, stillbirth and infant mortality. 5. Nicotine-containing products (which include e-cigarettes) are not considered to be safe in pregnancy. 6. Whilst current evidence on e-cigarettes suggests these may be less toxic than smoking, long term safety data in the general population are lacking. 7. There is even less data on the impact and safety of e-cigarettes on fertility and on the developing foetus and beyond. 8. In addition, there is increasing concern about the propellants used in e-cigarettes which may be responsible for a number of reported deaths. 9. Because of these safety concerns on the growing foetus and offspring, paragraph 9.2 has been removed.	1. Both partners are now included in the smoking restriction, and this is consistent with NICE guidance. 2. Practically, the rewritten paragraph 9.1 is unlikely to have an impact on activity. 3. Removal of paragraph 9.2 could potentially result in a small number of patients being refused treatment albeit temporarily. However, it remains to be seen whether, in practice, Providers follow this policy for Cheshire patients.

Section	Current CCG policies	Evidence-based policy suggestion & proposed policy section	Major changes and Rationale	Impact
10. Female and Male Drugs & Alcohol intake	10.1 Patients Male and female partners will be asked to give an assurance that their alcohol intake is within Department of Health guidelines, and they are not using recreational drugs. Any evidence to the contrary will result in the cessation of treatment https://www.gov.uk/government/policies/reducing-drugs-misuse-and-dependence https://www.gov.uk/government/policies/reducing-harmful-drinking **Alternative text in Mersey only** Additional text in green.	10.1 Both partners (i.e. female and/or male) partners will be asked to give an assurance that their alcohol intake is within Department of Health guidelines, and they are not using recreational drugs. Any evidence to the contrary may trigger a pause in treatment with possible referral for a welfare of the child assessment and/or further information sought from the GP. https://www.gov.uk/government/policies/reducing-drugs-misuse-and-dependence https://www.gov.uk/government/policies/reducing-harmful-drinking	1. The Mersey policy applies to the person who is receiving treatment only whereas the other policies apply to all partners whether they are receiving treatment or not. 2. There is evidence that alcohol and recreational drugs reduce the chance of conception in both men and women. Also, there are the well-recognised adverse effects of alcohol on the growing foetus. 3. Required assurances on alcohol/recreational drug intake should, therefore, apply to both partners irrespective of which one is receiving treatment. 4. In addition, the evidence-based policy has been expanded to included situations where the clinician might have concerns about a potential alcohol/drug misuser and if this could have implications for the welfare of the child.	1. Practically, changing the requirement to include both partners in Mersey is unlikely to have an appreciable impact. 2. Providers will be able to confirm that the need for a welfare of the child assessment has always been standard practice.
11. Intra-uterine Insemination (IUI)/Donor Insemination (DI) & Intracytoplasmic Sperm Injection (ICSI)	11.1 In advance of IVF treatment Consider unstimulated intrauterine insemination (to a maximum of 6 cycles) as a treatment option in the following groups as an alternative to vaginal sexual intercourse: • People who are unable to, or would find it very difficult to, have vaginal intercourse because of a clinically diagnosed physical disability or-psychosexual problem who are using partner or donor sperm; • People with conditions that require specific consideration in relation to methods of conception (for example, after sperm washing where the man is HIV positive); • People in same sex relationships. 11.2 For people with unexplained infertility, mild endometriosis or 'mild male factor infertility', who are having regular unprotected sexual intercourse, do not routinely offer intrauterine insemination, either with or without ovarian stimulation. Advise them to try to conceive for a total period of time as per section 3.3 before IVF will be considered.	11.1 Unstimulated intrauterine insemination is a treatment option in the following groups as an alternative to vaginal sexual intercourse: • People who are unable to, or would find it very difficult to, have vaginal intercourse because of a clinically diagnosed physical disability or-psychosexual problem who are using partner or donor sperm; • People with conditions that require specific consideration in relation to methods of conception (for example, after sperm washing where the man is HIV positive); • People in same sex relationships (please see section 5 regarding eligibility and the need for the first 6 cycles to be self-funded). 11.2 For people in 11.1 above who have not conceived after 6 cycles of donor or partner insemination, despite evidence of normal ovulation, tubal patency and semen analysis, should be offered a further 6 cycles of unstimulated intrauterine insemination before IVF is considered.	1. Policies in Mersey, E & W West Cheshire are very similar with minor differences in wording. 2. The main difference is that paragraph 11.5 is missing in the Cheshire policies. This details the number of IUI cycles required before treatment and is consistent with NICE. 3. Paragraphs 11.1, 11.2 are closely aligned to current NICE recommendations. 4. The Wirral “no commission” policy is of grave concern as it contradicts current NICE guidance and is open to legal challenge. 5. Overall, the best representation of the NICE guideline is provided by the Mersey policy. The evidence-based policy, therefore, is largely based on this and has been expanded to include more appropriate recommendations from NICE. 6. For example, the new paragraph 11.4 on donor insemination are all NICE recommendations. 7. For same sex couples and single women (in 11.1), reference is made to section 5	1. With the exception of Wirral’s “not routinely commissioned” stance, the evidence-based policy is based on the Mersey/Cheshire policies and has been revised to improve clarity and include some additional NICE recommendations. 2. There is unlikely to be an appreciable change in access. 3. Only Providers can confirm whether they have rigidly adhered to the Wirral policy in the past. If they have there will be a number of patients who will now be

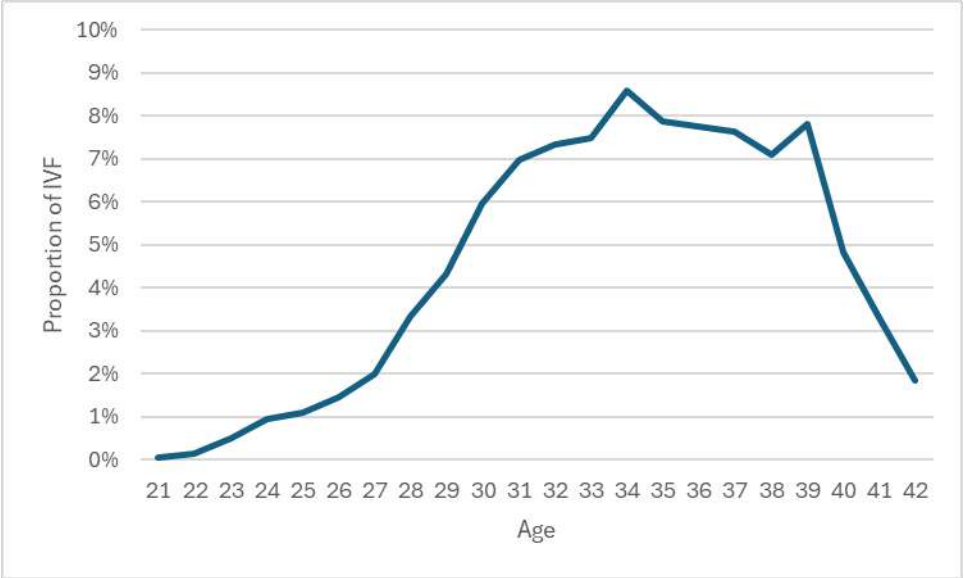
Section	Current CCG policies	Evidence-based policy suggestion & proposed policy section	Major changes and Rationale	Impact
	11.3 Donor insemination (with IUI) will be funded where clinically indicated. 11.4 Stimulated IUI will be funded where clinically indicated, due concern must be given to the risk of multiple births in this situation and insemination abandoned if this is felt to be a possibility. 11.5 Patients who are receiving IUI who have not conceived after 6 cycles of donor or partner insemination, despite evidence of normal ovulation, tubal patency and semen analysis, should be offered a further 6 cycles of unstimulated intrauterine insemination before IVF is considered. (NB this paragraph has been deleted in the Cheshire policies) 11.6 Patients who fail to achieve a pregnancy using IUI/DI will be considered for IVF. Alternative text in E & W Cheshire 1. Additional text in green. 2. Also note that paragraph 11.5 has been deleted in both Cheshire policies. **Section 11 Wirral only** **NB** Policy statement is "not routinely commissioned" for **ALL** of the above.	11.3 For people with unexplained infertility, mild endometriosis or 'mild male factor infertility', who are having regular unprotected sexual intercourse, do not routinely offer intrauterine insemination, either with or without ovarian stimulation. Advise them to try to conceive for a total of 2 years (or 12 months for women aged 36 and over) as per section 4 before IVF will be considered. 11.4 Donor insemination (with IUI) may be funded for the following indications:- • obstructive azoospermia • non-obstructive azoospermia • severe deficits in semen quality in couples who do not wish to undergo intracytoplasmic sperm injection (ICSI). • high risk of transmitting a genetic disorder to the offspring • high risk of transmitting infectious disease to the offspring or woman from the man • severe rhesus isoimmunisation 11.5 Stimulated IUI will be funded where clinically indicated, due concern must be given to the risk of multiple births in this situation and insemination abandoned if this is felt to be a possibility. 11.6 Patients who fail to achieve a pregnancy using IUI/DI will be considered for IVF. 11.7 For the sake of clarity, according to CG 156, 12 months of unprotected vaginal intercourse is considered to be equivalent to 6 cycles of artificial insemination. Further, the usual requirements for women aged ≥ 36 years are halved (in comparison to women aged <36 years) i.e. they may be required to experience a period of "watchful waiting" of 6 months (as opposed to 12 months in younger women) and/or to undergo 3 cycles of artificial insemination (as opposed to 6 cycles in younger women). 11.8 Intracytoplasmic Sperm Injection (ICSI) is routinely funded for:- • severe deficits in semen quality or • obstructive azoospermia or • non-obstructive azoospermia.	which specifies the need for self-funding of the first 6 cycles of artificial insemination. 8. The need for self-funding is discussed in more detail in section 5 above.	eligible for this treatment. However, our data shows that this will be minimal. Liverpool Women's Hospital data shows 56 cycles for 19 patients over a period of 6 years were completed. Care Fertility reported 0 IUI's over this same period.

Section	Current CCG policies	Evidence-based policy suggestion & proposed policy section	Major changes and Rationale	Impact
Overseas Visitors eligibility for NHS-funded IVF treatment	This is a new section and does not appear in any of the existing CCG policies.	6.1 An individual ordinarily resident in the UK is eligible for NHS funded fertility treatment. 6.2 Overseas visitors coming to, or remaining in, the UK for six months or more are usually required to pay the immigration health charge (referred to as the health surcharge, or IHS) unless an exemption from paying the surcharge applies or the charge is waived. 6.3 IVF is excluded from the list of NHS treatments overseas visitors can access, even if the above surcharge is paid. 6.4 Where a non-resident wishes to access IVF, they should be charged 150% of the National NHS tariff (or locally agreed price where applicable). IVF treatment charges should be made in advance of any treatment being given. 6.5 If care is deemed an emergency by the Fertility Consultant, the provider and ICB can enter a risk share scheme and split 50% of the costs each. 6.6 Current Guidance on Overseas Visitors and Eligibility can be found using the following link https://www.gov.uk/government/publications/nhs-cost-recovery-overseas-visitors.	1. This is a new section which has been written in conjunction with Liverpool Women's Hospital Overseas Visitors Team.	1. Although this section is new, the guidance on overseas visitor's access to fertility treatment is the same as the current position, it is just not called out in the policies.
16. Storage and cryopreservation of embryos, oocytes (eggs) and semen	19.1 Embryo, egg and sperm storage will be funded for patients who are undergoing NHS subfertility treatment in line with The Human Fertilisation and Embryology Authority guidance. The storage standard period for sperm, egg and embryo storage is normally ten years (subject to 4.3) **Additional text for E & W Cheshire** Additional text in green **Section 22: Cryopreservation** 22.1 Cryopreservation services in line with the relevant principals outlined in NICE IPG 156 Section 1.16 will be offered to: Women with premature ovarian failure under the age of 40 (see previous definition - see section 17).	17.1 Storage of embryos, oocytes or semen is routinely commissioned for eligible patients who are undergoing NHS subfertility treatment. Readers are required to interpret this section in conjunction with the ICB policy on "Childlessness". **Fertility Preservation before treatment for cancer (or other procedures which affect fertility)** 17.2 Cryopreservation of embryos, oocytes or semen is routinely commissioned before treatments or procedure (e.g. for cancer or other medically essential interventions such as a surgical procedure and/or administration of medication) which are known to affect fertility. This will be performed in accordance with the Human Fertilisation and Embryology Authority (HFEA) regulations and NICE guideline CG 156.	1. This section has been completely redrafted and combines sections 19 & 22. 2. It more accurately reflects the recommendations from NICE on this topic. 3. Strictly speaking, CG 156 recommends cryopreservation for patients about to receive treatment for cancer. However, reading the full guideline version, it is clearly apparent that the intention of the guideline committee was to provide cryopreservation for any treatment which could affect fertility. 4. Thus, paragraph 19.2 specifies cancer but also treatment for "other medically necessary interventions"	1.There is unlikely to be any cost implications for cryopreservation as this storage limit hasn't changed. 2. LWH finance colleagues have confirmed they are comfortable with all proposed changes and there is no significant financial impact.

Section	Current CCG policies	Evidence-based policy suggestion & proposed policy section	Major changes and Rationale	Impact
	Men and women with cancer, or other illnesses which may impact on fertility, may access tertiary care services to discuss fertility preservation (egg, embryo or sperm storage). Other illnesses are not defined in this policy but will be considered on an individual basis via an Individual Funding Request. Storage will be in-line with section 19. 22.2 The eligibility criteria set out in this policy do not apply to cryopreservation but do apply to the use of the stored material. 22.3 Storage of ovarian tissue will not be funded.	17.3 Patients must satisfy the prevalent subfertility criteria when the time comes to use this stored material and they must have been informed of this requirement before commencing cryopreservation. 17.4 The cryopreserved material may be stored for 10 years or up to the female partner's 43rd birthday, whichever comes sooner. **Following a live birth** 17.5 The ICB will fund up to 12 months' storage following the birth or adoption of a child (i.e. a "grace" period) to give the patient enough time to decide whether they wish to self-fund, donate the stored material or consent to having any remaining gametes or embryos destroyed. 17.6 This is in accordance with the ICB's policy on "Childlessness" and beyond the "grace" period, funding for storage will no longer be available. **18 Storage of Ovarian Tissue** 18.1 Storage of ovarian tissue is not routinely funded.	which is more in keeping with CG 156. 5. Patients will need to be confirmed as sub-fertile when the stored material is being used according to CG156 (recommendation 1.16.1.6) 6. The Working Group discussed the length of storage for a number of situations. 7. For cryopreservation, a period of 10 years was agreed, and this is consistent with the existing policy. 8. Section 17.5 'Following a live birth' was added to the policy at the request of the fertility experts on the working group. 9. The group were advised that a 6 – 12 months' storage period is standard for this situation.	

** Definition of Subfertility, Timing of Access to Treatment & Age Range - Impact

The graph below shows the IVF split over the past five years. It suggests that women aged 42 make up about 2% of all IVF activity at LWH. There's a clear pattern where the uptake increases from 29 onwards, peaking at age 34. It then starts to drop-off again gradually to 41, when it falls of steeply at age 42. Therefore, the impact of increasing this upper age limit by a year will have minimal impact on activity and costs.



NHS
Cheshire and Merseyside

Appendix 1.2

Equality Analysis Report

Pre-Consultation *(Use the same form but delete as applicable. If it is post-consultation it needs to include consultation feedback and results)*

C&M Wide

Start Date:	19/08/24	
Equality and Inclusion Service Signature and Date:	Nicky Griffiths	
Sign off should be in line with the relevant ICB's Operational Scheme of Delegation (*amend below as appropriate)		
***Place/ ICB Officer Signature and Date:**		
***Finish Date:**		
***Senior Manager Sign Off Signature and Date**		
***Committee Date:**		

1. Details of service / function:
Guidance Notes: Clearly identify the function & give details of relevant service provision and or commissioning milestones (review, specification change, consultation, procurement) and timescales.
This change concerns the number of IVF cycles within a harmonised sub-fertility policy. There is currently disparity across Cheshire and Merseyside on the number of IVF cycles offered as part of the sub-fertility policies: 1 cycle - Cheshire East 2 cycles – Liverpool, St Helens, Wirral, Cheshire West 3 cycles – Warrington, Southport & Formby, South Sefton, Halton, Knowsley The clinical policy harmonisation programme undertook an exercise to harmonise the number of cycles, and a working group set up to work through this. The working group proposed 1 or 2 cycles. Our data shows that the average number of cycles patients are currently having is 1.36. Following creation of the recovery programme, the review had to consider costing up both 1 and 2 cycles. This EIA considers the impact of a 1 IVF cycle policy.
What is the **legitimate aim** of the service change / redesign

For example

- Demographic needs and changing patient needs are changing because of an ageing population.
- To increase choice of patients
- Value for Money-more efficient service
- Public feedback/ Consultation shows need/ no need for a service
- Outside commissioning remit of ICB/NHS

- To ensure a harmonised approach across Cheshire and Merseyside for the number of IVF cycles offered within the sub-fertility policy.
- To ensure the ICB have had the opportunity to consider the risk and impact of reducing the number of IVF cycles to 1 across Cheshire and Merseyside in light of the current financial challenge.

2. Change to service.

To harmonise the number of IVF cycles across C&M – see above for current.

This EIA considers reducing to 1 cycle as there is a potential financial saving of @£1.2m

In addition, there are a number of other changes proposed to the policy to bring it in line with the latest evidence base including:

- The minimum age (23 years) has been removed as NICE no longer supports this.
- "Before the woman's 42nd birthday" has been changed to "before the woman's 43rd birthday" because this is consistent with NICE. NICE withdrew the recommendation for minimum age (23 years) in 2004, together with the increase of the upper age limit to forty-three.
- Some narrative has been changed to improve clarity and accuracy.
- The definition of childness confirms that any biological or adopted child would mean ineligibility for the policy.
- The right to a family has been confirmed to mean that once the patient has a successful live birth (baby has reached 12 months) they are no longer eligible for further treatment. This is only a change to E&W Cheshire whose current policy implies the patient can continue using the frozen embryos.
- BMI recommendations based on NICE guidance for women. Female partners will be required to achieve a BMI of 19-29.9 kg/m² before subfertility treatment begins. Women outside this range can still undergo investigations, but subfertility treatment will not commence until their BMI is within this range.
- Female and Male Smoking Status – The proposal is that both partners (i.e. female and/or male) should be confirmed non-smokers to access any subfertility treatment and must continue to be non-smoking throughout treatment. Providers should seek evidence from referrers and confirmation from patients. Providers should also include this undertaking on the consent form and ask patients to acknowledge that smoking could result in cessation of treatment. *****Smoking increases the risk of infertility in women and men. Nicotine alone is known to affect development of the foetus and long-term safety data on e-cigarettes are unknown. Because of these concerns and issues, all forms of smoking (which includes cigarettes, e-cigarettes or NRT) are not permitted. Both partners are now included in the smoking restriction, and this is consistent with NICE guidance. The change to specify both partners and to include Nicotine Replacements could potentially result in a small number of patients being refused treatment. The change regarding Nicotine replacement is in relation to East

and West Cheshire. Guidance states that all smoking and NRT can be harmful, including secondary smoking. This is **a change** in policy.

- Female and Male Drugs & Alcohol intake – Proposal: Male and female partners will be asked to give an assurance that their alcohol intake is within Department of Health guidelines, and they are not using recreational drugs. Any evidence to the contrary may trigger a pause in treatment with possible referral for a welfare of the child assessment and/or further information sought from the GP. The current Mersey policy applies to the person who is receiving treatment only whereas the other policies apply to all partners whether they are receiving treatment or not. In addition, the evidence-based policy has been expanded to included situations where the clinician might have concerns about a potential alcohol/drug misuser and if this could have implications for the welfare of the child. This means that there is **some change**.
- Intra-uterine Insemination (IUI) / Donor Insemination (DI) – the position in Mersey policies will be introduced to Cheshire (change to number of cycles required before IVF) and Wirral (not routinely commissioned).
- Overseas Visitors eligibility for NHS- funded IVF treatment – a new section has been added to confirm the position for those patients applying for treatment if they are not ordinarily resident in the UK. The policy states that where a non-resident wishes to access IVF, they should be charged 150% of the National NHS tariff (or locally agreed price where applicable). IVF treatment charges should be made in advance of any treatment being given.

  If care is deemed an emergency by the Fertility Consultant, the provider and ICB can enter a risk share scheme and split 50% of the costs each. This is **a change** as is it an addition to the proposed policy but not a change to patient access as it reflects the existing process.

3. Barriers relevant to the protected characteristics

Guidance note: describe where there are potential disadvantages.

[ENTER RESPONSE HERE]

[COMPLETE DIFFERENTIAL MATRIX]

Protected Characteristic	Issue	Remedy/Mitigation
Age	• The minimum age (23 years) has been removed as NICE no longer supports this. • "Before the woman's 42nd birthday" has been changed to "before the woman's 43rd birthday" because this is consistent with NICE. NICE withdrew the recommendation for minimum age (23 years) in 2004, together with the increase of the upper age limit to forty-three. • Some narrative has been changed to improve clarity and accuracy**.**	No action as this brings the policy in line with NICE guidance. This is a positive impact for patients and will increase the eligibility criteria for those patients under 23 and those over 42.

	• Overall, this will result in a positive impact due to clarity and NICE evidence-based age guidelines, including the removal of the minimum age of twenty-three requirement, therefore widening access. *All age guidance is based on the evidence of successful fertility treatment. The changes proposed will mean a positive impact.	
Disability (you may need to discern types)	The policy will have a positive impact on people who may have a disability as defined in the PSED / Equality Act 2010. This is because the policy has been designed so that fertility treatment is made available to those who have a medical condition and, or undergoing treatment that impacts on fertility. <u>Treatment for cancer or other procedures which affect fertility are considered thoroughly within the policy.</u> Cryopreservation of embryos, oocytes or semen is routinely commissioned before treatments or procedure (e.g. for cancer or other medically essential interventions such as a surgical procedure and/or administration of medication) which are known to affect fertility. This will be performed in accordance with the Human Fertilisation and Embryology Authority (HFEA) regulations and NICE guideline CG 156. Patients must satisfy the prevalent subfertility criteria when the time comes to use this stored material, and they must have been informed of this requirement before commencing cryopreservation. The cryopreserved material may be stored for 10 years or up to the female partner's 43rd birthday, whichever comes sooner. The ICB will ensure that communication needs are considered and factored into the Engagement and Consultation work.	No action
Gender reassignment	Eligibility for this treatment is that the patient must have a clinical reason for sub-fertility. Therefore, the policy is not inclusive for people who are proposing to undergo, or who are undergoing, or who have undergone gender reassignment. The policy is not clear, for example, where a male partner who has undergone gender realignment would be required to evidence subfertility if requesting fertility treatment	This is an interim policy in order to harmonise the number of IVF rounds. Revised guidance is expected 2025 so the wider issues within the policy will be reviewed in a separate project.

	(sperm donation) with a female partner. The policy needs to make clear the organisations position so that patients and staff have clear guidance. The proposed policy is an interim position because there is an expectation that NICE guidance will be reviewed and potentially could impact the stance the ICB propose on wider eligibility.	
Marriage and Civil Partnership	This group received protection under the Equality Act with regards to the main Equality Duty and it does not extend to service provision. The policy does not discriminate between marriage of either the opposite or same sex or Civil Partnerships. The policy does not have any criteria related to marital status and therefore this group is not a specific target for the Engagement and Consultation plan.	No action
Pregnancy and maternity	Key factors in the proposed policy regarding pregnancy and maternity include the storage periods and discontinuation of treatment after a live birth and the definition of childlessness. The Engagement and Consultation plan proposes to work with a range of groups including the Hewitt Fertility Centre. The HFC have also been represented on the working group.	Public consultation will take place once the ICB have approved an option, and comms will be provided to articulate the changes to the policy a part of this process.
Race	The working group considered the higher rates of Infant Mortality within the Black, Asian and other Ethnic groups. This factor was considered when agreeing that the proposed timescales for storage after a live birth would be 12 months. This is a positive impact. The policy proposal is - In accordance with the policy on “Childlessness”, the ICB will not fund storage of embryos and/or gametes following a live birth (or adoption of a child). However, the ICB will fund up to 12 months’ storage following the birth or adoption of a child to give the patient enough time to decide whether they wish	The ICB will ensure that cultural sensitivities and language needs are considered and factored into the Engagement and Consultation work.

	to self-fund, donate the stored material or consent to having any remaining gametes or embryos destroyed. However, the policy on “storage following a live birth” (above) also applies following a live birth (or adoption) and the patient is then permitted the 12 months’ period, beyond which NHS funding is no longer available.	
Religion and belief	Whilst there is a neutral impact in relation to the policy proposed, the ICB will ensure that religious and cultural sensitivities are considered and factored into the Engagement and Consultation work.	
Sex	The revision and harmonisation of the policy will result in a fairer, consistent, and clearer Subfertility policy across Cheshire and Merseyside. This will mean that couples accessing Fertility services will no longer be faced with disparity across the region. The policy has in the main been brought up to date with the best and latest guidance, NICE guidance CG 156. The harmonisation of the policy may mean that in some areas the number of cycles is increased, whilst in other areas they are reduced. This is unavoidable in ensuring equity. Both male and female patients will benefit from the clarity of position within the new policy. IVF Definition & Number of Cycles - The four policies are very similar but differ in terms of the number of cycles permitted. The definition of “IVF cycle” has been reviewed and is now more in line with NICE. The upper age limit has been increased to forty-three and the lower age limit of twenty-three has been removed. However, the ICB will need to agree its policy on the maximum number of permitted cycles which currently ranges from 1 to 3 cycles according to Place. For women aged <40, this option considers	Public engagement / consultation will take place once the ICB have approved progression of an option, and comms will be provided to articulate the changes to the policy a part of this process. This is an interim policy in order to harmonise the number of IVF rounds. Revised guidance is expected 2025 so the wider issues within the policy will be reviewed in a separate project.

	the maximum permitted cycles to be 1. The working group agreed that 1 or 2 cycles is appropriate. For information, over 90% of ICBs in England only permit two cycles (71% allow only one cycle). With regard to weight, the proposed policy now includes a statement that male partners with a BMI of over 30 should be informed that they are likely to have reduced fertility and should be encouraged to lose weight as this will improve their chances of a successful conception. Because this policy is the interim sub-fertility policy and eligibility is based on a clinical reason for sub-fertility, there is no change to provision for single sex couples therefore it may be that the policy disadvantages these patients as they have to self-fund some or all of the procedure.	
Sexual orientation	Because this policy is the interim sub-fertility policy and eligibility is based on a clinical reason for sub-fertility, there is no change to provision for single sex couples therefore it may be that the policy disadvantages these patients as they have to self-fund some or all of the procedure.	Public engagement / consultation will take place once the ICB have approved progression of an option, and comms will be provided to articulate the changes to the policy a part of this process
Whilst currently out of scope of Equality legislation it is also important to consider issues relating to socioeconomic status to ensure that any change proposal does not widen health inequalities. Socioeconomic status includes factors such as social exclusion and deprivation, including those associated with geographical distinctions (e.g. the North/South divide, urban versus rural). *Examples of groups to consider include:* *refugees and asylum seekers, migrant, unaccompanied child asylum seekers, looked-after children/ care leavers, homeless people, prisoners and young offenders, veterans, people who live in deprived areas, People living in remote, and rural locations.* *Health inclusion groups* *https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/what-are-healthcare-inequalities/inclusion-health-groups/* *For a more in-depth assessment of health inequalities please use the HEAT toolkit* https://www.gov.uk/government/publications/health-equity-assessment-tool-heat		

Refugees and asylum seekers	No impact	
Looked after children and care leavers	No impact	
Homelessness	No impact	
Worklessness	No impact	
People who live in deprived areas	No impact	
Carers	No impact	
Young carers	No impact	
People living in remote, rural and island locations	No impact	
People with poor literacy or health Literacy	No impact	
People involved in the criminal justice system: offenders in prison/on probation, ex-offenders.	No impact	
Sex workers	No impact	
People or families on a low income	If the patient does not have a successful live birth following a single IVF round, they would have to self-fund to try again. This may disadvantage those on a low income if they could not afford to self-fund as this may mean they cannot have a biological child.	Public engagement / consultation will take place once the ICB have approved progression of an option, and comms will be provided to articulate the changes to the policy a part of this process.
People with addictions and/or substance misuse issues	The proposed policy states that patients must demonstrate that their alcohol limits are within department of health guidelines and that they don't use recreational drugs. This is in line with both the existing Mersey policy and NICE guidance. Technically those patients who have addictions could be disadvantaged by this clause, however, there is a safeguarding aspect to children in this environment.	Public engagement / consultation will take place once the ICB have approved progression of an option, and comms will be provided to articulate the changes to the policy a part of this process.
SEND / LD	No impact	
Digital exclusion	No impact	

4. What data sources have you used and considered in developing the assessment?
There has been extensive research carried out in the development of this policy. The Communication and Engagement plan will further inform the policy development. The

policy has been written by a Public Health professional in conjunction with the Policy Harmonisation Steering Group and an Assisted Conception Working Group.

Key evidence includes the following:

- The main objectives of the Policy Harmonisation Group were to harmonise the policy positions across the region and to maintain consistency with the current NICE clinical guideline (CG 156) on fertility. The working group are aware that NICE are revising CG 156 which is due for publication in 2025. Because this represents a major revision, the ICB will review its policy again following publication of the revised CG 156.
  This policy has drawn on guidance issued by the Department of Health, Infertility Network UK and the NICE guidance (CG156) first published in February 2013 (updated in September 2017).
- https://fertilitynetworkuk.org/ & https://www.nice.org.uk/guidance/cg156/evidence/full-guideline-pdf-188539453https://www.nice.org.uk/guidance/cg156
- https://www.nice.org.uk/guidance/cg156/evidence/full-guideline-pdf-188539453 https://www.gov.uk/government/policies/reducing-drugs-misuse-and-dependence
- https://www.gov.uk/government/policies/reducing-harmful-drinking https://www.hfea.gov.uk/about-us/our-campaign-to-reduce-multiple-births/
- http://www.oneatatime.org.uk
- http://www.hfea.gov.uk/6195.html
- http://www.sexualhealthnetwork.co.uk/media/documents/HIV
- NHS cost recovery - overseas visitors - GOV.UK (www.gov.uk)

5. Involvement: consultation/ engagement

Guidance note: How have the groups and individuals been consulted with? What level of engagement took place? (If you have a consultation plan insert link or cut/paste highlights)

Once the options appraisal has been considered and a decision made on the number of IVF cycles, a public engagement / consultation exercise will be undertaken.

6. Have you identified any key gaps in service or potential risks that need to be mitigated

Guidance note: Ensure you have action for who will monitor progress.
Ensure smart action plan embeds recommendations and actions in Consultation, review, specification, inform provider, procurement activity, future consultation activity, inform other relevant organisations (NHS England, Local Authority).

This is an interim subfertility policy which aims to harmonise the C&M policies in line with NICE guidance and to harmonise the number of IVF cycles. There are other areas which are currently harmonised across C&M, and in line with guidance that haven't been addressed e.g. single sex assisted conception. Revised NICE guidance is expected in 2025 and the aim is to carry out a wider review at this time.

Risk	Required Action	By Who/ When
If the option of 1 IVF cycle round is approved, there is a risk of adverse publicity and a reputational risk for the ICB due to the reduction in access. This change	A public engagement exercise will be carried out and messaging will be particularly important.	Project Team supported by Comms

impacts 8 of the 9 Places so negative feedback is likely.	It is worth noting that our neighbouring ICBs in the main offer 1 cycle.	
If option of 1 IVF cycle is accepted, patients who rely on that second cycle of IVF to have a biological baby will not be eligible. Therefore, we would be disadvantaging these patients. Patients in all Places except Cheshire East would be impacted by this option.	A public engagement exercise will be carried out and messaging will be particularly important. It is worth noting that our neighbouring ICBs in the main offer 1 cycle.	Project Team supported by Comms
Planned activity data from 2024/2025 for Liverpool Women's Hospital (LWH) has been used to model the financial impact on the number of cycles offered, there is a risk that the data may not be 100% accurate as it is not patient identifiable – therefore is based on assumptions and averages.	This planned activity data has been modelled up to predict the number of IVF cycles and fertility treatments that LWH should complete in 2024/25.	Project Team

7. Is there evidence that the Public Sector Equality Duties will be met (give details) Section 149: Public Sector Equality Duty (review all objectives and relevant sub sections)
PSED Objective 1: Eliminate discrimination, victimisation, harassment and any unlawful conduct that is prohibited under this act: (check specifically sections 19, 20 and 29)
PSED Objective 2: Advance Equality of opportunity. (check Objective 2 subsection 3 below and consider section 4)
Analysis post consultation
PSED Objective 2: Section 3. sub-section a) remove or minimise disadvantages suffered by people who share a relevant protected characteristic that are connected to that characteristic.
Analysis post consultation

PSED Objective 2: Section 3. sub-section b) take steps to meet the needs of people who share a relevant protected characteristic that are different from the needs of people who do not share it
Analysis post consultation
PSED Objective 2: Section 3. sub-section c) encourage people who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such people is disproportionately low.
Analysis post consultation
PSED Objective 3: Foster good relations between persons who share a relevant protected characteristic and persons who do not share it. (consider whether this is engaged. If engaged consider how the project tackles prejudice and promotes understanding -between the protected characteristics)
Analysis post consultation
Health Inequalities: Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (s.14T);
[ENTER RESPONSE HERE]
PSED Section 2: Consider and make recommendation regards implementing PSED in to the commissioning process and service specification to any potential bidder/service provider (private/ public/charity sector)
Analysis post consultation
8. Recommendation to Board
Guidance Note: will PSED be met?
[ENTER RESPONSE HERE]
9. Actions that need to be taken
[ENTER RESPONSE HERE]

NHS Cheshire and Merseyside

QUALITY IMPACT ASSESSMENT

Project/Proposal Name	Unwarranted Variation Recovery Programme – Subfertility policy option 1 IVF round	Date of completion	06/05/2025
Programme Manager	Katie Bromley	Clinical Lead	Rowan Pritchard Jones

Background and overview of the proposals (can be copied from PID on Verto or from National/Regional commissioning guidance)

The Subfertility policy was included in the scope of the Clinical Policy Harmonisation programme, as currently each Place has its own policy and there is variation in access to these services across Cheshire and Merseyside. The Clinical Policy Harmonisation programme used an evidence-based approach to develop harmonised policies. There is currently disparity across Cheshire and Merseyside on the number of IVF rounds offered as part of the sub-fertility policies:
1 cycle - Cheshire East
2 cycles – Liverpool, St Helens, Wirral, Cheshire West
3 cycles – Warrington, Southport & Formby, South Sefton, Halton, Knowsley
The clinical policy harmonisation programme undertook an exercise to harmonise the number of cycles and a working group was set up to work through this. The working group proposed 1 or 2 cycles, an options appraisal is being undertaken to explore offering patients either 1 or 2 cycles of IVF.

Whilst NICE specifies 3 cycles should be offered, their Health Economics analysis describes the effectiveness of each cycle with regard to cumulative live birth rates and shows that whilst the chances of having a live birth increase with each cycle, the effectiveness and cost effectiveness of each cycle is reduced. For a woman aged 34, the birth rates for each cycle are estimated: 1 cycle: 30%, 2 cycles: 15%, 3 cycles 10%.
In addition, research shows that 73% of those ICBs that have already harmonised their position will fund only 1 cycle and 19% currently fund 2 cycles with <10% funding the full 3 cycles as recommended by NICE.

It is worth noting that our neighbouring ICBs offer the following:

- Lancashire and South Cumbria offer 1 IVF cycle.
- Greater Manchester currently under review.
- West Yorkshire offer 1 IVF cycle.
- Staffordshire and Stoke-on-Trent offer 1 IVF cycle.

Data from our provider Liverpool Women's Hospital shows that the average number of cycles that patients are currently having is 1.36 cycles (this was based on reviewing patient outcomes for patients receiving 2 and 3 IVF cycles over a 5 year period who did not have a live birth after the first cycle), therefore offering patients 2 cycles of IVF would enable the majority of our patients to achieve a successful outcome.

However, there is a requirement for the ICB to review its costs and use of resources, and therefore the option of reducing the offer to 1 cycle has been modelled and offers a potential saving of £1.3m.

To develop a harmonised policy, a decision needs to be made on the number of IVF cycles that patients are offered. An options appraisal is being undertaken to explore offering patients either 1 or 2 cycles. This QIA considers the impact of a 1 IVF cycle policy.

There are a number of other changes that have been made to bring the policy in line with NICE guidance e.g. minimum age, smoking status, weight requirements, definition of childness and right to a family definitions, which are documented in the corresponding EIA but where appropriate are called out in this document.

Reason For Change/Proposal

Currently C&M ICB has an unharmonised position with regard to the number of IVF cycles offered. A 2-cycle option is clinically recommended; however, a 1 cycle approach has been modelled due to our current financial situation and this reduction would offer savings.

This option would mean reducing the offer in 8 Places, who all currently offer either 2 or 3 cycles. Only Cheshire East patients would not be affected by this option as they are already entitled to 1 cycle, this option would result in estimated savings of £1.3m per year.

Who is likely to be Impacted?	Public	X	Patients	X	Workforce		Other parts of the system	X
Please provide additional details, including scale	671 per year (2019 data)						
Who has been consulted with as part of the QIA development	There has been no formal consultation, a request to Board in May 25 is being made to request permission to progress a public consultation, however, the Obs & Gynae Clinical Network and Liverpool Women's Hospital Clinical, Operational and Finance Teams have all be involved in reviewing the options, proposed policy and supporting with activity and finance modelling.						
Financial Considerations	Current Costs		£5,043,081 per year		Proposed Costs		£3,727,350 per year

Place/Local Sign off:						
Sign off group	Stage 2 QIA Panel	Date of meeting	12/05/25	Post mitigation risk score *(Likelihood x Consequence)*	Safety	3
					Effectiveness	12
					Experience	16
					Workforce/system	15

Has an EIA been completed?	Y	Has a DPIA been completed?	Y – full DPIA not required	Have identified risks been added to risk register?	N

Risk scores above 12 in any area of quality, including patient safety, clinical effectiveness or experience will be taken to QIA panel and must be included within the corporate risk register.

Patient safety						
Will the project or proposal impact on patient safety?	Positive impact Improved patient safety, such as reducing the risk of adverse events is anticipated	Neutral Impact May have an adverse impact on patient safety. Mitigation is in place or planned to mitigate this impact to acceptable levels	Negative impact Increased risk to patient safety. Further mitigation needs to be put in place to manage risk to acceptable level	Pre-mitigation Identified Risk Score (Prior to Mitigations)		
				L	C	Total L x C
Please consider… • Will this impact on the organisation's duty to protect children, young people and adults? • Impact on patient safety? • Impact on preventable harm? • Will it affect the reliability of safety systems? N/A • How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections to patients is reduced? N/A	There is no additional impact on adults and children at risk, however, the inclusion of males in the smoking and drug and alcohol intake criteria for Merseyside patients would have a positive impact on the child. If non-compliance evidence is found this could trigger a pause in treatment with possible referral for a welfare of the child assessment and/or further information sought from the GP. This is a positive impact on all patients including welfare of the child. The proposed policy is that both partners should be confirmed non-smokers due to the harmful impact nicotine	The proposals regarding the number of IVF cycles doesn't impact the risk of harm. If implemented the policy would impact patients positively as it would eliminate inequity across C&M.	For those patients who currently receive 2 or 3 cycles there may be an impact on their mental health if they were relying on NHS funded cycles to have a family, but aren't successful during the first cycle.	3	1	3

	has on fertility and foetal development. Likewise, the proposed policy on drug and alcohol intake applies to both partners as in the current Cheshire policy not just the partner undergoing treatment as in the current Mersey policy. This is a positive impact on all patients including welfare of the child.					

Mitigations					
Action	**Owner**	**Expected date of completion**	**Date completed**		
No specific mitigating actions identified for this section					
A comms and engagement approach would be developed to explain the rationale for the decision.	Katie Bromley	tbc			
		Post Mitigation Risk Score	3	1	3

Clinical Effectiveness	
Please confirm how the project uses the best, knowledge based, research	The proposed interim subfertility policy has, where possible, been developed using the latest NG156 NICE guidance and input from local expertise and knowledge. With regard to IVF cycles, it should be noted that NICE guidance (NG156) suggests 3 IVF cycles, however, this has been in place for over 10 years and processes are much improved. NICE Health Economics analysis describes the effectiveness of each cycle with regard to cumulative live birth rates and shows that whilst the chances of having a live birth increase with each cycle, the

	effectiveness and cost effectiveness of each cycle is reduced. For a woman aged 34, the birth rates for each cycle are estimated: 1 cycle: 30%, 2 cycles: 15%, 3 cycles 10%. The Working Group who helped develop the harmonised policy comprised fertility & GP clinicians who supported the review of number of IVF rounds based on this, however, 1 cycle is not an option that is supported clinically. C&M data shows that the average number of cycles is 1.36, with an average of 1.88 subsequent Frozen embryo transfers. For those patients who do not have a successful pregnancy after the first IVF round, there is an opportunity to learn from this and change the approach for the 2nd to increase the risks of success. If the ICB were to offer 1 cycle of IVF, this would remove this opportunity for those patients.					
Will the project or proposal impact on Clinical effectiveness?	**Positive impact** Clinical effectiveness will be improved resulting in better outcomes anticipated for patients	**Neutral Impact** May have an adverse impact on clinical effectiveness. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	**Negative impact** Significant reduction in clinical effectiveness. Further mitigation needs to be put in place to manage risk to acceptable level	Identified Risk Score (Prior to Mitigations)		
				L	C	Total L x C
Please consider… • How does it impact on implementation of evidence based practice? • How will it impact on clinical leadership N/A • Does it reduce/impact on variation in care provision? • Does it affect supporting people to stay well? N/A • Does it promote self-care for people with long term conditions? N/A • Does it impact on ensuring that care is delivered in the most clinically and cost effecting setting? N/A • Does it eliminate inefficiency and waste by design? N/A • Does it lead to improvements in care pathways? N/A	Where possible, the harmonised policy has been brought in line with NICE guidance. The harmonisation of policy in regard to childlessness, weight, smoking and drugs and alcohol intake and approach to Intra-Uterine Insemination (IUI) and ovarian reserve testing should support more patients to be successful in treatment. Outcomes will be monitored in the same way as they are now.	There would be no change to number of cycles for Cheshire East patients. There is a risk that for those patients are not successful in the first IVF cycle, would be disadvantaged by not being able to try a different approach in the second cycle.	The C&M Clinical Network do not support a 1 cycle option. The clinically supported option would be to offer 2 cycles of IVF; however, this QIA considers the impact of 1 cycle. NICE guidance NG156 advises that 3 cycles should be offered. However, C&M data suggests that the numbers of patients requiring 3 cycles is minimal with the average number of cycles being 1.36. Therefore a 1 cycle option is difficult to provide a clinical evidence base for, however, this proposal	3	4	12

	The subfertility policy has been developed with a MDT working group that consisted of Local Fertility Specialists, GPs, Healthwatch, Commissioners who helped to shape the policy. The working group recommended 1 or 2 cycles of IVF. The policy has been shared with the relevant clinical networks who were supportive of the alignment to NICE guidance across the whole of C&M and supported the "interim" approach whilst waiting for revised NICE guidance to ensure new policy positions are developed using all evidence.		would bring NHS C&M in line with over 70% of the ICBs who have already harmonised their policies (4 others have yet to do so). NICE health economics analysis describes that the effectiveness of each cycle with regard to cumulative live birth rate is reduced with each cycle (although there is still a greater chance of a live birth). For an average 34 year old, the 1st cycle is c 30% effective, the 2nd cycle is c 15% and the 3rd cycle is less than 10%.			

Mitigations					
Action	**Owner**	**Expected date of completion**	**Date completed**		
There are no mitigating actions specific to this criteria					
		Post Mitigation Risk Score	3	4	12

Patient Experience				
	Positive impact	Neutral Impact	Negative impact	Identified Risk Score (Prior to Mitigations)

Will the project or proposal impact on patient experience?	Improved patient and carer experience anticipated	May have an adverse impact on patient and carer experience. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	Significant reduction in patient and carer experience. Further mitigation needs to be put in place to manage risk to acceptable levels	L	C	Total L x C
Please consider… • What is the impact on protected characteristics, such as race, gender, age, disability, sexual orientation, religion and belief for individual and community health, access to services and experience? • What impact is it likely to have on self-reported experience of patients and service users? (Responses to national/local surveys/complaints/PALS/incidents) • How will it impact on the choice agenda? N/A • How will it impact on the compassionate and personalised care agenda? N/A • How might it impact on access to care or treatment? N/A	The proposed harmonised policy will ensure that patients have equal access to subfertility treatments in Cheshire and Merseyside. It will remove the current variation in the number of IVF cycles offered. The proposed harmonised policy would have a positive impact on patients younger than 23 years who want to start treatment as this minimum age has been removed as per NICE guidance. Women aged 42 are included in the policy in line with NICE guidance – previously the cut off was up to 42nd birthday. The current Mersey position on IUI / Donor Insemination (DI) has been introduced to Cheshire (clarification to number of cycles required before IVF) and Wirral (not routinely commissioned) however, activity for these treatments is minimal.	With regard to IVF cycles, a 1 cycle approach would have a neutral impact on Cheshire East patients as their offer would be in line with all other Places. Definitions of childlessness and right to a family have been clarified, however, this doesn't change the policy position except in Cheshire where previously patients were able to continue to use any remaining eggs following a live birth. The Department of Health (DoH) position on Overseas Visitors is now included in the proposed policy statement, however, this is not a change to process as it reflects the existing rules.	With regard to IVF cycles, a 1 cycle approach would negatively impact those patients who would have had a second or third attempt at IVF. They will have a worsened patient experience if they are unsuccessful in their first cycle particularly if they are unable to self-fund further cycles, they will be unable to have a biological family. • Patients in Knowsley, Halton, South Sefton, Southport & Formby & Warrington who currently are eligible for 3 cycles. • Patients in Liverpool, St Helens, Cheshire West and Wirral currently eligible for 2 cycles. The likelihood of PALS and complaints are expected to increase in these Places if the offer is reduced.	4	4	16

			With regard to the definition of childlessness, the current Cheshire policy implies that even if a patient had a live birth or adopted a child, they could continue with using all frozen embryos. This was not aligned across C&M and is not usual practice, so this has been removed, therefore these patients could feel disadvantaged. Because the status of male partners with regard to smoking & alcohol and drug use has an impact on eligibility in the proposed policy, treatment will only be provided if both partners comply with the requirements. This cohort could feel disadvantaged by this revised approach; however, the smoking requirement follows NICE CG156: “smoking can adversely affect fertility and the success rates of assisted reproductive techniques (in both men and women).” And the drugs and alcohol are based on evidence that			

			alcohol and recreational drugs reduce the chance of conception in both men and women.			

Mitigations					
Action	**Owner**	**Expected date of completion**	**Date completed**		
A comms and engagement approach would be developed to explain the rationale for the decision.	K Bromley / Olivia Billington	Tbc			
		Post Mitigation Risk Score	4	4	16

Workforce/System						
Will the project or proposal impact on the workforce or system delivery?	Positive impact Improved patient and carer experience anticipated	Neutral Impact May have an adverse impact on patient and carer experience. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	Negative impact Significant reduction in patient and carer experience. Further mitigation needs to be put in place to manage risk to acceptable levels	Identified Risk Score (Prior to Mitigations)		
				L	C	Total L x C

Please consider… • Capacity and demand on services • Changes in roles N/A • Training requirements • Staff experience & morale • Redundancies N/A • Opportunities (including staff development) N/A • Impact on other parts of the system, including changes in pathways or access N/A • Increased demand • Financial stability • Safety N/A	The relaunch of the revised policy would require strong communications with the provider in order to ensure any new elements were understood and implemented correctly.	The move to 1 cycle would negatively impact demand at our provider Liverpool Women's (LWH) as their current plans contain greater activity than is needed to deliver activity for 1 cycle.	It is likely that moving to 1 cycle will have a negative impact on staff experience and morale for those working in our Provider organisation as they were supportive of the 2 cycle option. LWH have confirmed that reducing to 1 cycle would have a detrimental financial impact of between £1m and £1.5m and whilst they can identify some productivity improvements, it won't mitigate this financial loss.	5	3	15

Mitigations					
Action	**Owner**	**Expected date of completion**	**Date completed**		
Discussions will be had with LWH to advise of the proposal	Katie Bromley	12/05/25			
		Post Mitigation Risk Score	5	3	15

Summary

Decision made	Pre Mitigated Score	Mitigated score	Impact
Progress	16	16	Catastrophic
Not progress	6	4	Moderate
Score summary (add to front page)			
Negligible and Low risk	Moderate risk	Major risk	Catastrophic risk
1-3	4 - 7	8 - 12	13 - 25

- The 'progressed' risk scores are applicable if the 1 cycle option is approved. The 'not progressed' risk scores are applicable if the 2 cycle option is approved. In line with the ICB Risk Management Strategy, an ICB wide risk score for a risk-in-common should mirror that of the highest domain risk score.

Risk Impact Score Guidance

LEVEL	DESCRIPTOR	DESCRIPTION – ICB LEVEL
5	Catastrophic (>75%)	**Safety** - multiple deaths due to fault of ICB OR multiple permanent injuries or irreversible health effects OR an event affecting >50 people. **Quality** – totally unacceptable quality of clinical care OR gross failure to meet national standards. **Health Outcomes & Inequalities** – major reduction in health outcomes and/or life expectancy OR major increase in health inequality gap in deprived areas or socially excluded groups **Finance** – major financial loss - >1% of ICB budget OR 5% of delegated place budget **Reputation** – special measures, sustained adverse national media (3 days+), significant adverse public reaction / loss of public confidence major impact on trust and confidence of stakeholders
4	Major (50% > 75%)	**Safety** - individual death / permanent injury/ disability due to fault of ICB OR 14 days off work OR an event affecting 16 – 50 people. **Quality** – major effect on quality of clinical care OR non-compliance with national standards posing significant risk to patients.

		Health Outcomes & Inequalities – significant reduction in health outcomes and/or life expectancy OR significant increase in health inequality gap in deprived areas or socially excluded groups **Finance** - significant financial loss of 0.5-1% of ICB budget OR 2.5-5% of delegated place budget **Reputation** - criticism or intervention by NHSE/I, litigation, adverse national media, adverse public significant impact on trust and confidence of stakeholders
3	**Moderate (25% > - 50%)**	**Safety** - moderate injury or illness, requiring medical treatment e.g., fracture due to fault of ICB. RIDDOR/Agency reportable incident (4-14 days lost). **Quality** – significant effect on quality of clinical care OR repeated failure to meet standards **Health Outcomes & Inequalities** – moderate reduction in health outcomes and/or life expectancy OR moderate increase in health inequality gap in deprived areas or socially excluded groups **Finance** - moderate financial loss - less than 0.5% of ICB budget OR less than 2.5% of delegated place budget **Reputation** - conditions imposed by NHSE/I, litigation, local media coverage, patient and partner complaints & dissatisfaction moderate impact on trust and confidence of stakeholders
2	**Minor (<25%)**	**Safety** - minor injury or illness requiring first aid treatment **Quality** – noticeable effect on quality of clinical care OR single failure to meet standards **Health Outcomes & Inequalities** – minor reduction in health outcomes and/or life expectancy OR minor increase in health inequality gap in deprived areas or socially excluded groups **Finance** - minor financial loss less than 0.2% of ICB budget OR less than 1% of delegated place budget **Reputation** - some criticism slight possibility of complaint or litigation but minimum impact on ICB minor impact on trust and confidence of stakeholders
1	**Negligible (<5%)**	**Safety** - none or insignificant injury due to fault of ICB **Quality** – negligible effect on quality of clinical care **Health Outcomes & Inequalities** – marginal reduction in health outcomes and/or life expectancy OR marginal increase in health inequality gap in deprived areas or socially excluded groups

	Finance - no financial or very minor loss **Reputation** - no impact or loss of external reputation

The likelihood of the risk occurring must then be measured. Table 2 below should be used to assess the likelihood and obtain a likelihood score. When assessing the likelihood, it is important to take into consideration the existing controls (i.e. mitigating factors that may prevent the risk occurring) already in place.

Table 2 - Risk Likelihood Score Guidance

1	2	3	4	5
Rare The event could only occur in exceptional circumstances (<5%)	**Unlikely** The event could occur at some time (<25%)	**Possible** The event may well occur at some time (25%> -50%)	**Likely** The event will occur in most circumstances (50% > 75%)	**Almost certain** The event is almost certain to occur (>75%)

The impact and likelihood scores must then be multiplied and plotted on table 3 to establish the overall level of risk and necessary action.

Table 3 - Risk Assessment Matrix (level of risk)

LIKELIHOOD of risk being realised	**IMPACT (severity)** of risk being realised				
	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)	1	2	3	4	5
Unlikely (2)	2	4	6	8	10
Possible (3)	3	6	9	12	15
Likely (4)	4	8	12	16	20
Almost Certain (5)	5	10	15	20	25

Low Risk	Moderate Risk	High Risk	Extreme Risk	Critical Risk

Risk Proximity

A further element to be considered in the risk assessment process is risk proximity. Risk proximity provides an estimate of the timescale as to when the risk is likely to materialise. It supports the ability to prioritise risks and informs the appropriate response in the monitoring of controls and development of actions.

A pragmatic approach to the use of risk proximity which supports leadership, decision making and reporting is used and is therefore determined to be applied to all Risks.

The proximity scale used is below:

Proximity and timescale for dealing with the risk	Within the current quarter	Within the financial year	Beyond the financial year
Rating	**A**	**B**	**C**

Likelihood, impact and proximity are dynamic elements and consequently all three must be reviewed and reassessed frequently in order to prioritise the response.

Sign off process			
Name	Role	Signature	Date
Olivia Billington	Project lead	Olivia Billington	06/05/25
Rowan Pritchard Jones	Clinical lead		
Katie Bromley	Programme manager	Katie Bromley	06/05/25
	PMO lead		
Once signed off by all above, then the QIA is submitted via qia@cheshireandmerseyside.nhs.uk **to QIA review group**			

PMO receipt					
Verto/PMO reference	N/A	Date QIA reviewed PMO		Reviewed by	

This section to be completed following review at the QIA review group				
Meeting Chair	Date of Meeting	Approved	Rejected	Comments/feedback
Chris Douglas	12.05.2025	14.05.25		Recommendations made for amendments to QIA for panel to be reconsidered at a later date: 1) Psychological impact to the patient to be articulated in patient safety domain 2) Negative impact on clinical effectiveness is to be reworded and centred on evidence 3) Further work to be undertaken on the system/workforce domain 4) Clarification of scores across all domains required

NHS
Cheshire and Merseyside

Appendix 1.4

Equality Analysis Report
(Equality Impact Assessment)

Pre-Consultation *(Use the same form but delete as applicable. If it is post-consultation it needs to include consultation feedback and results)*

C&M Wide

Start Date:	21/08/2024	
Equality and Inclusion Service Signature and Date:		
Sign off should be in line with the relevant ICB's Operational Scheme of Delegation (*amend below as appropriate)		
***Place/ ICB Officer Signature and Date:**		
***Finish Date:**		
***Senior Manager Sign Off Signature and Date**		
***Committee Date:**		

1. Details of current service, function or policy:

Guidance Notes: Clearly identify the function & give details of relevant service provision and or commissioning milestones (review, specification change, consultation, procurement) and timescales.

This change concerns the number of IVF cycles within a harmonised subfertility policy.

There is currently disparity across Cheshire and Merseyside on the number of IVF cycles offered as part of the subfertility policies:

1 cycle - Cheshire East

2 cycles – Liverpool, St Helens, Wirral, Cheshire West

3 cycles – Warrington, Southport & Formby, South Sefton, Halton, Knowsley

The clinical policy harmonisation programme undertook an exercise to harmonise the number of cycles, and a working group set up to work through this. The working group proposed either 1 or 2 cycles. Our data shows that the average number of cycles patients are currently having is 1.36 cycles. Following creation of the recovery programme, the review had to consider costing up both 1 and 2 cycles.

This EIA considers the impact of 2 IVF cycles.

What is the **legitimate aim** of the service change / redesign
For example

- Demographic needs and changing patient needs are changing because of an ageing population.
- To increase choice of patients
- Value for Money-more efficient service
- Public feedback/ Consultation shows need/ no need for a service
- Outside commissioning remit of ICB/NHS

- To ensure a harmonised approach across Cheshire and Merseyside for the number of IVF cycles offered within the subfertility policy.
- To ensure the ICB have had the opportunity to consider the risk and impact of reducing the number of IVF cycles to 2 across Cheshire and Merseyside, as currently some Places offer 3 cycles.

2. Proposed change service, function or policy

Guidance Note: Describe the proposed changes. (New service, change to service specification or service delivery, change to policy / practice).

To harmonise the number of IVF cycles across C&M – see above for current offer.

This EIA considers allowing for patients to have 2 cycles of IVF.

Other policy positions have been updated to reflect NICE guidance to bring the policy in line with the latest evidence base, this has been covered in the EIA for 1 IVF cycle.

3. Barriers relevant to the protected characteristics

Guidance note: describe where there are potential disadvantages.

[ENTER RESPONSE HERE]

[COMPLETE DIFFERENTIAL MATRIX]

Protected Characteristic	Issue	Remedy/Mitigation
Age	• The minimum age (23 years) has been removed as NICE no longer supports this. • "Before the woman's 42nd birthday" has been changed to "before the woman's 43rd birthday" because this is consistent with NICE. NICE withdrew the recommendation for minimum age (23 years) in 2004, together with the increase of the upper age limit to forty-three. • Some narrative has been changed to improve clarity and accuracy. • Overall, this will result in a positive impact due to clarity and NICE	No action as this brings the policy in line with NICE guidance. This is a positive impact for patients and will increase the eligibility criteria for those patients under 23 and those over 42.

	evidence-based age guidelines, including the removal of the minimum age of twenty-three requirement, therefore widening access. *All age guidance is based on the evidence of successful fertility treatment. The changes proposed will mean a positive impact.	
Disability (you may need to discern types)	The policy will have a positive impact on people who may have a disability as defined in the PSED / Equality Act 2010. This is because the policy has been designed so that fertility treatment is made available to those who have a medical condition and or undergoing treatment that impacts on fertility. Treatment for cancer or other procedures which affect fertility are considered thoroughly within the policy. Cryopreservation of embryos, oocytes or semen is routinely commissioned before treatments or procedure (e.g. for cancer or other medically essential interventions such as a surgical procedure and/or administration of medication) which are known to affect fertility. This will be performed in accordance with the Human Fertilisation and Embryology Authority (HFEA) regulations and NICE guideline CG 156. Patients must satisfy the prevalent subfertility criteria when the time comes to use this stored material, and they must have been informed of this requirement before commencing cryopreservation. The cryopreserved material may be stored for 10 years or up to the female partner's 43rd birthday, whichever comes sooner. The ICB will ensure that communication needs are considered and factored into the Engagement and Consultation work.	No action
Gender reassignment	Eligibility for this treatment is that the patient must have a clinical reason for sub-fertility. Therefore, the policy is not inclusive for people who are proposing to undergo, or who are undergoing, or who have undergone gender reassignment. The policy is not clear, for example, where a male partner who has undergone gender realignment would be required to evidence subfertility if requesting fertility treatment	This is an interim policy in order to harmonise the number of IVF rounds. Revised guidance is expected in 2025 so the wider issues within the policy will be reviewed in a separate project.

	(sperm donation) with a female partner. The policy needs to make clear the organisations position so that patients and staff have clear guidance. The proposed policy is an interim position because there is an expectation that NICE guidance will be reviewed and potentially could impact the stance the ICB propose on wider eligibility.	
Marriage and Civil Partnership	This group received protection under the Equality Act with regards to the main Equality Duty and it does not extend to service provision. The policy does not discriminate between marriage of either the opposite or same sex or Civil Partnerships. The policy does not have any criteria related to marital status and therefore this group is not a specific target for the Engagement and Consultation plan.	No action
Pregnancy and maternity	Key factors in the proposed policy regarding pregnancy and maternity include the storage periods and discontinuation of treatment after a live birth and the definition of childlessness. The Engagement and Consultation plan proposes to work with a range of groups including the Hewitt Fertility Centre (HFC). The HFC have also been represented on the working group.	Public engagement / consultation will take place once the ICB have approved an option, and comms will be provided to articulate the changes to the policy a part of this process.
Race	The working group considered the higher rates of Infant Mortality within the Black, Asian and other Ethnic groups. This factor was considered when agreeing that the proposed timescales for storage after a live birth would be 12 months. This is a positive impact. The policy proposal is - In accordance with the policy on “Childlessness”, the ICB will not fund storage of embryos and/or gametes following a live birth (or adoption of a child). However, the ICB will fund up to 12 months’ storage following the birth or adoption of a child to give the patient enough time to decide whether they wish to self-fund, donate the stored material or	The ICB will ensure that cultural sensitivities and language needs are considered and factored into the Engagement and Consultation work.

	consent to having any remaining gametes or embryos destroyed. However, the policy on “storage following a live birth” (above) also applies following a live birth (or adoption) and the patient is then permitted the 12 months’ period, beyond which NHS funding is no longer available.	
Religion and belief	Whilst there is a neutral impact in relation to the policy proposed, the ICB will ensure that religious and cultural sensitivities are considered and factored into the Engagement and Consultation work.	
Sex	The revision and harmonisation of the policy will result in a fairer, consistent, and clearer subfertility policy across Cheshire and Merseyside. This will mean that couples accessing fertility services will no longer be faced with disparity across Cheshire and Merseyside. The policy has in the main been brought up to date with the best and latest guidance, NICE guidance CG 156. The harmonisation of the policy may mean that in some areas the number of cycles is increased, whilst in other areas they are reduced. This is unavoidable in ensuring equity. Both male and female patients will benefit from the clarity of position within the new policy. IVF Definition & Number of Cycles - The four policies are very similar but differ in terms of the number of cycles permitted. The definition of “IVF cycle” has been reviewed and is now more in line with NICE. The upper age limit has been increased to forty-three and the lower age limit of twenty-three has been removed. However, the ICB will need to agree its policy on the maximum number of permitted cycles which currently ranges from 1 to 3 cycles according to Place. For women aged <40, this option considers the maximum permitted cycles to be 1. The working group agreed that 1 or 2 cycles is appropriate. For information, over 90% of ICBs in England only permit two cycles (71% allow only one cycle). With regard to weight, the proposed policy now includes a statement that male	Public engagement / consultation will take place once the ICB have approved an option, and comms will be provided to articulate the changes to the policy a part of this process. This is an interim policy in order to harmonise the number of IVF rounds. Revised guidance is expected 2025 so the wider issues within the policy will be reviewed in a separate project.

	partners with a BMI of over 30 should be informed that they are likely to have reduced fertility and should be encouraged to lose weight as this will improve their chances of a successful conception. Because this policy is the interim sub-fertility policy and eligibility is based on a clinical reason for sub-fertility, there is no change to provision for single sex couples therefore it may be that the policy disadvantages these patients as they have to self-fund some or all of the procedure.	
Sexual orientation	Because this policy is the interim sub-fertility policy and eligibility is based on a clinical reason for sub-fertility, there is no change to provision for single sex couples therefore it may be that the policy disadvantages these patients as they have to self-fund some or all of the procedure.	Public engagement / consultation will take place once the ICB has approved an option, and a communication will be provided to articulate the changes to the policy a part of this process.
Whilst currently out of scope of Equality legislation it is also important to consider issues relating to socioeconomic status to ensure that any change proposal does not widen health inequalities. Socioeconomic status includes factors such as social exclusion and deprivation, including those associated with geographical distinctions (e.g. North/South divide, urban versus rural). *Examples of groups to consider include:* *refugees and asylum seekers, migrants, armed forces community, unaccompanied child asylum seekers, looked-after children, homeless people, prisoners and young offenders.* ***The Health Equity Assessment Tool (HEAT) can also be used as a tool to systematically address health inequalities to a programme of work and identify what action can be taken to reduce health inequalities.*** ***https://www.gov.uk/government/publications/health-equity-assessment-tool-heat***		
Refugees and asylum seekers	No impact	
Looked after children and care leavers	No impact	
Homelessness	No impact	
Worklessness	No impact	
People who live in deprived areas	No impact	
Carers	No impact	
Young carers	No impact	

People living in remote, rural and island locations	No impact	
People with poor literacy or health Literacy	No impact	
People involved in the criminal justice system: offenders in prison/on probation, ex-offenders.	No impact	
Sex workers	No impact	
People or families on a low income	An option of 2 cycles is more inclusive to those patients on low income. If the patient does not have a successful live birth following the first IVF round, they would have a second chance under a 2-cycle policy. C&M data shows that the average number of cycles needed is 1.36 so this option would be not disadvantage those on a low income.	Public engagement / consultation will take place once the ICB has approved an option, and communications will be provided to articulate the changes to the policy a part of this process.
People with addictions and/or substance misuse issues	The proposed policy states that patients must demonstrate that their alcohol limits are within department of health guidelines and that they don't use recreational drugs. This is in line with both the existing Mersey policy and NICE guidance. Technically those patients who have addictions could be disadvantaged by this clause, however, there is a safeguarding aspect to children in this environment.	Public engagement / consultation will take place once the ICB have approved an option, and communications will be provided to articulate the changes to the policy a part of this process.
SEND / LD	No impact	
Digital exclusion	No impact	

4. What data sources have you used and considered in developing the assessment?
There has been extensive research carried out in the development of this policy. The communication and engagement plan will further inform the policy development. The policy has been written by a Public Health professional in conjunction with the clinical policy harmonisation steering group and an assisted conception working group. Key evidence includes the following: • The main objectives of the policy harmonisation group were to harmonise the policy positions across the region and to maintain consistency with the current NICE clinical guideline (CG 156) on fertility. The working group are aware that NICE are revising CG 156 which is due for publication in 2025. Because this represents a major revision, the ICB will review its policy again following publication of the revised CG 156.

This policy has drawn on guidance issued by the Department of Health, Infertility Network UK and the NICE guidance (CG156) first published in February 2013 (updated in September 2017). • https://fertilitynetworkuk.org/ & https://www.nice.org.uk/guidance/cg156/evidence/full-guideline-pdf-188539453https://www.nice.org.uk/guidance/cg156 • https://www.nice.org.uk/guidance/cg156/evidence/full-guideline-pdf-188539453 https://www.gov.uk/government/policies/reducing-drugs-misuse-and-dependence • https://www.gov.uk/government/policies/reducing-harmful-drinking https://www.hfea.gov.uk/about-us/our-campaign-to-reduce-multiple-births/ • http://www.oneatatime.org.uk • http://www.hfea.gov.uk/6195.html • http://www.sexualhealthnetwork.co.uk/media/documents/HIV • NHS cost recovery - overseas visitors - GOV.UK (www.gov.uk)
5. Engagement / Consultation
Guidance note: How have the groups and individuals been engaged or consulted with? What level of engagement took place? (If you have a consultation plan insert link or cut/paste highlights)
Once the options appraisal has been considered and a decision made on the number of IVF cycles, a public engagement / consultation exercise will be undertaken.
6. Have you identified any key gaps in service or potential risks that need to be mitigated
Guidance note: Ensure you have action for who will monitor progress. Ensure smart action plan embeds recommendations and actions in Consultation, review, specification, inform provider, procurement activity, future consultation activity, inform other relevant organisations (NHS England, Local Authority).
This is an interim subfertility policy which aims to harmonise the C&M policies in line with NICE guidance and to harmonise the number of IVF rounds. There are other areas which are currently harmonised across C&M, and in line with guidance that haven't been addressed e.g. single sex assisted conception. Revised NICE guidance is expected in 2025 and the aim is to carry out a wider review at this time.

Risk	Required Action	By Who/ When
If the option of 1 cycle of IVF is approved, there is a risk of adverse publicity and a reputational risk for the ICB due to a reduction in access. This would impact 8 of the 9 places, so negative feedback is likely.	A public engagement exercise will be carried out and messaging will be particularly important. It is worth noting that our neighbouring ICBs in the main offer 1 cycle.	Project team supported by Comms

If the ICB reduces the number of IVF cycles to 2, patients who rely on that third cycle of IVF to have a baby will not be eligible. This will affect patients in Knowsley, Halton, Warrington, Southport & Formby and South Sefton. Therefore, we would be disadvantaging these patients.	A public engagement exercise will be carried out and messaging will be particularly important. It is worth noting that our neighbouring ICBs in the main offer 1 cycle.	Project team supported by Comms
Planned activity data from 2024/2025 for Liverpool Women's Hospital (LWH) has been used to model the financial impact of the number of cycles offered, there is a risk that the data may not be 100% accurate as it is not patient identifiable – therefore is based on assumptions and averages.	This planned activity data has been modelled up to predict the number of IVF cycles and fertility treatments that LWH should complete in 2024/25.	Project team

7. Is there evidence that the Public Sector Equality Duties will be met (give details) Section 149: Public Sector Equality Duty (review all objectives and relevant sub sections)
PSED Objective 1: Eliminate discrimination, victimisation, harassment and any unlawful conduct that is prohibited under this act: (check specifically sections 19, 20 and 29)
Analysis post consultation
PSED Objective 2: Advance Equality of opportunity. (check Objective 2 subsection 3 below and consider section 4)
Analysis post consultation
PSED Objective 2: Section 3. sub-section a) remove or minimise disadvantages suffered by people who share a relevant protected characteristic that are connected to that characteristic.
Analysis post consultation

PSED Objective 2: Section 3. sub-section b) take steps to meet the needs of people who share a relevant protected characteristic that are different from the needs of people who do not share it
Analysis post consultation
PSED Objective 2: Section 3. sub-section c) encourage people who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such people is disproportionately low.
Analysis post consultation
PSED Objective 3: Foster good relations between persons who share a relevant protected characteristic and persons who do not share it. (consider whether this is engaged. If engaged consider how the project tackles prejudice and promotes understanding -between the protected characteristics)
Analysis post consultation
PSED Section 2: Consider and make recommendation regards implementing PSED in to the commissioning process and service specification to any potential bidder/service provider (private/ public/charity sector)
Analysis post consultation
Health Inequalities: Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (s.14T);
[ENTER RESPONSE HERE]
8. Recommendation to Board
Guidance Note: will PSED be met?
[ENTER RESPONSE HERE]
9. Actions that need to be taken
[ENTER RESPONSE HERE]

NHS Cheshire and Merseyside

QUALITY IMPACT ASSESSMENT

Project/Proposal Name	Reducing Unwarranted Clinical Variation – Subfertility policy option (2 IVF cycles)	Date of completion	14/05/2025
Programme Manager	Katie Bromley	Clinical Lead	Rowan Pritchard Jones

Background and overview of the proposals (can be copied from PID on Verto or from National/Regional commissioning guidance)

The Subfertility policy was included in the scope of the Clinical Policy Harmonisation programme, as currently each Place has its own policy and there is variation in access to these services across Cheshire and Merseyside. The Clinical Policy Harmonisation programme used an evidence-based approach to develop harmonised policies. There is currently disparity across Cheshire and Merseyside on the number of IVF rounds offered as part of the sub-fertility policies:
1 cycle - Cheshire East
2 cycles – Liverpool, St Helens, Wirral, Cheshire West
3 cycles – Warrington, Southport & Formby, South Sefton, Halton, Knowsley
The clinical policy harmonisation programme undertook an exercise to harmonise the number of cycles and a working group was set up to work through this. The working group proposed 1 or 2 cycles, an options appraisal is being undertaken to explore offering patients either 1 or 2 cycles of IVF.

Whilst NICE specifies 3 cycles should be offered, their Health Economics analysis describes the effectiveness of each cycle with regard to cumulative live birth rates and shows that whilst the chances of having a live birth increase with each cycle, the effectiveness and cost effectiveness of each cycle is reduced. For a woman aged 34, the birth rates for each cycle are estimated: 1 cycle: 30%, 2 cycles: 15%, 3 cycles 10%.
In addition, research shows that 73% of those ICBs that have already harmonised their position will fund only 1 cycle and 19% currently fund 2 cycles with <10% funding the full 3 cycles as recommended by NICE.

It is worth noting that our neighbouring ICBs offer the following:

- Lancashire and South Cumbria offer 1 IVF cycle.
- Greater Manchester currently under review.
- West Yorkshire offer 1 IVF cycle.
- Staffordshire and Stoke-on-Trent offer 1 IVF cycle.

Data from our provider Liverpool Women's Hospital shows that the average number of cycles that patients are currently having is 1.36 cycles (this was based on reviewing patient outcomes for patients receiving 2 and 3 IVF cycles over a 5 year period who did not have a live birth after the first cycle), therefore offering patients 2 cycles of IVF would enable the majority of our patients to achieve a successful outcome.

However, there is a requirement for the ICB to review its costs and use of resources, and this option would result in a cost increase of £40k per year. So a 1 cycle option has also been modelled, which would make an estimated £1.3m savings each year.

To develop a harmonised policy, a decision needs to be made on the number of IVF cycles that patients are offered. An options appraisal is being undertaken to explore offering patients either 1 or 2 cycles. This QIA considers the impact of a 2 IVF cycle policy.

There are a number of other changes that have been made to bring the policy in line with NICE guidance e.g. minimum age, smoking status, weight requirements, definition of childness and right to a family definitions, which are documented in the corresponding EIA but where appropriate are called out in this document.

Reason For Change/Proposal
Currently C&M ICB has an unharmonised position with regard to the number of IVF cycles offered. A 2-cycle option is clinically recommended; however, a 1 cycle approach has been modelled due to our current financial situation and this reduction would offer savings. A 2 cycle option would mean reducing the offer in 4 Places and increasing the offer in 1 Place, who all currently offer either 1 or 3 cycles. Those patients in Liverpool, St Helens, Cheshire West and Knowsley would not be affected.

Who is likely to be Impacted?	Public	X	Patients	X	Workforce	X	Other parts of the system	X
Please provide additional details, including scale	671 per year (2019 data)						
Who has been consulted with as part of the QIA development	There has been no formal consultation, a request to Board in May 25 is being made to request permission to progress a public consultation, however, the Obs & Gynae Clinical Network and Liverpool Women's Hospital Clinical, Operational and Finance Teams have all be involved in reviewing the options, proposed policy and supporting with activity and finance modelling.)						
Financial Considerations	Current Costs		£5,043,081 per year		Proposed Costs		£5,083,438 per year

Place/Local Sign off:						
Sign off group	Not required	Date of meeting		Post mitigation risk score *(Likelihood x Consequence)*	Safety	1
					Effectiveness	4
					Experience	4
					Workforce/system	1
Has an EIA been completed?	Y	Has a DPIA been completed?	Y – full DPIA not required	Have identified risks been added to risk register?	N	

Risk scores above 12 in any area of quality, including patient safety, clinical effectiveness or experience will be taken to QIA panel and must be included within the corporate risk register.

Patient safety						
Will the project or proposal impact on patient safety?	Positive impact Improved patient safety, such as reducing the risk of adverse events is anticipated	Neutral Impact May have an adverse impact on patient safety. Mitigation is in place or planned to mitigate this impact to acceptable levels	Negative impact Increased risk to patient safety. Further mitigation needs to be put in place to manage risk to acceptable level	Pre-mitigation Identified Risk Score (Prior to Mitigations)		
				L	C	Total L x C
Please consider… • Will this impact on the organisation's duty to protect children, young people and adults? • Impact on patient safety? • Impact on preventable harm? • Will it affect the reliability of safety systems? • How will it impact on systems and processes for ensuring that the risk of healthcare acquired infections to patients is reduced?	The proposed policy is that both partners should be confirmed non-smokers due to the harmful impact nicotine has on fertility and foetal development. Likewise, the proposed policy on drug and alcohol intake applies to both partners as in the current Cheshire policy not just the partner undergoing treatment as in the current Mersey policy. This is a positive impact on all patients including welfare of the child. There is no additional impact on adults and children at risk, however, the inclusion of males in the smoking and drug and alcohol intake criteria for Merseyside patients would have a positive impact on the child. If	The proposals regarding the number of IVF cycles doesn't impact the risk of harm, if implemented the policy would impact patients positively as it would eliminate inequity across C&M.	For those patients who currently receive 3 cycles there may be an impact on their mental health if they were relying on NHS funded cycles to have a family, but aren't successful during the first or second cycle.	2	1	2

	non-compliance evidence is found this could trigger a pause in treatment with possible referral for a welfare of the child assessment and/or further information sought from the GP. This is a positive impact on all patients including welfare of the child.					

Mitigations					
Action	**Owner**	**Expected date of completion**	**Date completed**		
Our modelling shows that patients have on average 1.36 cycles and a 2 cycle option is clinically supported.	Katie Bromley		Complete		
A comms and engagement approach would be developed to explain the rationale for the decision.			Tbc		
		Post Mitigation Risk Score	1	1	1

Clinical Effectiveness	
Please confirm how the project uses the best, knowledge based, research	The proposed interim sub-fertility policy has, where possible, been developed using the latest NG156 NICE guidance and input from local expertise and knowledge. It should be noted that NICE suggests 3 IVF cycles, however this guidance has been in place for over 10 years and fertility processes are much improved.

	C&M data shows that the average number of cycles is 1.36, with an average of 1.88 subsequent Frozen embryo transfers. For those patients who do not have a successful pregnancy after the first IVF round, there is an opportunity to learn from this and change the approach for the 2nd cycle to increase success.					
Will the project or proposal impact on Clinical effectiveness?	**Positive impact** Clinical effectiveness will be improved resulting in better outcomes anticipated for patients	**Neutral Impact** May have an adverse impact on clinical effectiveness. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	**Negative impact** Significant reduction in clinical effectiveness. Further mitigation needs to be put in place to manage risk to acceptable level	Identified Risk Score (Prior to Mitigations)		
				L	C	Total L x C
Please consider… • How does it impact on implementation of evidence based practice? • How will it impact on clinical leadership • Does it reduce/impact on variation in care provision? • Does it affect supporting people to stay well? • Does it promote self-care for people with long term conditions? • Does it impact on ensuring that care is delivered in the most clinically and cost effecting setting? • Does it eliminate inefficiency and waste by design? • Does it lead to improvements in care pathways?	Where possible, the harmonised policy has been brought in line with NICE guidance. For Cheshire East patients this will be positive, as patients will be eligible for an additional IVF cycle. Outcomes will be monitored the same way as they are currently. The harmonisation of policy in regard to childlessness, weight, smoking and drugs and alcohol intake and approach to Intra-uterine insemination and ovarian reserve testing should support more patients to be successful in treatment. Outcomes will be monitored in the same way as they are now.	For Liverpool, St Helens, Cheshire West and Wirral patients the number of IVF cycles eligible will remain at 2. For patients in Knowsley, Halton, S Sefton, Southport & Formby & Warrington patients this will have a negative impact as we are reducing the number of cycles from 3 to 2. Outcomes will be monitored in the same way as they are now.	This proposal is a higher offer than other ICB areas, with over 70% of the ICBs who have already harmonised their policies only offering 1 cycle (4 others have yet to do so). NICE guidance NG156 advises that 3 cycles should be offered. However, C&M data suggests that the numbers of patients requiring 3 cycles is minimal with the average number of cycles being 1.36. NICE health economics analysis describes that the effectiveness of each cycle with regard to cumulative live birth rate is reduced with each cycle (although there is still a greater chance of a live birth). For	2	3	6

	The subfertility policy has been developed with a MDT working group that consisted of Local Fertility Specialists, GPs, Healthwatch, Commissioners who helped to shape the policy. The working group recommended 1 or 2 cycles of IVF. The policy has been shared with the relevant clinical networks who also support the proposed policy including the 2-cycle option. The policy has been shared with the relevant clinical networks who were supportive of the alignment to NICE guidance across the whole of C&M and supported the "interim" approach whilst waiting for revised NICE guidance to ensure new policy positions are developed using all evidence.		an average 34 year old, the 1st cycle is c 30% effective, the 2nd cycle is c 15% and the 3rd cycle is less than 10%.			

Mitigations			
Action	**Owner**	**Expected date of completion**	**Date completed**
Our modelling shows that patients have on average 1.36 cycles and a 2 cycle option is clinically supported.	Katie Bromley		Complete
A comms and engagement approach would be developed to explain the rationale for the decision.			Tbc

		Post Mitigation Risk Score	2	2	4

Patient Experience						
Will the project or proposal impact on patient experience?	Positive impact Improved patient and carer experience anticipated	Neutral Impact May have an adverse impact on patient and carer experience. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	Negative impact Significant reduction in patient and carer experience. Further mitigation needs to be put in place to manage risk to acceptable levels	Identified Risk Score (Prior to Mitigations)		
				L	C	Total L x C
Please consider… • What is the impact on protected characteristics, such as race, gender, age, disability, sexual orientation, religion and belief for individual and community health, access to services and experience? • What impact is it likely to have on self-reported experience of patients and service users? (Responses to national/local surveys/complaints/PALS/incidents)? • How will it impact on the choice agenda? • How will it impact on the compassionate and personalised care agenda? • How might it impact on access to care or treatment?	The proposed harmonised policy will ensure that patients have equal access to subfertility treatments in Cheshire and Merseyside. It will remove the current variation in the number of IVF cycles offered. For patients in Cheshire East, they will be offered an additional cycle. Positive impact on patients younger than 23 years who want to start treatment as this minimum age has been removed as per NICE guidance. Women aged 42 are included in the policy in line with NICE guidance – previously the cut off was up to 42nd birthday. The current Mersey position on Intra-uterine	Patients in Knowsley, Halton, South Sefton, Southport & Formby & Warrington who currently are eligible to 3 cycles will be impacted neutrally, as data shows the average number of cycles to be 1.36 cycles – so the likelihood is that minimal patients would be having the cycles. For patients in Liverpool, St Helens, Cheshire West and Wirral it will have a neutral impact as these patients are currently eligible to 2 cycles – so there will be no change. Definitions of childlessness and right to a family have been clarified, however, this	The current Cheshire policy implies that even if a patient had a live birth or adopted a child, they could progress with using all frozen embryos. This was not aligned across C&M and is not usual practice, so this has been removed, therefore these patients could feel disadvantaged. Because the status of male partners with regard to smoking & alcohol and drug use has an impact on eligibility in the proposed policy, treatment will only be provided if both partners comply with the requirements. This cohort may feel disadvantaged by this revised approach, however, the smoking	2	3	6

	Insemination (IUI) / Donor Insemination (DI) has been introduced to Cheshire (clarification on the number of cycles required before IVF) and Wirral (not routinely commissioned)	doesn't change the policy position except in Cheshire where previously they were able to continue to use any remaining eggs. The DoH position on eligibility of Overseas Visitors is now included in the proposed policy statement, however, this is not a change to process as it reflects the existing rules.	requirement follows NICE CG156: "smoking can adversely affect fertility and the success rates of assisted reproductive techniques (in both men and women)." And the drugs and alcohol is based on evidence that alcohol and recreational drugs reduce the chance of conception in both men and women.			

Mitigations					
Action	**Owner**	**Expected date of completion**	**Date completed**		
Our modelling shows that patients have on average 1.36 cycles and a 2-cycle option is clinically supported.	Katie Bromley		Complete		
A comms and engagement approach would be developed to explain the rationale for the decision.			Tbc		
		Post Mitigation Risk Score	2	2	4

Workforce/System				
	Positive impact	Neutral Impact	Negative impact	Identified Risk Score (Prior to Mitigations)

Will the project or proposal impact on the workforce or system delivery?	Improved patient and carer experience anticipated	May have an adverse impact on patient and carer experience. Mitigation is in place or planned to mitigate this impact to acceptable risk levels	Significant reduction in patient and carer experience. Further mitigation needs to be put in place to manage risk to acceptable levels	L	C	Total L x C
Please consider… • Capacity and demand on services • Changes in roles • Training requirements • Staff experience & morale • Redundancies • Opportunities (including staff development) • Impact on other parts of the system, including changes in pathways or access • Increased demand • Financial stability • Safety	The relaunch of the revised policy would require strong communications with the provider in order to ensure any new elements were understood and implemented correctly. It is likely that moving to 2 cycles would have a positive impact on staff experience and morale for those working in our Provider organisation as they were supportive of offering 2 cycles.			1	1	1

Mitigations					
Action	**Owner**	**Expected date of completion**	**Date completed**		
There are no mitigating actions					
		Post Mitigation Risk Score	1	1	1

Summary

Decision made	Pre Mitigated Score	Mitigated score	Impact
Progress	6	4	Moderate
Not progress	16	16	Catastrophic
Score summary (add to front page)			
Negligible and Low risk	Moderate risk	Major risk	Catastrophic risk
1-3	4 - 7	8 - 12	13 - 25

- The ‘progressed’ risk scores are applicable if the 2-cycle option is approved. The ‘not progressed’ risk scores are applicable if the 1-cycle option is approved. In line with the ICB Risk Management Strategy, an ICB wide risk score for a risk-in-common should mirror that of the highest domain risk score.

Risk Impact Score Guidance

LEVEL	DESCRIPTOR	DESCRIPTION – ICB LEVEL
5	Catastrophic (>75%)	**Safety** - multiple deaths due to fault of ICB OR multiple permanent injuries or irreversible health effects OR an event affecting >50 people. **Quality** – totally unacceptable quality of clinical care OR gross failure to meet national standards. **Health Outcomes & Inequalities** – major reduction in health outcomes and/or life expectancy OR major increase in health inequality gap in deprived areas or socially excluded groups **Finance** – major financial loss - >1% of ICB budget OR 5% of delegated place budget **Reputation** – special measures, sustained adverse national media (3 days+), significant adverse public reaction / loss of public confidence major impact on trust and confidence of stakeholders
4	Major (50% > 75%)	**Safety** - individual death / permanent injury/ disability due to fault of ICB OR 14 days off work OR an event affecting 16 – 50 people. **Quality** – major effect on quality of clinical care OR non-compliance with national standards posing significant risk to patients. **Health Outcomes & Inequalities** – significant reduction in health outcomes and/or life expectancy OR significant increase in health inequality gap in deprived areas or socially excluded groups **Finance** - significant financial loss of 0.5-1% of ICB budget OR 2.5-5% of delegated place budget **Reputation** - criticism or intervention by NHSE/I, litigation, adverse national media, adverse public significant impact on trust and confidence of stakeholders
3	Moderate (25% > - 50%)	**Safety** - moderate injury or illness, requiring medical treatment e.g., fracture due to fault of ICB. RIDDOR/Agency reportable incident (4-14 days lost). **Quality** – significant effect on quality of clinical care OR repeated failure to meet standards **Health Outcomes & Inequalities** – moderate reduction in health outcomes and/or life expectancy OR moderate increase in health inequality gap in deprived areas or socially excluded groups **Finance** - moderate financial loss - less than 0.5% of ICB budget OR less than 2.5% of delegated place budget

		Reputation - conditions imposed by NHSE/I, litigation, local media coverage, patient and partner complaints & dissatisfaction moderate impact on trust and confidence of stakeholders
2	**Minor (<25%)**	**Safety** - minor injury or illness requiring first aid treatment **Quality** – noticeable effect on quality of clinical care OR single failure to meet standards **Health Outcomes & Inequalities** – minor reduction in health outcomes and/or life expectancy OR minor increase in health inequality gap in deprived areas or socially excluded groups **Finance** - minor financial loss less than 0.2% of ICB budget OR less than 1% of delegated place budget **Reputation** - some criticism slight possibility of complaint or litigation but minimum impact on ICB minor impact on trust and confidence of stakeholders
1	**Negligible (<5%)**	**Safety** - none or insignificant injury due to fault of ICB **Quality** – negligible effect on quality of clinical care **Health Outcomes & Inequalities** – marginal reduction in health outcomes and/or life expectancy OR marginal increase in health inequality gap in deprived areas or socially excluded groups **Finance** - no financial or very minor loss **Reputation** - no impact or loss of external reputation

The likelihood of the risk occurring must then be measured. Table 2 below should be used to assess the likelihood and obtain a likelihood score. When assessing the likelihood, it is important to take into consideration the existing controls (i.e. mitigating factors that may prevent the risk occurring) already in place.

Table 2 - Risk Likelihood Score Guidance

1	2	3	4	5
Rare The event could only occur in exceptional circumstances (<5%)	**Unlikely** The event could occur at some time (<25%)	**Possible** The event may well occur at some time (25%> -50%)	**Likely** The event will occur in most circumstances (50% > 75%)	**Almost certain** The event is almost certain to occur (>75%)

The impact and likelihood scores must then be multiplied and plotted on table 3 to establish the overall level of risk and necessary action.

Table 3 - Risk Assessment Matrix (level of risk)

LIKELIHOOD of risk being realised	**IMPACT (severity)** of risk being realised				
	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Rare (1)	**1**	**2**	**3**	**4**	**5**
Unlikely (2)	**2**	**4**	**6**	**8**	**10**
Possible (3)	**3**	**6**	**9**	**12**	**15**
Likely (4)	**4**	**8**	**12**	**16**	**20**
Almost Certain (5)	**5**	**10**	**15**	**20**	**25**

Low Risk	**Moderate Risk**	**High Risk**	**Extreme Risk**	**Critical Risk**

Risk Proximity

A further element to be considered in the risk assessment process is risk proximity. Risk proximity provides an estimate of the timescale as to when the risk is likely to materialise. It supports the ability to prioritise risks and informs the appropriate response in the monitoring of controls and development of actions.

A pragmatic approach to the use of risk proximity which supports leadership, decision making and reporting is used and is therefore determined to be applied to all Risks.

The proximity scale used is below:

Proximity and timescale for dealing with the risk	Within the current quarter	Within the financial year	Beyond the financial year
Rating	**A**	**B**	**C**

Likelihood, impact and proximity are dynamic elements and consequently all three must be reviewed and reassessed frequently in order to prioritise the response.

Sign off process			
Name	Role	Signature	Date
	Project lead		
	Clinical lead		
	Programme manager		
	PMO lead		
Once signed off by all above, then the QIA is submitted via qia@cheshireandmerseyside.nhs.uk **to QIA review group**			

PMO receipt					
Verto/PMO reference		Date QIA reviewed PMO		Reviewed by	

This section to be completed following review at the QIA review group				
Meeting Chair	Date of Meeting	Approved	Rejected	Comments/feedback

Appendix 2

Plan for public consultation

Changes to fertility treatment policies in Cheshire and Merseyside

Introduction

NHS Cheshire and Merseyside Integrated Care Board (ICB) has been reviewing its subfertility policies.

Currently, there are ten separate policies covering NHS fertility treatments for people in Cheshire and Merseyside. These are called NHS Funded Treatment for Subfertility policies.

NHS Cheshire and Merseyside is proposing a new single policy for the whole of Cheshire and Merseyside.

The new policy would include a number of changes based on the latest national guidance, but we are also proposing to make some changes for financial reasons. This includes the number of in vitro fertilisation (IVF) cycles.

Subject to Board approval, we are planning to hold a six-week public consultation between 3 June and 15 July 2025, so that people can find out more, and share their views. We will use the feedback we receive to make a final decision.

This document outlines the plan for public consultation. It should be read alongside the Board paper Sub Fertility Clinical Policy Status and Options for consideration, which contains additional background information about the proposal. The plan has been developed by NHS Cheshire and Merseyside's Communications and Engagement team, and will be presented to the Board of NHS Cheshire and Merseyside for approval ahead of public consultation launching.

Objectives

The public consultation objectives are:

- To inform patients and the public, carers/family members, and key stakeholders about the proposal to have a single subfertility policy for Cheshire and Merseyside, and explain what changes this would mean.

- To gather feedback on the proposal, including from people who are currently accessing or have accessed fertility services, organisations who support them (where applicable), their carers/family members, and the wider public, to understand views, including how people might be impacted if changes were to go ahead.

- To understand where there might be differences in responses between different groups/communities, including those with protected characteristics, in line with equalities duties.

- To use public consultation feedback to inform final decision-making around the proposal.

Consultation mechanisms and materials

Feedback will be gathered using a questionnaire containing a series of qualitative and quantitative questions, available online, or in a printed/alternative format or alternative language on request. Respondents will be able to contact NHS Cheshire and Merseyside's communications and engagement team for help completing the questionnaire, including providing their feedback over the phone if required.

A consultation document will be made available, setting out supporting information about the proposed change. This will also be available in an Easy Read version, with alternative languages and formats available on request.

Both the questionnaire and supporting information will be hosted on a dedicated page in the 'Get involved' section of the NHS Cheshire and Merseyside website.

As part of the consultation, NHS Cheshire and Merseyside will offer to attend meetings of existing groups and networks to provide information about the proposal.

Members of the public will be directed to contact engagement@cheshireandmerseyside.nhs.uk or 0151 295 3052 with any enquiries about the consultation. NHS Cheshire and Merseyside's Patient Experience Team will be briefed on the engagement so that any enquiries that come through central routes can be directed appropriately.

Stakeholder enquires will be directed to communications@cheshireandmerseyside.nhs.uk

Analysis and reporting

Responses to the consultation will be analysed and compiled into a feedback report by NHS Cheshire and Merseyside's communications and engagement team.

The NHS Cheshire and Merseyside programme team which has been reviewing subfertility policies will use the consultation findings to produce a paper for the NHS Cheshire and Merseyside Board, so that they can make a final decision on the proposal. The feedback report will be appended to this paper, which will be presented to a meeting of the Board. It is expected that this will take place in public, in late summer/early autumn 2025.

Communications and promotion

NHS Cheshire and Merseyside will promote the opportunity to take part in the consultation across its own channels, including website, social media and in regular newsletters and briefings.

A toolkit for promoting the consultation – including social media assets and short and long form copy for newsletters and websites – will be shared with partners and wider networks for use on their own internal and external channels. This will include local authorities, hospital trusts, GP practices, Healthwatch organisations, the VCFSE (voluntary, community, faith and social enterprise) sector, and other relevant groups, including those which support people experiencing fertility issues.

To ensure that those who would be most impacted by any potential change have an opportunity to share their views, we will also work with colleagues at Liverpool Women's

Hospital (NHS University Hospitals of Liverpool Group) to utilise existing patient communication routes, where possible.

Audiences and methods of communication and engagement

The table below provides an overview of key stakeholder groups, and details of how we intend to communicate with them during the public consultation. This is not exhaustive – during the consultation period we will continue to actively identify opportunities to reach different groups and communities to encourage them to take part, including those highlighted in the equality impact assessment (EIA).

The intention will be to issue an initial stakeholder briefing at the point the NHS Cheshire and Merseyside Board papers are published on 22 May 2025, followed by a second update on 3 June 2025 to launch the consultation (subject to Board approval).

Audience	**Proposed channel/method of communication and engagement**
Internal	
NHS Cheshire and Merseyside Integrated Care Board (ICB)	• General covering email with stakeholder briefing.
NHS C&M Staff	• Information in weekly staff brief.
NHS CM exec team and: • Ads of Quality and Improvement • Place directors. • Place clinical directors. • AD Place transformation leads	• Covering email with stakeholder briefing.
GP practice staff LMC and LPC	• Tailored email with stakeholder briefing. • GP Practice Bulletin – information and link to communications toolkit.
UK Health Security Agency – North West	• Covering email with stakeholder briefing.
HCP Partnership Board	• General covering email with stakeholder briefing.
Hewitt Fertility Centre Liverpool Women's Hospital (University Hospital Liverpool Group)	• Share stakeholder briefing
NHS trust communications teams – to share with COO / deputy / chair / CEO / medical directors	• Covering email with stakeholder briefing and comms toolkit for use on their channels.
NHS England NW Communications Team	• General covering email with stakeholder briefing.
Assisted Conception Working Group, Reducing Unwarranted Variation Steering Group and the Obs & Gynae Clinical Network	• Tailored covering email with link to stakeholder briefing to clinical networks and other groups.
External	

Current/previous patients	• Hewitt Fertility Centre to share information about consultation across existing patient communication channels, including utilising patient portal, patient participation group, patient support group and Facebook page. Wider Liverpool Women's communications channels will also be utilised.
General public across Cheshire and Merseyside	• Promotion across existing NHS Cheshire and Merseyside and partner channels, including social media and website, utilising toolkit.
Democratic services / committee clerks for OSC / HWBs	• Stakeholder briefing shared with OSC Chairs across C&M via democratic services teams in each local authority.
LA leaders / councillors / LA chief execs / Directors of Public Health/ LA comms team	• Tailored covering email to communications teams with stakeholder briefing for onward sharing, and communications toolkit for using on their channels. • Monthly stakeholder bulletin – copy with link to stakeholder briefing.
CHAMPS	• General covering email with stakeholder briefing and communications toolkit.
MPs	• General covering email with link to stakeholder briefing. • MP Briefing (distributed bi-monthly after Board meeting,)
Local voluntary, community, faith and social enterprise organisations (VCFSEs) and CVS organisations	• Tailored covering email with stakeholder briefing and communications toolkit for their channels.
Place communications and engagement collaboratives	• Share communications toolkit and request that they utilise information across their channels and networks.
Local Healthwatch organisations	• Tailored covering email with stakeholder briefing and comms toolkit for their channels • Stakeholder bulletin – copy with link to stakeholder briefing. • Discuss at quarterly communications and engagement meeting.
The media	• Press release to be issued at point Board papers are published, then (subject to Board approval) at point public consultation gets underway.
Community Voices	• Email to be sent to panel members.
Wider groups and networks	• Stakeholder briefing and communications toolkit to be shared with wider groups and networks,

	including those which represent people experiencing fertility issues.

Legal and statutory context

The main duties on NHS bodies to make arrangements to involve the public are set out in the National Health Service Act 2006, as amended by the Health and Care Act 2022 (section 14Z45 for integrated care boards and section 242(1B) for NHS trusts and NHS foundation trusts). As part of our legal duties, we are required to involve people when we are considering and developing proposals for change which would have an impact on the way in which services are delivered.

Involvement also has links with separate duties around equalities and health inequalities (section 149 of The Equality Act 2010 and section 14Z35 of the National Health Service Act 2006). As part of our work, we need to involve people with protected characteristics, social inclusion groups and those who experience health inequalities.

Local authority scrutiny

NHS commissioners must consult local authorities when considering any proposal for a substantial development or variation of the health service. Subject to the Board's approval of this plan, NHS Cheshire and Merseyside will commence discussions with each of the relevant local authorities.

Evaluation

It's important that we understand the effectiveness of different routes for reaching people, so that we can utilise this for future activity, and the questionnaire will ask people to state where they heard about the engagement. We will summarise this information – along with other measures such as number of enquiries received and visits to the website page – in the final consultation report.

ENDS

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

29 May 2025

2025/26 Cheshire and Merseyside Operational & Financial Delivery Plan Update

Agenda Item No: ICB/05/25/16

Responsible Director: Mark Bakewell, Interim Executive Director of Finance

2025/26 Cheshire and Merseyside Operational & Financial Delivery Plan Update

1. Executive Summary

1.1 The purpose of this paper is to provide the Board with an update on the work that has been undertaken to finalise the ICS financial plan for the 2025/26 financial year in accordance with national NHS England planning requirements.

1.2 The paper provides an overview of the latest financial position reported to NHS England (NHSE) for C&M ICB as at 30th April 2025 and build on the assumptions as described in the last paper to board at the end of March 2025.

1.3 The **ICB** has submitted a **£50.3m surplus** plan position for the 25/26 financial year offset by an **NHS Provider £228.6m deficit** to result in a **£178.3m system deficit** which is line with the maximum system deficit control total of £178.3m for the 25/26 financial year as set by NHS England.

1.4 The paper also outlines the 2025/26 operational plans, aligning with national priorities across urgent and elective care, cancer, mental health and primary care. , and financial performance. Key system-wide goals include reducing elective and cancer waiting times, improving A&E and ambulance performance, expanding access to mental health and primary care services. **Collaborative planning across providers has ensured that all submitted plans meet or exceed mandated benchmarks for performance and service improvement at ICB level.**

2. 2025/26 Planning Background

2.1 Cheshire & Merseyside ICS systems draft finance position (pre-audit) for the 24/25 financial year was a £196m deficit, this being an adverse £46m variance compared to an agreed deficit control total of £150m.

2.2 The 25/26 planning round has been a challenging process, against a background of changing political priorities together with late planning guidance and contract / tariff consultation processes which are still not completed as at the middle of May.

2.3 Cheshire & Merseyside ICS did not meet the national planning requirement regarding its financial position for the 25/26 year based on its planning submission at the end of March 25. Based on the system plan submission of £255m deficit (resulting in a gap of £77m to the £178m control total) this resulted in a series of additional review processes and a 'Board to Board' meeting with NHS England at the end of April 2025. This required the system to ensure that its final plan submission met the requirement of a £178m deficit.

3. Plan Resubmission and Organisational Positions

3.1 As of the 30th April, the ICS has submitted a final plan of **£178.3m deficit** which is line with the maximum system deficit control total for the 25/26 financial year as set by NHS England.

3.2 Cheshire & Merseyside ICS final 25/26 plan submission (excluding deficit support funding) at organisational level is as per Table One including additional information regarding relative surplus / deficit % as a proportion of income (excluding deficit support funding).

Table One

	I&E (excluding Deficit Support £m	I&E Plan as a % of Income (excluding deficit support) %
Alder Hey Children's	7.2	1.6%
Liverpool Heart & Chest	9.6	3.7%
Liverpool University Hospitals	(56.6)	(4.5%)
Liverpool Women's	(31.0)	(19.6%)
Mersey Care	14.3	1.9%
The Clatterbridge Centre	0.9	0.3%
The Walton Centre	6.9	3.4%
Liverpool Cluster	**(48.8)**	
Cheshire & Wirral Partnership	4.0	1.4%
Countess of Chester Hospitals	(34.0)	(9.5%)
East Cheshire Trust	(17.9)	(8.5%)
Mid Cheshire Hospitals	(39.4)	(9.6%)
Cheshire Cluster	**(87.4)**	
Bridgewater Community	(1.5)	(1.5%)
Mersey & West Lancs	(40.9)	(4.4%)
Warrington & Halton Hospitals	(28.7)	(7.7%)
Mid Mersey Cluster	**(71.2)**	
Wirral Community	0.9	0.8%
Wirral University Hospitals	(22.1)	(4.3%)
Wirral Cluster	**(21.2)**	
TOTAL Providers	**(228.6)**	
C&M ICB	**50.3**	
Total ICS	**(178.3)**	

4. Deficit Support Funding

4.1 As in 2024/25, a non-recurrent deficit support revenue allocation will be issued to those systems with a deficit plan limit in 2025/26 that is equal to the size of the limit. Allocation of this £178m within the system is as per below on the basis of where deficit sits within the system and also to help manage with cash management issues faced in particular by deficit trusts. See Table Two:

Table Two

	I&E £m	Deficit Support Funding £m	25/26 Plan £m
Alder Hey Children's	7.2		7.2
Liverpool Heart & Chest	9.6		9.6
Liverpool University Hospitals	(56.6)	44.5	(12.1)
Liverpool Women's	(31.0)	15.3	(15.7)
Mersey Care	14.3		14.3
The Clatterbridge Centre	0.9		0.9
The Walton Centre	6.9		6.9
Liverpool Cluster	(48.8)	59.8	11.1
Cheshire & Wirral Partnership	4.0		4.0
Countess of Chester Hospitals	(34.0)	19.6	(14.4)
East Cheshire Trust	(17.9)	10.3	(7.6)
Mid Cheshire Hospitals	(39.4)	23.0	(16.4)
Cheshire Cluster	(87.4)	53.0	(34.4)
Bridgewater Community	(1.5)	0.0	(1.5)
Mersey & West Lancs	(40.9)	30.2	(10.7)
Warrington & Halton Hospitals	(28.7)	18.3	(10.4)
Mid Mersey Cluster	(71.2)	48.6	(22.6)
Wirral Community	0.9		0.9
Wirral University Hospitals	(22.1)	16.9	(5.2)
Wirral Cluster	(21.2)	16.9	(4.3)
TOTAL Providers	(228.6)	178.3	(50.3)
ICB	50.3	0.0	50.3
Total ICB	(178.3)	178.3	0.0

5. ICB Final Budget Position

5.1 ICB Planned expenditure for the 25-26 financial year is as per Table Three and across the relevant categories.

6. Specific investments

6.1 The ICB's initial draft plan produced in March 25 included a number of working assumptions in order to support system risks / emerging pressures.

6.2 Unfortunately, due to constraints of the system position in meeting the deficit control total and the additional stretch required by the ICB to meet the position, a number of these original assumptions are in the process of being reviewed through the organisations decision making processes.

Table Three

Total 'Revenue' Resource Available	**8.130,588 £bn**
Category	
Acute Services	3,763,402 £bn
Community Health Services	709,660 £m
Continuing Care Services	474,146 £m
Mental Health Services - PACKAGES OF CARE	212,065 £m
Mental Health Services - CONTRACTS	561,384 £m
Other Commissioned Services	15,710 £m
Other Programme Services	50,942 £m
Reserves / Contingencies	5,822 £m
Delegated Primary Care - Medical	608,243 £m
Delegated Primary Care - Community Dental	13,433 £m
Delegated Primary Care - Primary Dental	150,154 £m
Delegated Primary Care - Secondary Dental	40,689 £m
Delegated Primary Care - Ophthalmic	29,079 £m
Delegated Primary Care - Pharmacy	72,342 £m
Delegated Primary Care - Property Costs	818 £m
Prescribing including Medicines Management	549,406 £m
Primary Care - Other	107,652 £m
Delegated Specialised Commissioning	674,702 £m
Running Costs	40,597 £m
Total Net Expenditure	**8,080,246 (£bn)**
TOTAL Surplus/(Deficit)	**50,342** £m

7. Cash Releasing Efficiency Savings (CRES) - ICB

7.1 Detail of required savings as per Table Four below

25-26 CRES	
Continuing Health Care Savings	38,225
Prescribing Savings (Multiple Areas)	10,000
Prescribing Savings (Oral Nutritional Supplements)	6,293
Additional GP Prescribing savings (dependent upon TOM)	5,500
High-Cost Drugs System Savings	8,000
Demand Management / Activity Savings	30,000
Mental Health Packages	16,752
Other - Unwarranted Variation	3,163
Commissioning	1,000
Digital	2,900
Estates & Facilities	1,600

Primary Care	1,486
Corporate	550
Total before Management Costs	**124,469**
Management Costs	13,883
TOTAL	**139,352**

8. Total Cost Improvement Plans (CIP) - Provider & Cash Releasing Efficiency Savings (CRES) - ICB

8.1 Delivery of the £178.3m deficit is based on achievement of £572.5m of cost improvement / efficiency savings as per the below table. This includes £433.1m of provider and £139.4m commissioner savings within the financial year at an average of 5.9% (as a percentage of total operating expenditure for providers) and 7.5% (as a percentage of 'influenceable spend' for the ICB)

8.2 This figure increases to 6.3% when high cost drugs and devices are excluded from the operating expenditure denominator (as they are on a pass through basis).

8.3 Of these savings, trusts are planning on average that 93% of CIP savings would recurrent but as of the plan submission date only £328m of the £573m are assessed as 'fully developed' (£102.1m) or 'plans in progress' (£226.6m).

Table Five

	25/26 CIP Plan 30th April			
	£m	% of Op Ex	% (excluding HCD)	% of planned CIPs recurrent
Alder Hey Children's	22.7	5.1%	5.6%	96%
Bridgewater Community	5.5	5.2%	5.3%	100%
Cheshire & Wirral Partnership	14.9	5.0%	5.1%	100%
Countess of Chester Hospitals	27.7	5.9%	7.0%	100%
East Cheshire Trust	12.2	5.1%	5.2%	100%
Liverpool Heart & Chest	13.5	5.2%	6.0%	75%
Liverpool University Hospitals	117.2	8.3%	8.4%	91%
Liverpool Women's	12.7	6.3%	6.3%	89%
Mersey Care	40.7	5.0%	5.2%	82%
Mid Cheshire Hospitals	31.7	6.7%	6.9%	89%
Mersey & West Lancs	48.2	4.9%	4.9%	100%
The Clatterbridge Centre	14.8	4.6%	6.8%	89%
The Walton Centre	12.2	5.9%	6.7%	100%
Warrington & Halton Hospitals	21.5	5.1%	5.3%	86%
Wirral Community	5.7	5.2%	5.2%	100%
Wirral University Hospitals	32.0	5.8%	6.0%	100%
TOTAL Provider	**433.1**	**5.9%**	**6.3%**	**93%**
C&M ICB	139.4	7.5%	7.5%	100%
TOTAL ICS	**572.5**	**7.1%**	**7.5%**	**94%**

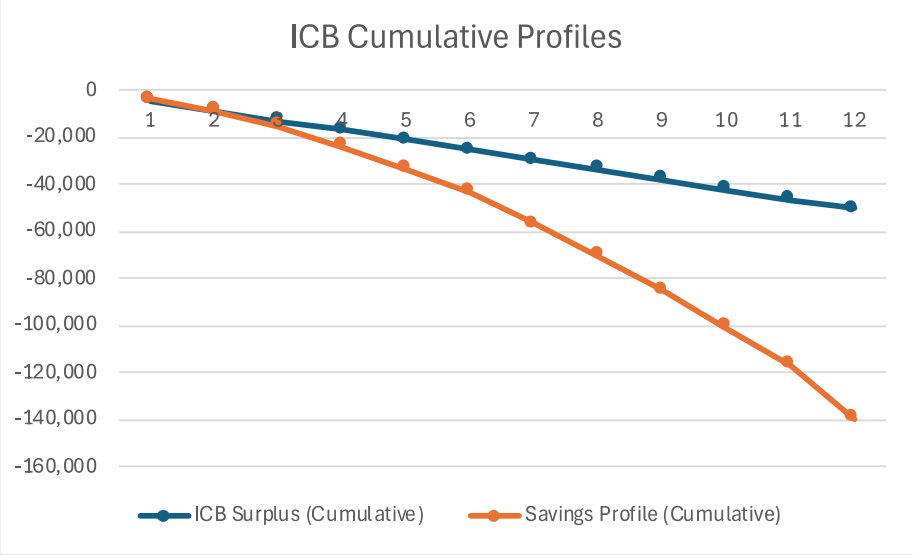
9. Plan Profiles - ICB

9.1 The ICB plan position is profiled as per below basis including the requirement impact of the Cash Releasing savings programme over the duration of the year.

9.2 The ICB plan position is profiled as per below basis including the requirement impact of the Cash Releasing savings programme over the duration of the year.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
ICB Surplus (Month on Month)	-4,195	-4,195	-4,195	-4,195	-4,195	-4,195	-4,195	-4,195	-4,195	-4,195	-4,195	-4,197	-50,342
Savings (Month on Month)	-3,490	-5,126	-6,252	-8,810	-9,531	-9,900	-13,517	-13,602	-14,473	-15,925	-16,012	-22,714	0

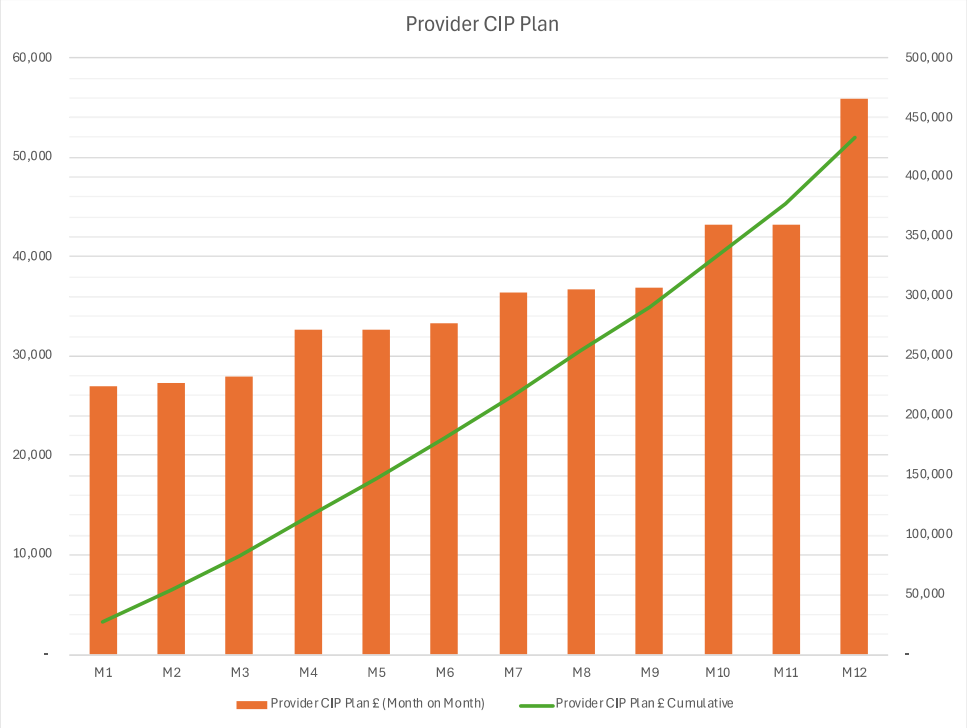
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
ICB Surplus (Cumulative)	-4,195	-8,390	-12,585	-16,780	-20,975	-25,170	-29,365	-33,560	-37,755	-41,950	-46,145	-50,342
Savings Profile (Cumulative)	-3,490	-8,616	-14,868	-23,678	-33,209	-43,109	-56,626	-70,228	-84,701	-100,626	-116,638	-139,352



10. Plan Profiles - Provider

10.1 The provider plan position is profiled as per below basis including the requirement impact of the cost improvement plan over the duration of the year.

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Provider CIP Plan £ (Month on Month)	27,028	27,282	27,924	32,635	32,623	33,321	36,422	36,682	36,927	43,189	43,188	55,897
Provider CIP Plan %	6.2%	6.3%	6.4%	7.5%	7.5%	7.7%	8.4%	8.5%	8.5%	10.0%	10.0%	12.9%
Provider CIP Plan £ Cumulative	27,028	54,310	82,234	114,869	147,493	180,813	217,235	253,917	290,844	334,033	377,222	433,118



11. Capital Plans

11.1 A summary of the system capital investment plan for 2025/26 is set out in Table Six with a number of elements still a work in progress and subject to NHS England approval.

11.2 For 2025/26, the C&M ICS has been allocated £199.989m of capital resources to support day to day operational requirements and any locally agreed capital schemes. This is after a £8.736m reduction in capital resource allocation due to the ICS having more than fair share of revenue deficit funding in the 25/26 revenue plan. The capital resource has been allocated using a combination of depreciation costs / locally agreed priorities and prior commitments.

11.3 In addition to the £199m of core capital the system plan has planned for an allocation of £41.5m and £2m for 24/25 capital freedoms and 24/25 UEC Incentive respectively (pending NHSE approval). The £41.5m capital freedoms is available from those organisations reporting the equivalent I&E surpluses in 24/25, with the capital resources distributed in 25/26 to all organisations as a % of core capital allocation. The UEC Incentive is potentially available to those high performing organisations in Q4 of 24/25 with a Type 1 A&Es, for which Alder Hey Children's maybe eligible.

11.4 Plans continue to be developed but at the time of writing there remains around £17.7m to be allocated during 2025/26.

Table Six

ICS Capital Plan - as of 30th April	Core Operational Capital					National Programme Allocation							
	Internally Funded Schemes	IFRS16 Leases	Capital Freedoms	UEC Incentive	TOTAL 25/26 Operational Capital	Estates Safety	CSR - Diagnostics	CSR - Elective	CSR - UEC inc MH	RAAC	Mental Health - Reducing Out of Area Placements	Net zero	TOTAL 25/26 Other National Programme Capital
	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000
Alder Hey Children's	9,326	- 203	2,254	2,000	**13,377**	-	120	-	2,119	-	-	1,440	**3,679**
Bridgewater Community	2,100	1,669	773	-	**4,542**	-	-	-	-	-	-	160	**160**
Cheshire & Wirral Partnership	6,600	965	957	-	**8,522**	-	-	-	6,600	-	2,040	373	**9,013**
Countess of Chester Hospitals	5,500	2,949	1,840	-	**10,289**	567	-	15,000	-	6,000	-	-	**21,567**
East Cheshire Trust	4,654	4,410	1,298	-	**10,362**	910	171	-	-	-	-	-	**1,081**
Liverpool Heart & Chest	5,461	465	2,009	-	**7,935**	708	-	850	-	-	-	-	**1,558**
Liverpool University Hospitals	25,653	12,495	9,439	-	**47,587**	827	403	1,000	-	27,900	-	124	**30,254**
Liverpool Women's	5,035	-	1,853	-	**6,888**	534	-	600	-	-	-	196	**1,330**
Mersey Care	16,008	2,005	3,866	-	**21,879**	894	-	-	5,200	-	-	1,740	**7,834**
Mid Cheshire Hospitals	5,646	3,239	2,077	-	**10,962**	2,648	11,523	-	-	27,787	-	33	**41,991**
Mersey and West Lancs	24,926	2,338	3,698	-	**30,962**	2,932	7,635	-	-	-	-	851	**11,418**
The Clatterbridge Centre	7,013	216	2,580	-	**9,809**	175	4,000	-	-	-	-	730	**4,905**
The Walton Centre	5,390	2,515	1,615	-	**9,520**	1,071	-	-	-	-	-	-	**1,071**
Warrington & Halton Hospitals	7,632	1,492	2,808	-	**11,932**	3,142	2,540	1,900	-	-	-	-	**7,582**
Wirral Community	2,284	648	840	-	**3,773**	-	-	-	-	-	-	-	-
Wirral University Hospitals	9,765	93	3,593	-	**13,451**	3,675	211	-	6,978	-	-	656	**11,520**
Unallocated IFRS16	3,974	-	-	-	**3,974**	-	-	-	-	-	-	-	-
TOTAL Planned Expenditure	**146,967**	**35,296**	**41,500**	**2,000**	**225,763**	**18,083**	**26,603**	**19,350**	**20,897**	**61,687**	**2,040**	**6,303**	**154,963**

Capital allocations - confirmed / pending

C&M Core ICS Allocation	confirmed	208,725							
Capital reduction for fair share reduction	confirmed	(8,736)							
Capital Freedoms Allocation	NHSE approval pending	41,500							
UEC Incentive	NHSE approval pending	2,000							
TOTAL Allocation		**243,489**	**18,083**	**26,603**	**19,350**	**20,897**	**61,687**	**2,040**	**6,303**	**154,963**
Allocation Value Remaining		**17,726**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

11.5 Additional national allocations of £155m have been received for 2025-26 to reflect national priorities as per the above table. The basis for allocation is as per below:

- Estates safety - £18.1m allocated to providers using Significant and High-Risk backlog, with an additional allocation to address Maternity non-compliance in WHH.
- Diagnostics - £26.6m allocated for CDC expansion, Audiology and Echo.
- Elective – £19.4m Schemes to improve productivity within the elective pathway.
- Urgent Pathway - £20.9m to address existing UEC projects, plus mental health crisis centres.
- RAAC – £61.7m as per nationally determined schemes.
- Mental Health – £2.0m to support Reducing Out of Area placements.
- Net Zero - £6.3m to support installation of solar power and battery storage solutions to improve energy efficiency.

11.6 All of the £155m national programme allocation remains subject to NHSE approval of providers' short form business cases which also require an ICB letter of support.

12. In-Year Delivery

12.1 The ICB has initiated a number of actions in April in order to improve confidence in delivery and de-risk the financial plan as set out below

- Commencing April - Weekly Financial Control & Oversight Group rotating between ICB and System facing activities
  - **ICB**; detailed reviewed of internal Cash Releasing Efficiency Savings (£139.3m) with Senior Responsible Owners to track delivery and resolve issues
  - **System** facing; progress on 9 areas (as below) including Cost Improvement Plan and Performance
    - Planned Care
    - UEC
    - Patient transport
    - Mental health Out of Area and Contracted Beds
    - Workforce
    - Procurement
    - Estates
    - Medicines Optimisation
    - Digital

- Commencing May - Monthly System Leadership Meeting (Arranged by 'devolution' footprints (Liverpool City Region and Warrington & Cheshire) attended by Trust Chair / Chief Executive and core executives.

- Commencing June. For Trusts that trigger deficit and risk thresholds, detailed review of progress on the whole financial plan
  - Liverpool University Hospitals NHS Foundation Trust & Liverpool Womens NHS
  - Foundation Trust
  - East Cheshire NHS Trust
  - Countess of Chester Hospital NHS Foundation Trust
  - Mid Cheshire Hospitals NHS Foundation Trust
  - Warrington & Halton Hospitals NHS Foundation Trust
  - Wirral University Teaching Hospitals NHS Foundation Trust

- Commencing Quarter 2 We will be developing a methodology for identifying Trusts that will be required to attend a Board to Board, which will be led by the ICB and involve regional colleagues. The triggers for this will be actuals v plan and risks to plan delivery.

13. Risks

13.1 The main finance risks for the system in respect of the 2025/26 financial year are as per below and are in accordance with the finance business rules:

ICB

- ensuring that ICB expenditure does not exceed the funding received for both revenue and capital allocations
- as a minimum that the ICB achieves its statutory 'break-even' duty (NB noting that the ICB has set a surplus plan of £50m)
- complies with its duty to not to exceed the ICB running cost allowance limit set by NHS England
- comply with relevant 'Mental Health' and 'Better Care Fund' planning guidance
- that in-year expenditure exceeds plan assumptions in respect of both prices and activity based levels.

System

- reflecting the collective objective for system partners to work together to seek to achieve system financial balance (e.g £178m deficit as per NHSE control total)
- significant level of in-year risks have been included within plans in order to submit required financial plans including 'stretch'. These are being monitored/ escalated through the System Financial Control & Oversight group
- ongoing risks regarding in-year / future receipt of deficit support funding.
- longer term sustainability risks given system expenditure exceeding resource allocations and continue to be subject to convergence (distance from target currently stands at 4 % for ICB programme allocation & 6% for specialised commissioning).

14. Operational Priorities

14.1 Alongside the finance and associated workforce plans, systems also had to set out how they would address the national priorities set out in the planning guidance , which are summarised in the table below:

Priority	Success measure
Reduce the time people wait for elective care	Achieve 65% of patients waiting ≤18 weeks for treatment by March 2026, with a minimum 5% improvement per trust.
	Achieve 72% of patients waiting ≤18 weeks for a first appointment by March 2026, with a minimum 5% improvement per trust.
	Reduce patients waiting >52 weeks to <1% by March 2026.

Priority	Success measure
	Reach 75% performance against the 62-day cancer standard by March 2026.
	Reach 80% performance against the 28-day cancer Faster Diagnosis Standard by March 2026.
Improve A&E waiting times and ambulance response times	Achieve 78% of patients admitted, discharged, or transferred within 4 hours by March 2026 and a higher proportion within 12 hours in 2025/26 compared to 2024/25.
	Improve Category 2 ambulance response time to an average of 30 minutes in 2025/26.
Improve access to general practice and urgent dental care	Improve patient experience of access to general practice
	Increase urgent dental appointments to meet national target of 700,000 more
Improve mental health and learning disability care	Reduce average length of stay in adult acute mental health beds
	Achieve the national ambition of 345,000 more CYP accessing services compared to 2019
	Reduce reliance on mental health inpatient care for people with a learning disabilities and autism by at least 10%
Live within the budget allocated, reducing waste and improving productivity	Deliver a balanced net system financial position for 2025/26
	Reduce agency spending by at least 30% across all systems
	Close the activity/ WTE gap against pre-Covid levels
Maintain our collective focus on the overall quality and safety of our services	Improve safety in maternity and neonatal services, delivering the key actions of the of the 'Three year delivery plan'
Address inequalities and shift towards prevention	Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people
	Increase % of patients with hypertension treated per NICE guidance, and % of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance

14.2 The ICB has a well-established approach for coordinating the planning round across Cheshire and Merseyside. A core planning group, with representation from finance, performance, workforce, and contracting, leads the development of the plan.

14.3 Support from subject matter experts, including the Cheshire and Merseyside Provider Collaborative (CMCP), the Cancer Alliance, and ICB leads for dental, primary care, and mental health services, helps interpret national guidance, develop delivery trajectories, liaise with national teams, and align plans with system-wide transformation programs. The ICB's March submission included a

best practice checklist for national priorities, with no significant changes, outlining planned improvements and actions across several areas.

15. Urgent and Emergency Care

15.1 The ICB's 2025/26 UEC Improvement Plan aims to reduce corridor care by 50% ahead of winter, improving patient safety, outcomes, staff experience, and reducing costs. This will be achieved by improvements in patient flow which will in turn improve A&E 4 and 12 hour performance and ambulance response times. The programme is structured around five localities in Cheshire & Merseyside, focusing on alternatives to admission, in-hospital flow, and discharge, alongside initiatives to address performance and financial challenges. The plans align with national UEC priorities, including:

- optimising demand management and access to urgent care outside hospitals.
- creating a single access point for ambulance services to increase see & treat and hear & treat activity.
- implementing 'discharge to assess' for short-term recovery at home, aligned with Better Care Fund objectives.
- tackling UEC inequalities, particularly for mental and physical health, and reducing long waits for mental health patients in ED.
- providing alternatives to hospital admission, like 24/7 streaming, redirection, senior decision-making, SDEC, and ‘criteria to admit’.
- aiming for a 15-minute ambulance handover response time.
- ensuring effective hospital flow with 7-day specialty responses, straight-to-specialty referrals, and 7-day ward rounds.

15.1 The system has set out a plan that is compliant with the national guidance as per the table below:

Provider Name	A&E 4-Hr Wait			
	Walk in Centre Plan	Type 1,2 &3 Plan	Total Plan	Target
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	5.0%	83.0%	88.0%	78.0%
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	n/a	78.0%	78.0%	
EAST CHESHIRE NHS TRUST	n/a	78.1%	78.1%	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	4.0%	74.0%	78.0%	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	n/a	90.0%	90.0%	
MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	6.5%	71.5%	78.0%	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	n/a	78.0%	78.0%	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	4.5%	73.5%	78.0%	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	11.7%	66.3%	78.0%	
NHS CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD	-	-	**78.0%**	

16. Elective Care & Cancer

16.1 The Cheshire and Merseyside Provider Collaborative (CMCP) has an Elective Reform and Transformation Programme which worked with providers and the ICB to develop compliant elective plans. The programme ensures oversight of supporting actions, monitors performance, and manages risks and issues.

16.2 The key metric for elective care is the national goal to improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% by March 2026. Each Trust must achieve a minimum 5% improvement, reaching at least 60%, with Cheshire and Merseyside set a target of 62.7%.

16.3 The plans align with national priorities, including addressing health inequalities, validating RTT waiting lists every 12 weeks, expanding outpatient transformation (PIFU, standardizing clinic templates, reducing missed appointments), improving inpatient productivity (day-case rates, theatre utilisation), and ensuring diagnostic capacity meets RTT and cancer targets.

16.4 The system has set out a plan that is compliant with the national guidance as per the table below:

Provider Name	RTT 18 weeks		Time to First Appointment		Reduce 52ww to 1% Total WL	
	Plan	Target	Plan	Target	Plan	Target
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	63.1%	63.1%	67.2%	67.2%	1.0%	1%
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	60.0%	60.0%	67.0%	67.0%	1.0%	
EAST CHESHIRE NHS TRUST	66.2%	66.2%	67.0%	67.0%	0.9%	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	76.7%	76.7%	84.4%**	86.0%	0.0%	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	60.7%	60.7%	67.0%	67.0%	1.0%	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	60.0%	60.0%	58.2%**	67.0%	1.0%	
MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	60.0%	60.0%	67.0%	67.0%	1.0%	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	63.7%	63.7%	77.1%	77.1%	1.0%	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	98.0% *	100.0%	98.1%**	100.0%	0.0%	
THE WALTON CENTRE NHS FOUNDATION TRUST	64.2%	64.2%	67.0%	67.0%	1.0%	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	64.5%	64.5%	70.5%	70.5%	0.8%	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	63.3%	63.3%	71.3%	71.3%	1.0%	
PROVIDER TOTAL	**62.7%**	**62.7%**	**69.7%**		**1.0%**	

* Clatterbridge already exceeds the NHS Constitution standard of 92% in terms of RTT so is an exception
** Specialist Trusts were not mandated to achieve this standard, however Liverpool Heart and Chest and Clatterbridge already exceed the 72% standard.

16.5 Similarly, the Cheshire and Merseyside Cancer Alliance (CMCA) plays a key role in the planning cycle by reviewing operational plans, year-to-date (YTD) performance, and cancer alliance deliverables to inform provider planning.

16.6 CMCA supports providers by analysing their performance against key metrics and using business intelligence to create plans that align with system targets, consider seasonality, and incorporate local insights. CMCA collaborates with providers to adjust plans until an agreed version is submitted and works closely with the ICB to ensure plans are suitable.

16.7 Plans align with national cancer priorities, which focus on transforming cancer pathways, including managing low-risk GI, gynae, breast referrals, tele-dermatology, and non-medical prostate biopsies. CMCA has developed plans with each provider to realise performance improvement in each of the priority pathways. For Breast and Skin, the alliance will work toward delivery of 90% FDS and for LGI, Gynae and Urology, it is expected these will reach at least 70% across all providers for FDS.

16.8 CMCA worked with providers to agree a compliant plan at a C&M level. All providers are expected to meet both key priorities, with the exception of Liverpool Women's, where the underlying constraints the provider is managing has meant that a non-compliant plan was agreed on the basis that it demonstrated a significant stretch on current performance. Cancer performance at the Trust is also currently subject to additional oversight via the NHS England Tiering process:

Provider Name	Cancer 62d		Cancer Faster Diagnosis Standard	
	Plan	Target	Plan	Target
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	n/a	75.0%	96.4%	80.0%
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	79.9%		80.0%	
EAST CHESHIRE NHS TRUST	75.3%		80.0%	
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	75.0%		80.0%	
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	75.0%		80.0%	
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	64.3%		78.1%	
MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	75.3%		80.0%	
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	81.3%		80.0%	
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	76.7%		81.8%	
THE WALTON CENTRE NHS FOUNDATION TRUST	77.7%		80.0%	
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	77.7%		80.1%	
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	77.5%		80.0%	
NHS CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD	**75.0%**		**80.0%**	

17. Mental Health

17.1 The ICB and CMCP have worked with mental health providers to develop plans that address national mental health priorities and set improvement trajectories. Key actions include:

- implementing 10 High Impact Actions for mental health discharges, focusing on reducing stay lengths, improving local beds, and minimising out-of-area placements.
- reducing 12-hour A&E waits through crisis alternatives.
- increasing productivity by addressing unwarranted variation in CYP service access.
- reducing inequalities in CYP mental health services, especially for disadvantaged groups.
- expanding Mental Health Support Teams and NHS Talking Therapies and reducing inactivity with Individual Placement Support (IPS).
- ensuring people with learning disabilities or autism are only admitted for necessary assessments or treatments.

Provider Name	Average Length of Stay for Adult Acute Beds			
	Plan		Target	
MERSEY CARE NHS FOUNDATION TRUST	56.0		<62.2	
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	45.8		<57.8	
	Access to Children and Young People Mental Health Services		Individual Placement Support access	
	Plan	Target	Plan	Target
NHS CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD	37,590	>34,660	1,629	>1,200

18. Primary Care

18.1 The ICB has responded to the planning guidance, which includes improving access to general practice and dental appointments. Systems are also required to:

- develop action plans to improve general practice contract oversight and reduce unwarranted variation.
- support modern general practice with funding for digital tools and optimize access through services like Pharmacy First.
- commission additional urgent dental appointments to meet the government's target of 700k more.
- implement Primary Care Contracts, including the 2025/2026 GP contract.

ICB	Appointments in General Practice and Primary Care Networks		Percentage of resident population seen by an NHS dentist - adult	
	Plan	Target	Plan	Target
NHS CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD	1,404,738	> 1,194,197	42.25	>41.34

19. Ask of the Board and Recommendations

19.1 The Board is asked to:

- note the progress made on both revenue and capital financial plans for 25/26 since the end of March plan submission.
- note a revised submission of a £178.3m system deficit plan (£50.3m surplus for the ICB / £228.6m deficit for NHS Providers) in accordance with NHS England control totals.
- note that the ICB has submitted compliant plans in respect of key operational standards.

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NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

29 May 2025

NHS Cheshire and Merseyside Polypharmacy Programme Briefing

Agenda Item No: ICB/05/25/17

Responsible Director: Professor Rowan Pritchard- Jones, Medical Director

NHS Cheshire and Merseyside
Polypharmacy Programme Briefing

1. Purpose of the Report

1.1 This briefing paper provides a comprehensive overview of the Cheshire and Merseyside Polypharmacy Programme, highlighting its key objectives and primary workstreams. It outlines the strategic approach being taken to address polypharmacy challenges within Cheshire and Merseyside. In addition, the briefing identifies the main risks and issues currently associated with the programme and sets out the next steps to ensure continued progress and effective implementation.

2. Ask of the Board and Recommendations

2.1 The Board is asked to:

- **note** the current position and progress of the programme.
- **endorse** the ICB Polypharmacy Programme and approach.
- **note** further reporting will be via the ICB Quality and Performance Committee.

3. Background

3.1 Addressing polypharmacy is a key priority for NHS Cheshire and Merseyside, driven by national and local data. The National Overprescribing Review highlights it as a serious concern. As of February 2025, NHS Cheshire and Merseyside was ranked third highest nationally for the average number of unique medicines per patient, second for patients prescribed 10 or more medicines, and first for those prescribed 15 - 20 or more. It also ranked sixth for falls in people aged 65 and over. In response, NHS Cheshire and Merseyside has adopted a strategic, system-wide approach to improve patient safety and outcomes.

3.2 In 2024/25, Medicines Management teams delivered £1m in prescribing savings, and all Places have incorporated polypharmacy indicators into their 2025/26 work plans. The Polypharmacy Strategy (Appendix One), approved in November 2024, set out a clear framework and priorities for the 2025/26 programme. A follow-up scoping exercise defined the programme's aims, principles, and objectives, ensuring data and quality are central to its delivery.

3.3 The programme aims to:

- to improve health outcomes through safer and more effective prescribing practices.

- to reduce health inequalities by targeting areas and populations with the greatest need.
- to increase system efficiency and sustainability by reducing unnecessary prescribing.

3.4 In addition to being shaped by national and regional strategic priorities and influence from the Cheshire and Merseyside Polypharmacy strategy, the creation and development of a dedicated polypharmacy dashboard by the ICB business intelligence team has been critical to ensuring the work is targeted, providing detail on key indicators and bench marking NHS Cheshire and Merseyside against the national average, providing the ability to measure benefits throughout the lifespan of the programme.

3.5 The programme consists of a series of interconnected projects aligned with its overarching aims and is guided by established principles to ensure consistent, safe, and effective medicines use. Several key projects have received transformation funding on an invest to save basis to prove the concept and support delivery of the ICB financial plans.

3.6 **Key Projects**:

Risk stratification of patient cohorts
This workstream involves including polypharmacy reviews in general practice prescribing quality schemes across C&M. Agreed searches on clinical systems will support consistent identification and prioritisation of patients at highest risk due to problematic polypharmacy to be reviewed by ICB medicines management teams and PCN pharmacists. Savings and associated patient outcomes will be tracked via the polypharmacy dashboard e.g. falls.

Sefton Place hub work
The ICB Sefton Place Medicines Management Team hub was established prior to the formation of ICBs. Amongst other prescribing related functions, the hub reviews and reconciles post hospital discharge patients across Sefton. It receives referrals for medication reviews with a clinical pharmacist in GP practices and in patient's homes. As well as facilitating referrals for technician led post hospital discharge, home visits to care homes and to patients in their own home who have had multiple medication changes in hospital, thus supporting patients receiving polypharmacy. An evaluation undertaken by ICB Population Health colleagues has demonstrated the hub has delivered a 9% reduction in GP appointments (2,920 fewer) and a 32% reduction in A&E attendances (949 fewer) in the six months following discharge during a 12-month period.

In partnership with Liverpool University Hospitals NHS Foundation Trust (LUHFT) and the Northwest Kidney Network, the hub is undertaking a project to improve outcomes for patients who experience acute kidney injury (AKI) during hospital admission. With 20–25% of AKI survivors readmitted within 30 days, Sefton pharmacy technicians will conduct home visits within five days of

discharge to review medication changes and provide tailored resources developed by the Kidney Network. Outcomes from the hub have been shared nationally and will be used to inform future ways of working across C&M to support the polypharmacy programme, alongside improving access and reducing urgent care activity.

Medication reviews in hospitals
In response to interest from providers such as Clatterbridge, Wirral University Teaching Hospital NHS Foundation Trust, and Mersey and West Lancashire Teaching Hospitals NHS Trust, several projects have been developed to embed pharmacist-led polypharmacy reviews within acute care settings. These roles create structured opportunities to address inappropriate polypharmacy during admissions and outpatient visits, reducing risk and improving treatment outcomes. Multidisciplinary collaboration and shared decision-making are central to ensuring safe, patient-centred care. This model promotes consistent, proactive management of high-risk patients and aligns with wider medicines optimisation goals.

Consultant led multi-disciplinary team meetings (MDTs)
To enhance medication reviews and support ICB medicines management teams, the programme will introduce consultant input. This will strengthen polypharmacy MDTs by giving pharmacists direct access to expert guidance on complex cases. The sessions will promote shared learning and support clinical decision-making, especially where evidence for deprescribing is limited. This expert input is expected to reduce preventable readmissions, lower medication burden, and curb inappropriate prescribing.

Anti-depressant de-prescribing
Cheshire and Merseyside ICB have expressed interest in joining a national pilot led by NHS England, in collaboration with the National Clinical Director for Prescribing and the Lived and Professional Experience Advisory Panel for Prescribed Drug Dependence. The pilot aims to address inappropriate antidepressant prescribing. Local mental health providers have already taken part in early discussions. The initiative will support ICBs in developing safer, more effective deprescribing services, with objectives including reducing inappropriate long-term use, minimising withdrawal-related harm, lowering unnecessary antidepressant spending, and improving overall medicines safety.

Communities of practice and educational masterclasses
A system-wide Polypharmacy Community of Practice (CoP) and a series of masterclasses were launched in 2024. Following strong engagement, the quarterly masterclasses will continue into 2025/26. These initiatives promote best practice, support evidence-based approaches to reducing problematic polypharmacy, and foster collaborative learning across professions. Featuring expert speakers, the sessions offer a valuable platform for clinicians and system leaders to explore safer prescribing and person-centred care.

Data and research
The programme is also integrated into the Data into Action programme and University of Liverpool academic initiatives, ensuring an evidence-based approach with plans to develop a research bid to support the programme. Additionally, efforts are underway to align polypharmacy initiatives with broader system-wide falls prevention work.

3.7 **Governance**
The inaugural meeting of the Polypharmacy Steering Group is scheduled for May 2025. The group includes representation from providers leading key projects and will serve to monitor progress, provide a forum for escalation, and support coordinated delivery. The Steering Group will report monthly to the Medicines Optimisation Programme (MOP) Group, with detailed updates provided to the ICB Quality and Performance Committee to ensure appropriate oversight and assurance.

4. Finance

4.1 Delivery of the ICB polypharmacy programme will support delivery £2.4m towards the ICB financial plan.

5. Next Steps and Responsible Person to take forward

5.1 The programme will now move into the next phase of implementation, focusing on progressing key workstreams with associated timelines and ensuring effective oversight of delivery.

5.2 **Key actions include:**

- establishment of posts relating to medication reviews
- development of associated processes for medication reviews to ensure consistency
- project level impact assessments where required
- further conversations with mental health colleagues
- development of polypharmacy research bid
- continuation of Communities of practice and educational masterclasses
- utilise the learning and delivery from the projects to inform future strategic commissioning in relation to polypharmacy.

6. Officer contact details for more information

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7. Appendices

THE APPENDIX CAN BE ACCESSSED BY CLICKING HERE
Appendix One: ICB Polypharmacy Strategy

NHS Cheshire and Merseyside (C&M) ICB Polypharmacy Strategy 2023-2028

NHS Cheshire and Merseyside

Executive Summary

The national overprescribing review, Good for you, Good for us, Good for everybody was published in September 2021. The review identified that overprescribing is a serious problem that has grown over the last 25 years. The review makes recommendations on how to reduce overprescribing in order to improve patient care, support the NHS and reduce carbon emissions. NHS C&M ICB pledges to reduce overprescribing and inappropriate polypharmacy as a priority by involving the whole system, using data to inform our work and working with patients and clinicians to ensure a holistic approach to multi-morbidity and medicine burden. NHS C&M ICB is the 2nd highest (out of 42 ICBs) for the average number of unique medicines per patient 22/23.

Vision

- To ensure patients are involved in all prescribing and deprescribing decisions, are on the most appropriate medication for their needs, are fully informed about the benefits and risks and are being reviewed in line with best practice and adherence is considered at all stages.
- Clinicians are skilled in shared decision making, have access to reliable and robust resources to support them including materials to use with their patients.
- Decisions are evidence based and consider the impact on their patient's overall medicine burden, cost-effectiveness, safety, carbon footprint and health inequalities.

Delivery across three priority areas

PATIENTS - SHARED DECISION MAKING and RAISING AWARENESS

Patients will be involved in all prescribing decisions and their views will be actively sought at every opportunity.

What matters to a patient will be paramount.

Patients will be aware of what a medication review is, why it is done and will play an active role in the process.

Reducing health inequalities will be a priority.

Patients will have co-designed any materials that we use with them to support the review process.

DATA & TECHNOLOGY - IDENTIFICATION, ACCESS, EFFICIENCY, PROGRESS & OUTCOMES

The wealth of data available across C&M will be triangulated and collated for clinicians, commissioners and other stakeholders to access to benchmark and identify outliers.

Clinical systems & technology will be used to target, risk stratify and search for priority patients that we can have the greatest impact with.

Patient selection will be key to getting this right locally, using resources cost effectively.

We will use data to monitor our progress with regards to reducing the average number of unique medicines per patient and other national polypharmacy metrics.

SKILLS, EDUCATION AND TRAINNG – CLINCIAL and NON-CLINICAL

Our clinicians will be skilled in shared decision making to ensure reviews are patient centred.

Clinical training and education will be designed and delivered locally to ensure we have the right skills to prescribe and deprescribe for our population.

We will have a capable, highly skilled, sustainable, flexible workforce across all sectors.

Training and education will be delivered with the support of evidenced based tools and resources and through local clinical champions and experts.

Training for non-clinical staff will also be a focus to ensure we make every contact.

Tackling problematic pharmacy is everyone's responsibility

NHS Cheshire and Merseyside (C&M) ICB Polypharmacy Strategy 2023-2028

NHS Cheshire and Merseyside

PROBLEMATIC POLYPHARMACY MAP

STRATEGIC DIRECTION AND PRIORITIES

National Influences & National Drivers - Reduction in emergency admissions, national overprescribing review, national polypharmacy programme including improving outcomes, integrated working, reducing risks of opioids/drugs of dependence, contractual levers and requirements, waste reduction, reducing prescribing spend and influence of target driven prescribing

Overarching ICB strategy and action plan → Place Strategy and individual organisational strategies & action plans

DELIVERY PROGRAMMES

Patient awareness and engagement

- Shared decision making.
- Healthwatch and patient groups.
- Communications Teams.
- Patient sessions/ forums (targeted or general).
- Patient materials including easy read.
- Changing our conversations.
- English not first language and seldom heard populations

Governance and Workforce

- Primary care & secondary care processes.
- Community pharmacy requirements/processes.
- Workforce required to complete reviews.
- Competing priorities & target driven approach.
- Single speciality clinics versus general multidisciplinary approach.
- Capacity and recruitment.

Use of Technology & Clinical Systems

- Consistent clinical searches & risk stratification tools across C&M.
- Templates for Clinical systems – used across setting to capture same information.
- Priority Cohorts.
- Use of technology and systems to support clinicians e.g. DynAIRx system in development.

Patient Identification & Data

Identify priority cohorts to ensure highest impact & demonstrate value of medication review:

- Over 10 medicines.
- Opioids & medicines of dependence
- National STOMP/STAMP agenda.
- Learning disability.
- Long term antibiotics.
- High risk medicines.
- High anticholinergic burden.
- Care Homes/Social Care
- Moderate to severe frailty
- Compliance aids
- Seldom heard patients
- Housebound patients

Clinical & Non-clinical education

- Action Learning Sets & train the trainer.
- C&M wide programme of learning with shared decision making as a focus.
- Patient stories.
- Tools & resources.
- Clinical Champions.
- Local experts & masterclasses.
- Community of Practice.
- Practice staff.
- Medicines Managers/ coordinators.
- Social Care & Local Authority Staff.

Reducing Health Inequalities

- Core20 Plus 5 agenda.
- Place strategy and priorities.
- Health literacy and digital exclusion.
- Seldom heard populations.
- Patient populations to target in a different way.

ENABLERS

Community Pharmacy - Existing services, potential for new services - Referral/identification/follow up after review, use of prescribing skills, support with medicines taking pre-review/ assessment. Integrated approach with secondary care – rehab wards, long stay patients – structured medication review and deprescribing, could support packages of care on discharge .

Supporting Pharmacy sectors – Integration of primary care staff, secondary care, mental health and community trusts, health and justice system, community pharmacy including independent prescriber pathfinder sites.

Resources: EMIS, SystemOne, Epact2, PresQIPP, IMPACT, NHSBSA data, national recommendations, guidelines, NICE, medication review tools

What does good look like?

- Reduction in the unique number of items per patient at ICB level
- Reduction in the level of falls linked to medicines
- Reduction in the anticholinergic burden scores across the ICB
- Patient resources available that address the literacy needs of the population to compliment good quality medication reviews and deprescribing supported by a structured awareness programme
- An easy access ICB structured educational programme for health professionals
- Creation of a specialist resource to support decision making with regards to complex polypharmacy and deprescribing across all settings

Tackling problematic pharmacy is everyone's responsibility

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

29 May 2025

NHS Cheshire and Merseyside Integrated Research and Innovation System (IRIS): Research and Innovation Priorities

Agenda Item No: ICB/05/25/18

Responsible Director: Prof. Rowan Pritchard-Jones

NHS Cheshire and Merseyside Integrated Research and Innovation System (IRIS): Research and Innovation Priorities

1. Purpose of the Report

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

1.2 In line with the statutory responsibility for ICBs to deliver research and the Cheshire and Merseyside Research and Innovation Leadership team outline within this paper the ask of the Board of NHS Cheshire and Merseyside to support the strategic priority areas that align with both local and national research and innovation priorities.

1.3 This paper also shares the progress of IRIS as a core function within the ICB to date and highlights how IRIS has added value to the Cheshire and Merseyside health and care ecosystem by attracting considerable investment, strongly supporting innovation, and enabling the ICS to evolve into a world-class system of research and innovation excellence.

2. Executive Summary

2.1 In 2024, NHS Cheshire and Merseyside ICB approved the establishment of an Integrated Research and Innovation System (IRIS) to fulfil its statutory responsibility to deliver research and innovation under the Health and Social Care Act 2022. This also aligns with NHS England's guidance for ICBs on Maximising the Benefits of Research. The Explanatory Notes to the Act suggest that ICBs have board-level discussions on research activity.

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

2.3 The new model ICB Blueprint reinforces the need for strong strategic partnerships with academia and industry to support the population health strategy. It also highlights the need for robust evaluation methodologies, as well as evidence synthesis using both qualitative and quantitative data, feedback,

and insights to inform the development of care pathways and neighbourhood delivery models.

2.4 This paper sets out future priority areas for IRIS focusing on Population Health and Neighbourhoods, aligning with both the ICB's Joint Forward Plan and Delivery Plan, as well as with local and national research and innovation priorities. These are closely aligned with the three shifts in the health mission, where it was highlighted that research and innovation will play a key role in achieving these goals. At the same time we will continuing to promote and support the excellent life science and research in the secondary care setting.

2.5 It builds on findings from our Research Engagement Network including the recent report on Healthy Neighbourhood Models and what these should look like and building on recent strategic investment such as the NIHR Capital Investment Award. It identifies key enablers for delivery and areas that set us apart and ahead, such as inclusive research in the primary care and community settings.

2.6 The paper also shares the progress IRIS has made as a core function within the ICB —particularly to support the population health strategy and develop robust evaluation methodologies and evidence synthesis using qualitative and quantitative data, feedback, and insights to support care pathway development.

2.7 These plans have been developed with considerable input from a wide range of stakeholders through the IRIS Steering Committee, including patient and public involvement.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- **recognise** the current duty to promote research and innovation is still held within the ICB to help support delivery of the Joint Forward Plan and ICB Delivery Plan.

- **support** the proposed priorities that build strategic partnerships to support the population health strategy and new neighbourhood models.

4. Reasons for Recommendations

4.1 The 2022 Health and Social Care Act introduced specific legal duties for Integrated Care Boards requiring them to facilitate and promote research relevant to health and social care service. The Explanatory Notes to the Act suggest that ICBs have board-level discussions on research activity.

4.2 By focusing on Population Health and Neighbourhoods as priority areas IRIS will support the delivery of the ICB delivery plan triple aim of improving

population health and wellbeing, enhancing service quality, and ensuring efficient, sustainable use of NHS resources. Aligned with the four core ICS objectives, IRIS will contribute to tackling health inequalities, improving population health, enhancing productivity, and supporting wider social and economic development. It will also enable the delivery of four key priorities: Financial sustainability; Urgent care improvement; Planned care; Neighbourhood and population health.

4.3 Our recommendation will allow the ICB to develop its response to the Model ICB Blueprint document. Notably supporting the ICBs critical role as a strategic commissioner that is going to be central to realising the ambitions that will be set out in the 10 Year Health Plan.

5. Background

5.1 The Health Mission set out an ambition to build a health and care system fit for the future. It states that we must reduce the amount of time people spend in poor health, reduce health inequalities, drive economic growth, and ultimately improve the financial sustainability of the health and care system. This includes (a) an NHS that is there when people need it, (b) fewer lives lost to major conditions, and (c) a fairer Britain, where everyone lives well for longer. Key shifts include:

- Hospital to community care
- Analogue to digital transformation
- Sickness to prevention.

5.2 The report highlights that research and innovation will play a key role in achieving these goals, as well as in preparing the NHS for the future.

5.3 A third of the Cheshire and Merseyside population live in the most deprived 20% of neighbourhoods in England, with consequent low life expectancy and the need to consider health and deprivation together in public health and prevention initiatives. Healthy life expectancy is up to six years below the national average in our most deprived lower-tier local authority regions. This reflects high rates of early-onset long-term conditions including those amenable to facilitated lifestyle choices, low life expectancy and the need to consider health and deprivation together in public health and prevention initiatives, contributing towards the national priority of 'A Fairer Britain'.

5.4 Our region’s high rates of ill health require research and innovation to help deliver equitable social care. Inequalities in accessing suitable social care services, including day/ home/ respite and residential care, lead to worse health outcomes for people with care needs. Additionally, barriers accessing social care cause significant economic strain on the NHS, leading to worse health outcomes.

5.5 The gap between most and least advantaged is widening, driven by differences in the availability of resources, quality of living environments, and access to and uptake of preventative interventions between those of differing socio-economic status. Long-term sustained improvement requires a whole system shift towards prevention. IRIS will support this shift driving forward innovation in prevention.

5.6 Research and innovation should happen where patients live and receive most of their care. Focusing on research in primary care, community and social care settings enables this to take place. For example, in the NHS, ~90% of all consultation take place in primary care, with 2 million GP contacts per working day. Primary care manages the majority of chronic diseases—such as type 2 diabetes and asthma—and benefits from long-established, comprehensive digital systems that support both prevention and research. GP practices also play a crucial role in reaching underserved and deprived communities, helping to reduce health inequalities through inclusive research.

How will this be achieved: Building on success that sets us apart and ahead

5.7 Whilst continuing to promote the excellent life science and research in the secondary care setting we will support a complimentary track of integrative care to build strategic partnerships to support population health strategy and health neighborhood models. The plan has alignment with those of key strategic partners including NIHR North West Coast Applied Research Collaboration, NIHR North West Coast Applied Research Collaboration, NIHR North West Research Delivery Network, Health Innovation North West Coast, Liverpool City Region Innovation plan, Liverpool Health Partners strategic plans and strategic plan for commercial research activity in University Hospitals of Liverpool Group.

5.8 Cheshire and Merseyside has a strong foundation in primary and community research, with 349 practices engaged, 131 actively recruiting, and 53 involved in commercial studies—more than twice the national average (15% vs 6%). The region ranks among the top three nationally for total primary care recruitment, alongside North West London and Oxford, and leads all ICBs for research recruitment in the most deprived communities. It also tops the country for the total number of primary care studies opened and for recruitment in the most deprived communities demonstrating its commitment to inclusive and impactful research.

5.9 IRIS will expand research across public health primary care, social care and community settings to generate evidence that improves quality and outcomes. It will play a key role in aligning local and national research priorities with stakeholders, enhance research capacity and coordination, and embedding evidence-based practice in urgent and planned care, neighbourhood health, and system sustainability. Additionally, IRIS will drive standardisation, develop the research and innovation workforce, and leverages commercial research for economic and patient benefit.

5.10 The plan builds on recent investment in primary care and community settings, such as the NIHR Capital Investment that established a network of primary care

research hubs and mobile research units. It aims to strengthen and diversify the research pipeline—both commercial and non-commercial—by promoting primary care as a valuable setting to sponsors and funders through the NIHR Research Delivery Network and the NIHR Cheshire and Merseyside Commercial Research Delivery Centre (CRDC) - an ICS wide network designed to enhance the delivery of commercial clinical research across the UK by streamlining the setup and execution of industry-sponsored studies providing patients with faster access to innovative treatments and therapies.

5.11 This approach includes delivering research across diverse settings such as pharmacies and dental practices, supported by public engagement initiatives like Be Part of Research. Expanding commercial contract research through the NIHR Cheshire and Merseyside CRDC, alongside the creation of new workforce opportunities, will help increase research capacity. Addressing ongoing challenges—such as incentivisation, data governance, infrastructure, sponsorship, and clinician training—while ensuring consistent support across ICBs, will be critical to building a sustainable and inclusive research environment.

5.12 Key enablers include but are not limited to:

Research Engagement Network
The ICS Research Engagement Network Development Programme, led by the ICB and supported by the CRN and ARC, launched four REN bids in 2023/24 across Cheshire & Merseyside and Lancashire & South Cumbria, totalling £530K and focused on involving communities traditionally excluded from research. Each project, led by VCFSE organisations with ICS/CRN/ARC support, explores different aspects of community engagement to embed research more meaningfully in local settings. Building on this learning, the programme is strengthening collaborations, promoting research awareness in clinical practice, and working to make research more inclusive, representative, and impactful. Recent work has focused on Healthy Neighbourhood models and what these should look like.

The Civic Health Innovation Labs (CHIL)
CHIL promotes health, social, and economic wellbeing through research and innovation in civic data and health technology, uniting experts from academia, the NHS, local government, charities, and industry to advance responsible data use and AI. Aligned with the Cheshire & Merseyside ICB's priorities, CHIL supports investigator-led research and strengthens integration with the Population Health and Data Into Action functions. It also convenes a range of projects leveraging the region's Secure Data Environment (formerly CIPHA), turning data into actionable insights through a unified programme. The award-winning System P research programme explores system-level approaches to improving population health outcomes, focusing on integration, prevention, and digital transformation. The MRIC (Medical Research and Innovation Centre), a flagship initiative within CHIL, received £10.5million in government funding from the Office for Life Sciences and the NIHR as part of the UK's Mental Health

Mission, and focuses on advancing patient centred innovations and clinical research across primary and secondary care settings.

NIHR North West Coast Applied Research Collaboration
The ICB currently hosts the North West Coast ARC, which received a total programme award of £14.6 million. From the start of the ARC in October 2019 until the end of the last financial year, the total external funding amounted to just under £48.8 million. A new ARC2 bid hosted by University Hospitals of Liverpool Group on behalf of the ICB will aim to improve lives, strengthen the health and social care workforce, and guide service improvements through the use of evidence. It focuses on key research themes, including public health, workforce resilience, social care, long-term conditions, and women's health. These are supported by digital innovation, impactful research design, and wide dissemination of results. Through strong partnerships with over 60 organisations including including universities, local authorities, charities, and NHS Trusts and deep community engagement, the ARC promotes equity, builds research capacity, and ensures that underrepresented groups are central to shaping fairer, more effective health and social care.

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

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

Health Innovation North West Coast
In collaboration with our local Health Innovation Network, we will focus on the adoption of proven innovations, at scale across our ICS. We will work with Health Innovation North West Coast to deliver key goals to: Increase the spread and adoption of innovation through collaboration; Develop cultures that promote equity and allow innovation to thrive; Stimulate economic growth and create jobs in the health and life sciences sector. Examples include C2-Ai, an automated patient tracking system that helps hospitals improve patient safety, reduce mortality and complication risk, and address variation in clinical outcomes by delivering globally unique, AI-backed insights. Its implementation has been enabled through collaboration with executive clinical teams and system partners, supported by funding including resources for real-world

evaluation to inform national scaling. The initiative has benefitted from the strength of the Health Innovation Network (HIN), leveraging its locally embedded and nationally coordinated structure to support the scale, spread, and adoption of innovation. In recognition of its impact, C2-Ai received the 2024 Innovate Awards for both Best Digital Innovation and Overall Innovation.

UKRI Hartree Centre

The UKRI Hartree Centre is developing cutting-edge quantum computing infrastructure and leading expertise in data security to support national research and innovation. Based at Sci-Tech Daresbury in Cheshire, the Centre is at the forefront of secure, high-performance computing in the UK. It works closely with the life sciences industry to accelerate breakthroughs in areas such as drug development, genomics, and personalised medicine by combining quantum computing, AI, and secure data handling. These collaborations drive more efficient research and deliver real-world health benefits. The Hartree Centre partners with NHS organisations across Cheshire and Merseyside, including Mersey Care NHS Foundation Trust. This work focuses on applying AI and quantum technologies to improve patient outcomes, develop personalised care, and increase operational efficiency. These efforts help tackle complex regional challenges - such as optimising patient flow and giving children the best start in life - while supporting NHS staff with advanced digital tools.

NIHR RDN

The recently formed NIHR Research Delivery Network (RDN) aims to position the UK as a global leader in delivering high-quality, inclusive, and accessible research that improves health and care. It will enable the health and care system to attract, optimise, and deliver research, acting as an active partner in the wider research ecosystem. The RDN will increase the capacity and capability of the research delivery infrastructure, ensure more people can access research in their local communities, and support a broader range of studies that reflect changing population needs, particularly in areas of greatest need. It will help embed research as a routine part of care, provide support to the health and care system through research, and contribute to economic growth by attracting investment into the UK. The RDN will play a key role in supporting research across all care settings, with a strong focus on community-based delivery, local funding to practices, clinical leadership, and agile teams. Identifying effective levers for research in primary and community settings is complex, and the RDN has established infrastructure and communities of practice to help address these challenges. For example, in partnership with the ICB, the NIHR has supported Capital Investment funding across Integrated Care Systems to develop world class research infrastructure. This includes the development of a primary care research hub network, the establishment of new secondary care research units, and the deployment of mobile research units, all designed to support and promote inclusive research across diverse communities. The RDN has supported the development of the Deep End GP network across Cheshire & Merseyside to strengthen research activity in the most deprived practices and communities.

Liverpool Health Partners (LHP)
LHP is a strategic collaboration of research-intensive NHS organisations and universities in the Liverpool City Region and beyond, committed to improving population health through world-class research, education, and innovation. As a convener and advocate, LHP amplifies the region's collective voice—bringing together academia, healthcare providers, industry, and civic bodies to align efforts, accelerate adoption of evidence into practice, and influence national policy agendas. A key enabler of the NIHR C&M Commercial Research Delivery Centre (CRDC), LHP drives inclusive, data-driven research and supports the life sciences sector as a growth engine for the region. One of LHP's core areas of focus is the development of a life-course bio-resource—building a rich, longitudinal dataset that integrates biological, social, and clinical information to inform early intervention, personalised medicine, and long-term population health strategies. Through these efforts, LHP strengthens the region's reputation as a national leader in translational health research and innovation

Commercial Research Delivery Centres
Cheshire and Merseyside organisations, including primary care, social care, voluntary groups, and ten secondary care providers, are working together to support the NHS 10-year health plan through participation in the new £5.7M NIHR C&M Commercial Research Delivery Centres (CRDCs), which aim to promote better patient outcomes and a healthier population, support UK economic growth, and contribute to a financially sustainable NHS. The NHS University Hospitals of Liverpool Group has been named one of 21 UK CRDCs, giving patients faster access to innovative clinical trials and treatments. This recognition highlights the strength of collaboration within the region's healthcare research ecosystem, supported by Liverpool Health Partners—a partnership between research-intensive universities and NHS trusts. The region is home to one of the largest bio-manufacturing clusters, and its scientists are driving breakthroughs in infection prevention and control, therapeutics, mental health, and the use of data and AI to improve lives. The CRDC will provide a vital link to connect this industry to the NHS.

Place based Research and Innovation Collaborations
Supported by ICB directed NIHR Research Capability Funding, several Place-Based Research and Innovation Collaborations have been established, including the Wirral Research Collaborative, Halton Research Alliance, and the St Helens Research and Innovation Academy. The Wirral Research Collaborative is a partnership of health and care providers across the Wirral, united in their commitment to improving outcomes for the local population through high-quality evaluation and research. By fostering synergy between primary care, secondary care, and wider health and care agencies, the collaboration supports a thriving research and innovation ecosystem across the community. The Wirral Research Collaborative has recently submitted a £1million NIHR Primary Care–Commercial Research Collaborative that if successful would further strengthening the region's capacity to deliver cutting-edge research at the interface of public health and commercial innovation.

Liverpool City Region Investment Zone
The Liverpool City Region's Life Sciences Investment Zone supports initiatives that create high-tech facilities, drive business innovation, and develop future talent. A key example is Alder Hey Children's NHS Foundation Trust, awarded over £4 million as part of a £9.44 million investment by the Combined Authority to establish the Paediatric Open Innovation Zone (POIZ). This initiative enhances the region's leadership in children's healthcare innovation. Alder Hey, home to the UK's largest hospital-led innovation centre, has a proud legacy of pioneering paediatric care. POIZ will develop and deploy cutting-edge technologies to tackle health challenges facing children and young people. It will also enable collaboration with local innovators, giving them access to Alder Hey's clinical teams and expertise. The initiative supports businesses in testing healthcare solutions and provides training to embed innovation-led care across the region. It will also help NHS and industry partners benefit from Alder Hey's experience and global reputation

Champs Public Health Collaborative
The Champs Public Health Collaborative has established a comprehensive, system-wide approach to addressing public health priorities through large-scale action and collaborative leadership across Cheshire and Merseyside. Its focus includes strengthening communication between public health and academic partners and fostering community connections across initiatives such as the All Together Fairer programme.

6. How will we know if we have made a difference?

6.1 Over the next five years, Cheshire and Merseyside aim to create a world-class, research- and innovation-driven healthcare ecosystem that improves population health and addresses inequalities. The I.M.P.R.O.V.E. framework outlines ambitions to make research more inclusive, impactful, and accessible, while promoting community engagement, overcoming barriers to participation, and enhancing research culture across all care settings. By aligning with local priorities and working collaboratively across sectors, the system seeks to accelerate innovation, translate evidence into practice, and ensure all communities benefit from research.

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

Objective One: **Tackling Health Inequalities in access, outcomes and experience**
IRIS has supported the ICB to fulfil its legal duty in the 2022 Act to reduce health inequalities in access to health services and the outcomes achieved. Focusing on these priority areas can give a better understanding of local populations and the wider

determinants of health, and with this the steps to maintain health and narrow health inequalities.

Objective Two: **Improving Population Health and Healthcare**
IRIS has created opportunities for research to inform and be informed by population health management. Tools such as Cheshire & Merseyside Secure Data Environment will play key role within IRIS for enabling data integration and population health action.

Objective Three: **Enhancing Productivity and Value for Money**
IRIS has provided an opportunity to consider research delivery within the ICS and across ICS boundaries, increasing flexibility of workforce or recruitment while reducing bureaucracy and improving research productivity and value for money.

Objective Four: **Helping to support broader social and economic development**
An active research ecosystem working in a coordinated way and to national standards brings revenue and jobs to regions. IRIS will leverage and help to improve the scale and pace of commercial contract research and innovation.

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

8.1 IRIS will enable to delivery of the four key priorities in the annual delivery plan: 1) financial sustainability, 2) urgent care improvement, 3) planned care, and 4) neighbourhood and population health. These priorities will be delivered through targeted research & innovation programmes such as admission avoidance, improved hospital flow, diagnostics, cancer care, and integrated neighbourhood services.

9. Link to meeting CQC ICS Themes and Quality Statements

Theme One: **Quality and Safety**
In addition to the direct benefits of research and innovation, there is strong evidence that research engagement by healthcare organisations and staff positively influences patient outcomes and care processes. IRIS strengthens the key factors that enhance this impact by fostering a supportive context—through active research networks and collaborative initiatives—encouraging deeper engagement across healthcare teams and promoting widespread participation. By enabling targeted outreach and inclusive involvement, IRIS helps ensure the benefits of research are equitably distributed and contribute to reducing health inequalities

Theme Two: **Integration**
IRIS supports the REN (Research Engagement Network) programme, which strengthens integration by embedding research into care pathways and promoting collaboration across the NHS, local authorities, and community partners. The

programme enhances inclusivity by engaging underserved populations and expanding access to research, while also building system-wide capacity through training and infrastructure to make research a routine element of integrated care.

Theme Three: Leadership

IRIS has supported and is actively aligning with the Well-Led Framework across the Integrated Care System (ICS), helping to embed clinical research as a core component of high-quality patient care. It supports the development of integrated plans that position research activity as essential to improving outcomes, while ensuring that service users and carers are given opportunities to participate in or contribute to clinical research. IRIS has become a national leader in the delivery of research and innovation within ICS structures by developing targeted exemplars—such as data integration and population health—and by contributing to national leadership efforts through platforms such as UKRD and the NIHR.

10. Risks

10.1 IRIS stakeholder partners maintain risk registers with well-established mechanisms for reporting risks directly through to the ICB.

10.2 If the ICB were to not maintain a research and innovation function aligned to the delivery plan several strategic and operational risks could arise:

- **Loss of strategic influence**: The ICB would have reduced ability to align research and innovation with local health priorities, limiting its influence on shaping services and policy based on emerging evidence.
- **Reduced integration**: Without an embedded IRIS function aligned with the delivery plan research activity may become siloed, weakening links between research, service improvement, and population health outcomes.
- **Disconnection from frontline services**: Not maintaining an integrated research and innovation aligned to the delivery plan risks diminishing relationships with local providers, clinicians, and communities—making it harder to embed research into everyday care and engage underserved populations.
- **Funding and investment risks**: The ICB could lose access to research and innovation related funding streams and may be less competitive in attracting future investment.
- **Slower adoption of innovation**: Without embedded research and innovation the pace of evaluating and scaling innovative interventions may slow, leading to missed opportunities to improve outcomes and efficiency.

- **Workforce and capability impact**: Research-active systems tend to attract and retain high-calibre staff; loss of this function could affect workforce morale, development, and recruitment.

10.3 Each of the above risks could be mitigated by maintaining research and innovation as a core function of the ICB.

11. Finance

11.1 There are no requests for new funding or investment of existing funding as the resource for the IRIS is already embedded within the system.

11.2 The total directly awarded and external funding secured across programmes and initiatives above stands at approximately £75 million.

11.3 **Key sources of income have included:**

- In 2023, Cheshire and Merseyside ICB secured a Capital Award of £1,220,896. Liverpool University Hospitals NHS Foundation Trust was awarded £4,226,429 through the same capital funding stream
- The region received a programme award of £14,622,000 for the NIHR Applied Research Collaboration North West Coast (ARC NWC)
- An additional £535,000 was awarded to support the Research Engagement Network (REN), including a recent contingency award
- A successful bid for £5.7 million has been submitted to the NIHR Clinical Research Delivery Centre (CRDC) to support research delivery
- Since October 2019, the total external funding secured via ARC has reached just under £48.8 million.

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

12. Communication and Engagement

12.1 These plans have been developed with considerable input from a wide range of stakeholders through the IRIS Steering Committee, including patient and public involvement.

13. Equality, Diversity and Inclusion

13.1 Inclusivity and health equity are integral to our approach. We align with current NIHR operating principles to support inclusion. We also utilise and promote the NIHR North West Coast ForEquity.uk toolkit guiding researchers to embed socio-economic factors, equity and diversity in research and innovation.

14. Climate Change / Sustainability

14.1 IRIS has actively supports research and innovation grants that align with the ambitions of the ICB regarding the delivery of its Green Plan and Net Zero obligations. One such example is the recent UKRI SmartGrow bid that in partnership with industry and academia utilises novel machine learning approaches to support and optimise local food security and food procurement in the NHS.

15. Next Steps and Responsible Person to take forward

15.1 The outcome from Board will be taken back to the IRIS committee and ICB steering group to develop a plan for operationalisation by the Chair of the research and Innovation Committee, Prof. Paul Kingston, ICB Director of the Research and Innovation (Prof Terry Jones) and the Associate Director for Research and Innovation (Prof Greg Irving).

16. Officer contact details for more information

Prof. Rowan Prichard Jones – Medical Director Cheshire and Merseyside ICB.
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NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

29 May 2025

NHS Cheshire and Merseyside NHS Staff Survey 2024: Results and next steps

Agenda Item No: ICB/05/25/19

Responsible Director: Mike Gibney, Chief People Officer

NHS Cheshire and Merseyside NHS Staff Survey 2024: Results and Actions

1. Purpose of the Report

1.1 To provide Board members with an outline of the ICBs NHS Staff Survey 2024 results and an overview of the activity undertaken to date with our staff.

2. Executive Summary

2.1 This paper and supporting presentation (Appendix One) provides an overview to Board of the ICBs NHS staff survey results for 2024. The results are presented against the seven areas of the NHS People Promise and the key themes of staff engagement and morale.

2.2 The presentation and report also provides an overview on the progress on the action plan from 2023 survey and an overview of activity to date in respect of sharing the survey results with staff, taking into account the current workforce cuts. The survey is an important factor of our current staff experience as it describes the world on which the current context has landed.

2.3 The report also includes a high-level overview of the staff engagement scores for organisations across the Cheshire and Merseyside system with identification in movement from the previous survey year. Organisations are currently sharing their own results and developing localised action plans in line with staff feedback.

2.4 A presentation on the results for the ICB was delivered to the Executive Team on 06 March 2025 by our independent survey provider. This was supported by 121 meetings with Executive Directors, a dedicated session of our Staff Engagement Forum on held on 02 April 2025 and four open staff engagement sessions to share the results and engage with staff to help inform areas of improvement and plans for future engagement. It is important to understand that in the current climate we have used the results of the staff survey to lay the foundation of how staff were feeling and then used the framework of the NHS People Promise to engage on what support is needed over the next six months and then what support/ initiatives will be needed in the future.

3. Ask of the board and recommendations

3.1 The Board is asked to:

- **note** the ICB staff survey results
- **endorse** the actions taken to review, disseminate and respond to the NHS Staff Survey results 2024
- **support** the areas of improvements identified from the staff engagement sessions.

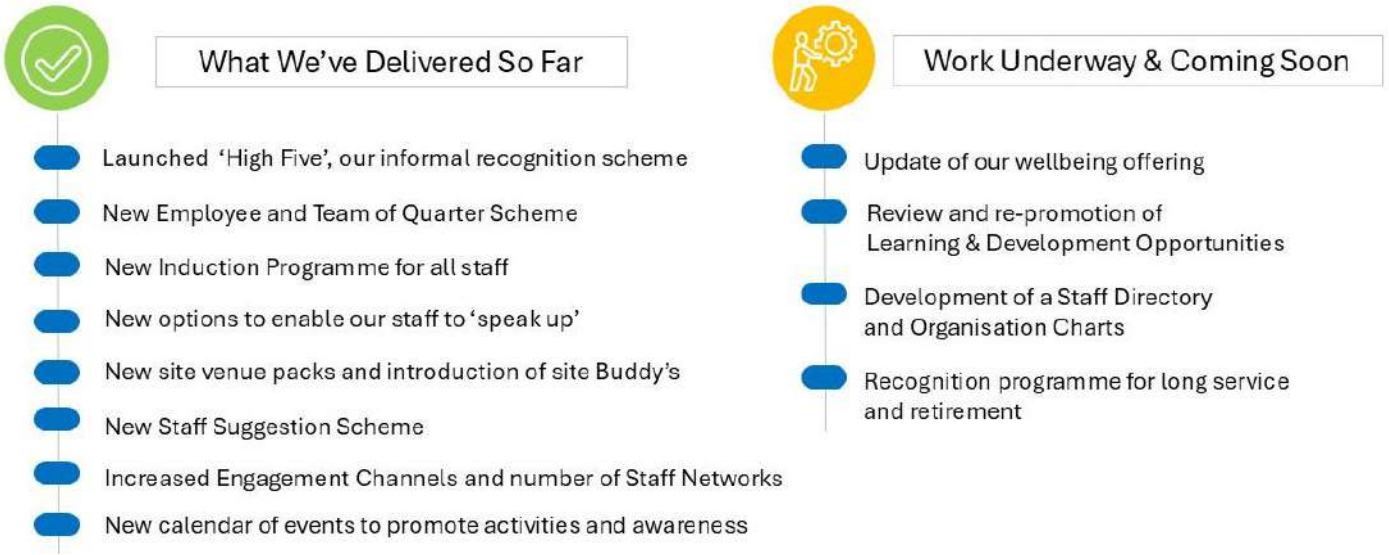
4. Background

4.1 The national Staff Survey was undertaken during the period September to November 2024 and follows an agreed national format with questions aligned to the seven areas of the People Promise and the themes of staff engagement and morale. Although not mandated, this is the third year the ICB has ran the survey to ascertain staff opinion and to establish a baseline of staff views for future benchmarking and comparison. We also now have a baseline of two years results for individual places and corporate functions.

4.2 In 2024 our response was 73%, compared with 74% in 2023 and 65% in 2022. With 199 staff also providing free text comments.

5. Action Plan 2023

5.1 An action plan from the 2023 staff survey was developed following an extensive period of staff engagement, this included 18 121 meetings with Executive Directors and 18 staff led People Promise engagement events where over 600 staff attended (over 60% of our workforce). The below image is a summary our 'You Said, We Did' that was communicated to staff:



6. Staff survey results 2024

6.1 The ICB results are detailed in the complementary staff survey presentation (Appendix One). At a high level, the ICB staff engagement score is 6.65 and staff morale is 5.73 The ICB score against the seven areas of the People Promise are detailed below with comparison scores for 2022 and 2023 also detailed:

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

6.2 The ICB scored higher than the peer group average in all People Promise Themes including Staff Engagement and Morale.

6.3 Narrative free text comments were also submitted from staff in support of the structured questions within the survey, we received 199 comments. We have conducted a thematic review of the feedback with key themes emerging around: -

1. **Improve Workforce Planning** – Address recruitment freezes and career progression barriers to retain skilled staff.
2. **Enhance Communication** – Increase transparency in decision-making and strengthen engagement between central and Place teams.
3. **Support Staff Wellbeing** – Prioritise mental health support, management training, and a fair workload distribution.
4. **Invest in IT and Infrastructure** – Provide training for new systems and improve office working conditions.
5. **Develop Hybrid Working Strategies** – Balance remote work benefits with the need for team collaboration.

6.4 Following the initial sharing of our high-level results (under embargo conditions) the following actions have been undertaken to share, review and action plan in relation to the feedback.

- Presentation by the Survey Provider to the Executive Team
- Individual review meetings with Leaders of respective teams with full involvement of Team representatives from both the People Operations Group and Staff Engagement Forum
- Presentation and dissemination at both the People Operations Group and
- Staff Engagement Forum
- Four online engagement sessions open to all staff, led by the People's Team. Over 150 staff have attended and shared their views
- Individual team development sessions, led by individual teams.

6.5 Following the government announcements of the ICB cuts the online engagement sessions were amended to include asking staff what support they needed now. The aims of the sessions became:

- play back the staff survey results and outcomes from last year
- check in with staff – how are people feeling?
- hear what you need from us now to feel supported, valued, and motivated during this challenging period.

6.6 Using the NHS People Promise themes, which are aligned to the staff survey, we asked staff in the short term:

- we are safe and healthy: What support would help you stay healthy both physically and mentally while going through these organisational changes?
- we have a voice that counts: What are the best ways for you to share your views, concerns, questions or suggestions?
- we are compassionate and inclusive: What currently helps you feel valued, what else would you like to see?

6.7 Regarding their future aspirations and what they would like to see in the long term we discussed:

- we are always learning: Have you experienced any barriers to accessing any learning or development over the last 12 months? What else would you like to see?
- we are a team: How can we better connect colleagues across the organisation?
- we are recognised and rewarded: How can we better recognise staff for the positive impact they deliver across Cheshire and Merseyside?

6.6 We were able to break down the staff survey results into staff demographics, including age, if staff have caring responsibilities, if staff had a physical or mental health issues impacting them for over 12months, if staff identified as LQBT and ethnicity. Working with our staff networks we are discussing the results and comparisons with the organisation average to determine key actions that the network can support us to achieve.

6.7 Following review of the results and all the engagement activities a number of key areas were identified for further development:

- work pressures
- increased staff engagement
- discrimination and bullying
- ensuring teams feel supported through ongoing changes
- positivity regarding our increased health and wellbeing offer
- promote having organisational permission to prioritise health and wellbeing
- be kind to each other and ourselves
- review learning and development offer
- the importance of a simple thank you
- review of 2023 action plan.

6.8 Following the conclusion of the staff engagement sessions and work with our staff networks we will continue to work in collaboration with leaders and Staff Engagement Representatives to agree and develop local priorities for the next 12 months based on survey data and regular staff feedback related to staff engagement, morale and the promotion of organisational values.

6.9 The People Operations Group and People Committee will oversee the action plan and progress

7. NHS Cheshire and Merseyside Integrated Care System results

7.1 The national embargo was lifted in March and results for our Trusts are now available. In summary:

- Cheshire and Merseyside (CM) ICS, response rate for 2024 was 50.83% or 36,862. This was 3,671 more people in 2024 than in 2023. This was higher than the Northwest average of 47.9%
- CM ICS scored above the national average in 3/9 themes: "We are safe and healthy" by 0.14, "We are compassionate and inclusive" by 0.13 and "We each have a voice that counts" by 0.12. The remaining survey themes were consistent with the national average
- CM ICS has seen no statistically significant change[1] across any of the 9 themes or any of the sub-scores compared to 2023
- at individual question level, most questions have remained statistically the same. The most improved questions related to respondents reporting bullying & harassment if they saw it or experienced it, people saying they had had an appraisal and feeling the organisation was committed to supporting work life balance.
- there were minor deteriorations in people reporting feeling they have unrealistic time pressures and reporting that there are opportunities to develop their career

7.2 Appendix 1 shows the highest and lowest scoring organisations, and the most improved/deteriorated since 2023.

7.3 With regard to the themes of the People Promise and staff engagement and moral the results are shown below, in comparison from 2021:

[1] The Staff Survey 2024 uses 2 decimal places rather than 1. National direction is that change should only be counted as statistical deviation/change of over **0.098**. Changes less than this are counted as being “the same”/consistent.

Survey Themes	2021	2022	2023	2024	Change between 23 - 24	Change Between 21 - 24
We are compassionate and Inclusive	7.32	7.33	7.4	7.41	0.01	0.09
We are recognised and rewarded	5.96	5.84	6.06	6.07	0.01	0.11
We each have a voice that counts	6.79	6.78	6.81	6.81	0	0.02
We are safe and healthy	6.08	6.07	6.26	6.28	0.02	0.20
We are always learning	5.09	5.24	5.58	5.60	0.02	0.51
We work flexibly	6.07	6.08	6.24	6.29	0.05	0.22
We are a team	6.68	6.73	6.85	6.87	0.02	0.19
Staff engagement	6.87	6.85	6.95	6.92	-0.03	0.05
Morale	5.84	5.82	6.02	6.04	0.02	0.20

7.4 Overall score staff engagement saw a slight decrease, but not statistically significant, 6.92 -0.03 since 2023 and +0.05 since 2021 (Consistent with the national median). When compared to overall National Scores, C&M ICS scored above the national average (6.85) for engagement with Liverpool Heart & Chest scoring well above average (7.72) compared to their peer group. Out of our 16 Trusts, Mersey Care saw a statistically significant increase in their engagement score from 6.96 to 7.11, with five showing a very minor deterioration compared to 2023, however, their scores remained fairly consistent with previous year.

7.5 Our collaborative efforts in relation to delivering the People Promise are reflected in in the work undertaken by our Staff Retention Forum. The forum is facilitated by NHS Cheshire and Merseyside and brings together HR and Operational Leaders from our 16 Trusts, also social care and primary care, working in partnership to develop new and innovative ways to retain staff. At the June Forum, the staff survey results will be presented and the Trusts will be able to have a discussion about sharing learning and best practice and agree and collectively prioritise.

7.6 The elements of the ‘People Promise are well embedded within the group and regular updates are provided by our ‘People Promise’ Exemplar Leads

which grew over 2024/5 to 8 following the receipt of additional funding from NHSE. In addition, the North West ICB's has also benefitted from this funding and has had a 'People Promise' Manager in post for 12 months. The 12month programme is now coming to a close but working with NHS England we will be exploring how we can share lessons, resources and best practice across the ICS.

8. Next steps

- Publish the organisation's staff survey action plan in early June 2025
- Assurance reporting to the People Committee in July
- Ongoing reporting and monitoring to People Operations Group and Staff Engagement Forum
- Further analysis once the staff engagement sessions have been completed and areas for ongoing review and deep dive are identified.
- Identify ongoing staff engagement sessions and mechanisms to ensure we have a robust continuously cycle of engagement
- Undertake mid-year review of progress against our actions and conduct regular check ins with Place/Departments to support progress against local 'People Promise' activities and priorities
- Continue to work with our ICS partners to encourage collaboration and share learning.

9. Officer contact details

Paul Martin, Workforce Programmes Manager via
Paul.Martin@cheshireandmerseyside.nhs.uk
or
Katie Horan, Programme Manager Staff Retention and Experience via
Katie.horan@cheshireandmerseyside.nhs.uk

Appendix

Appendix One: Staff Survey 2023 Results Presentation

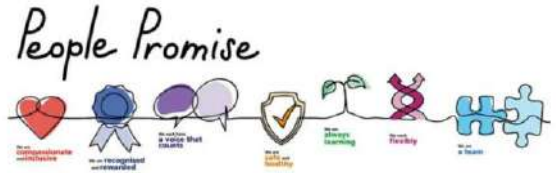
NHS Cheshire and Merseyside

Staff Survey Results 2024

May 2025

Staff Survey Results

Timeline/Communication Cascade



Oct 2024 – Survey opened

Nov 2025 – Survey closed

Dec 2025 – NHS C&M received 1st release high level results

Jan 2025 – Data preparation and analysis

March 2025 – Detailed presentation to Executive Team by external consultants

March 2025 – High level data sharing with Place/Departmental Senior Leaders/ SEF/POG members

March 2025 – Following 'embargo lift' Detailed presentations at: POG and SEF

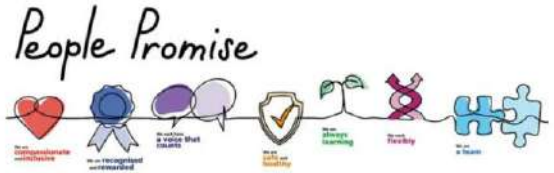
April 2025 – Staff engagement for ICB and team actions plans development

May 2025 – Assurance report delivered to People Committee Date

Implementation of plans and priorities for 2025

Staff Survey Results

Response Rates/Content



Response Rate

73%

Compared to 77% in 2023

Total Staff In Post

1179

Compared to 1070 in 2023 (10% increase)

Staff Participation

852

Compared to 809 in 2023 (5% increase)

Survey Content

7	21	107		
Themes	Sub- categories	Survey Questions	Organisation	Place/Department
7 Elements of the 'People Promise' plus an engagement and morale score	Questions directly related to sub-categories of each of the 'People Promise themes'	• Your job • Your team • People in your organisation • Your managers • Your health, Wellbeing and Safety at work • Your personal development • Your organisation • Background information	Themes/sub scores presented as a whole organisation	Themes/sub scores/questions, broken down for areas with a minimum of 10 respondents

Staff Engagement session

Summary of feedback

4

Online sessions open to all staff

>150

Staff attended and feedback

Describe in one word how you are feeling

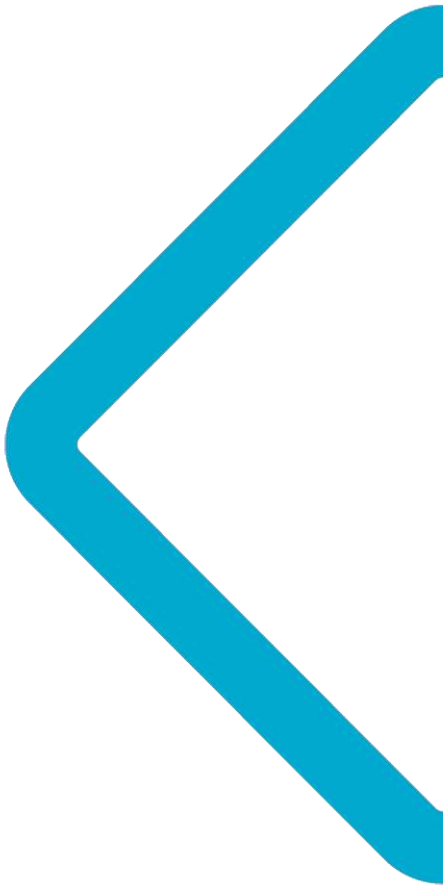
Immediate support/actions

- Positive feedback on wellbeing sessions
- Reinforcement of the importance of self-care
- Wider colleague connection
- Drop ins
- Informal team meetings/huddles
- The importance of a simple ‘thank you’
- Opportunities to have a voice
- Regular feedback/1:1s

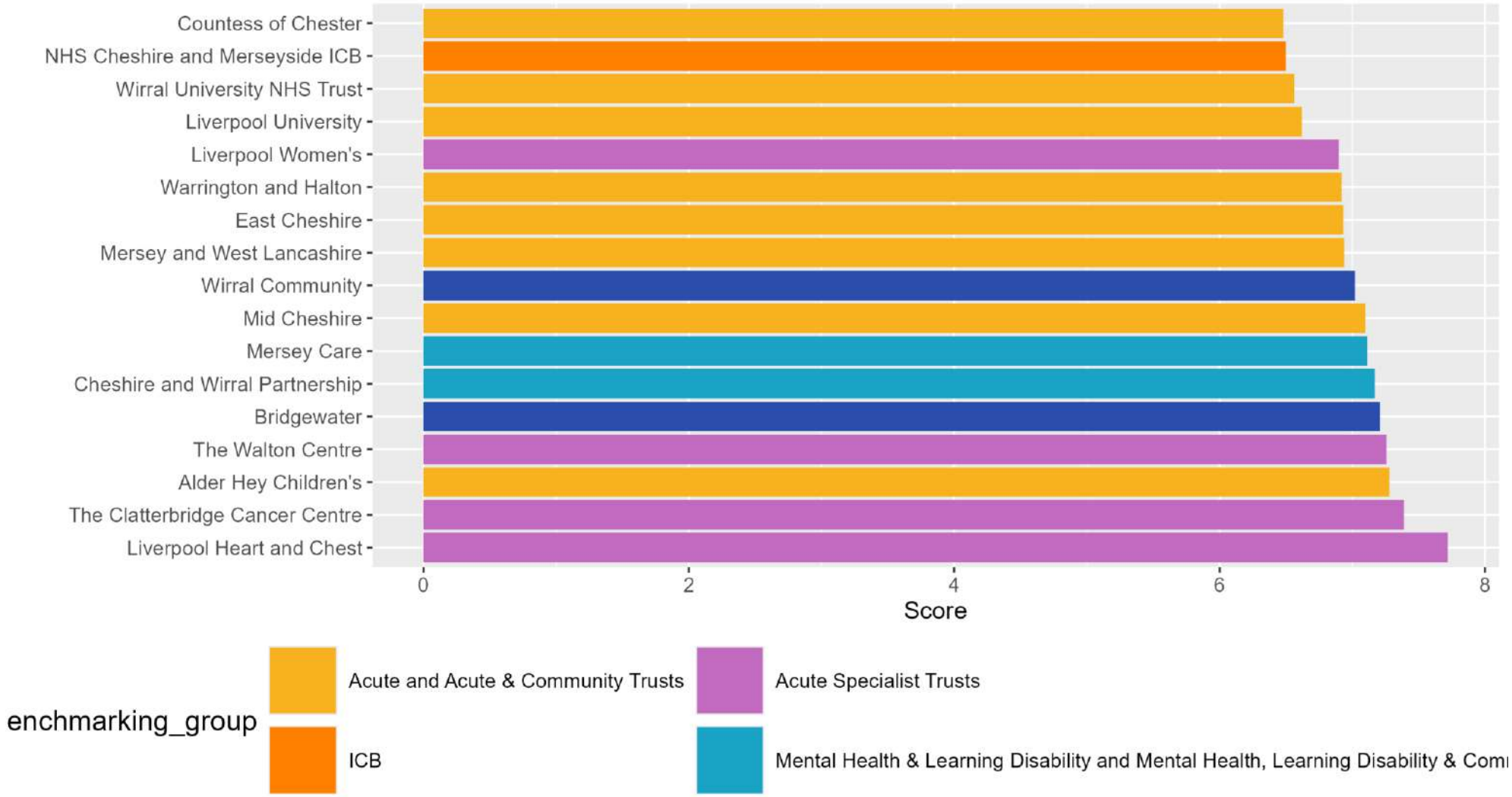
Future aspirations

- Time/capacity issues
- Communication of L&D offer
- More face to face/office working encouraged
- Face to face all staff event
- Embedded We Are One culture, not Place and Central
- Accurate and updated staff directory
- Increased awareness raising around Employee/Team of the Quarter
- Long service awards

Thank You



Staff engagement



ICS Staff engagement

Acute and Acute & Community Trusts

Trust	2024	Benchmark Median	Difference from Benchmark Median	2023	Difference from 2023	2021	Difference from 2021
Alder Hey Children's	7.28	6.84	0.44	7.24	0.04	7.18	0.10
Mid Cheshire	7.10	6.84	0.26	7.17	-0.07	7.07	0.03
Mersey and West Lancashire	6.94	6.84	0.10	7.05	-0.11		
East Cheshire	6.93	6.84	0.09	6.90	0.03	6.88	0.05
Warrington and Halton	6.92	6.84	0.08	6.98	-0.06	6.94	-0.02
Liverpool University	6.62	6.84	-0.22	6.63	-0.01	6.46	0.16
Wirral University NHS Trust	6.56	6.84	-0.28	6.67	-0.11	6.67	-0.11
Countess of Chester	6.48	6.84	-0.36	6.43	0.05	6.40	0.08

Mental Health Trusts

Trust	2024	Benchmark Median	Difference from Benchmark Median	2023	Difference from 2023	2021	Difference from 2021
Cheshire and Wirral Partnership	7.17	7.07	0.10	7.23	-0.06	7.03	0.14
Mersey Care	7.11	7.07	0.04	6.96	0.15	7.01	0.10

ICS Staff engagement

Acute Specialist Trusts

Trust	2024	Benchmark Median	Difference from Benchmark Median	2023	Difference from 2023	2021	Difference from 2021
Liverpool Heart and Chest	7.72	7.34	0.38	7.74	-0.02	7.50	0.22
The Clatterbridge Cancer Centre	7.39	7.34	0.05	7.41	-0.02	7.20	0.19
The Walton Centre	7.26	7.34	-0.08	7.37	-0.11	7.30	-0.04
Liverpool Women's	6.90	7.34	-0.44	7.04	-0.14	6.89	0.01

Community Trusts

Trust	2024	Benchmark Median	Difference from Benchmark Median	2023	Difference from 2023	2021	Difference from 2021
Bridgewater	7.21	7.23	-0.02	7.29	-0.08	7.17	0.04
Wirral Community	7.02	7.23	-0.21	7.18	-0.16	6.95	0.07

Cheshire & Merseyside ICB

Trust	2024	Benchmark Median	Difference from Benchmark Median	2023	Difference from 2023	2021	Difference from 2021
Cheshire & Merseyside ICB	6.50	6.63	0.13	6.65	-0.15		

ICS – Highest and lowest people promise themes

The below table provides the highest performing trusts in 2024 by each theme

We are compassionate and inclusive	• Liverpool Heart and Chest • The Clatterbridge Cancer Centre • Bridgewater
We are recognised and rewarded	• Liverpool Heart and Chest • Mersey Care • The Clatterbridge Cancer Centre
We each have a voice that counts	• Liverpool Heart and Chest • The Clatterbridge Cancer Centre • Bridgewater
We are safe and healthy	• Liverpool Heart and Chest • The Clatterbridge Cancer Centre • Mersey Care
We are always learning	• Liverpool Heart and Chest • The Clatterbridge Cancer Centre • Wirral Community
We work flexibly	• Bridgewater • Liverpool Heart and Chest • Cheshire and Wirral Partnership
We are a team	• Liverpool Heart and Chest • Mersey Care • The Clatterbridge Cancer Centre
Staff engagement	• Liverpool Heart and Chest • The Clatterbridge Cancer Centre • Alder Hey Children's
Morale	• Liverpool Heart and Chest • The Clatterbridge Cancer Centre • Mersey Care

The below table provides the lowest performing trusts in 2024 by each theme

We are compassionate and inclusive	• Countess of Chester • Liverpool University • Wirral University NHS Trust
We are recognised and rewarded	• Countess of Chester • Wirral University NHS Trust • Liverpool University
We each have a voice that counts	• Countess of Chester • Wirral University NHS Trust • Liverpool University
We are safe and healthy	• Countess of Chester • Wirral University NHS Trust • East Cheshire
We are always learning	• Countess of Chester • Liverpool University • Wirral University NHS Trust
We work flexibly	• Countess of Chester • Liverpool University • Mersey and West Lancashire
We are a team	• Liverpool Women's • Countess of Chester • Liverpool University
Staff engagement	• Countess of Chester • Wirral University NHS Trust • Liverpool University
Morale	• Countess of Chester • Wirral University NHS Trust • Liverpool University

ICS – Most improved and most deteriorated people promise themes

The below table provides the most improved trusts since 2023 by each theme

We are compassionate and inclusive	• Mersey Care • Countess of Chester • Alder Hey Children's
We are recognised and rewarded	• Mersey Care • Alder Hey Children's • East Cheshire
We each have a voice that counts	• Mersey Care • Countess of Chester • East Cheshire
We are safe and healthy	• Mersey Care • Alder Hey Children's • Liverpool Heart and Chest
We are always learning	• Mersey Care • Mersey and West Lancashire • Countess of Chester
We work flexibly	• Bridgewater • Mersey Care • Alder Hey Children's
We are a team	• Mersey Care • Bridgewater • Wirral University NHS Trust
Staff engagement	• Mersey Care • Countess of Chester • Alder Hey Children's
Morale	• Mersey Care • Alder Hey Children's • Liverpool Heart and Chest

The below table provides the most deteriorated trusts since 2023 by each theme

We are compassionate and inclusive	• Liverpool Women's • The Walton Centre • Cheshire and Wirral Partnership • Mersey and West Lancashire
We are recognised and rewarded	• Liverpool Women's • Wirral Community • Mersey and West Lancashire
We each have a voice that counts	• Liverpool Women's • Wirral Community • Mersey and West Lancashire
We are safe and healthy	• Wirral Community • Wirral University NHS Trust • Liverpool Women's
We are always learning	• Wirral Community • Cheshire and Wirral Partnership • Bridgewater
We work flexibly	• Wirral Community • Liverpool Heart and Chest • The Walton Centre
We are a team	• Liverpool Women's • Wirral Community • The Walton Centre
Staff engagement	• Wirral Community • Liverpool Women's • The Walton Centre • Mersey and West Lancashire • Wirral University NHS Trust
Morale	• Wirral Community • Liverpool Women's • Wirral University NHS Trust

ICS - Most improved or deteriorated questions

- The most improved questions when compared to 2023 were:
- Q14d - The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it? +2.19%
- Q23a - In the last 12 months have you had an appraisal. +2.03%
- Q6b - My organisation is committed to helping me balance my work and home life. +1.19%

- The most improved question since 2021 with year-on-year improvement were:
- Q23a - In the last 12 months have you had an appraisal +10.72%
- Q7b - The team I work in often meets to discuss the team's effectiveness. +6.14%
- Q11c - During the last 12 months have you felt unwell as a result of work-related stress? -5.72%

- The most deteriorated questions when compared to 2023 were:
- Q5a - I have unrealistic time pressures. +1.36%
- Q24b - There are opportunities for me to develop my career in this organisation. -1.15%
- Q2a - I look forward to going to work. -1.01%

- The most deteriorated questions since 2021 with year-on-year deterioration were:
- Q2c - Time passes quickly when I am working. -2.09%
- Q5c - Relationships at work are strained. +3.93%

NHS
Cheshire and Merseyside

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

Held in The Events Hall, The Heath Business and Technical Park, Runcorn, WA7 4QX

Thursday 27 March 2025
9am-12.20pm

Unconfirmed Minutes

ATTENDANCE	
Name	**Role**
Members	
Raj Jain	Chair, Cheshire & Merseyside ICB (voting member)
Graham Urwin	Chief Executive, Cheshire & Merseyside ICB (voting member)
Tony Foy	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Erica Morriss	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Mike Burrows	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Dr Ruth Hussey, CB, OBE, DL	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Mark Bakewell	Executive Director of Finance (Interim), Cheshire & Merseyside ICB (voting member)
Christine Douglas, MBE	Executive Director of Nursing and Care, Cheshire & Merseyside ICB (voting member)
Prof. Rowan Pritchard-Jones	Medical Director, Cheshire & Merseyside ICB (voting member)
Adam Irvine	Partner Member (Primary Care) (voting member)
Andrew Lewis	Partner Member (Local Authority) (voting member)
Prof. Stephen Broomhead	Partner Member (Local Authority) (voting member)
Ann Marr	Partner Member (NHS Trust) (voting member)
Warren Escadale	Partner Member (VCFSE) (voting member)
Trish Bennett	Partner Member (NHS Trust) (voting member)
In Attendance	
Clare Watson	Assistant Chief Executive, Cheshire & Merseyside ICB (regular participant)
Anthony Middleton	Director of Performance and Planning, Cheshire & Merseyside ICB (regular participant)
Dr Fiona Lemmens	Deputy Medical Director, Cheshire & Merseyside ICB (regular participant)
John Llewellyn	Chief Digital Information Officer, Cheshire & Merseyside ICB (regular participant)
Mike Gibney	Chief People Officer, Cheshire & Merseyside ICB (regular participant)
Prof. Ian Ashworth	Director of Population Health, Cheshire & Merseyside ICB (regular participant)
Carl Marsh	Warrington Place Director, Cheshire & Merseyside ICB
Alison Lee	Knowsley Place Director, Cheshire & Merseyside ICB
Prof. Paul Kingston	Lead Chair of Research Committee, University of Chester
David Aspin	Healthwatch
Louise Robson	Chair, Health Innovation North West Coast (regular participant)
Prof. Paul Kingston	Lead Chair of Research Committee, University of Chester
Rev. Dr Ellen Loudon	Director of Social Justice & Canon Chancellor of Liverpool Cathedral, Vice Chair C&M Health and Care Partnership
Jon Hayes	Managing Director, Cancer Alliance – *item 03/25/10*
John McCabe	Medical Director, Cancer Alliance – *item 03/25/10*

ATTENDANCE	
Name	**Role**
James Sumner	Joint Chief Executive, ULHG – *item 03/25/11*
Tim Gold	Joint Chief Transformation Officer – *item 03/25/11*
Megan Underwood	Board Administrator, Cheshire & Merseyside ICB

Apologies	
Name	**Role**
Dr Naomi Rankin	Partner Member, Cheshire & Merseyside ICB
Prof. Hilary Garratt	Non-Executive Member, Cheshire & Merseyside ICB (voting member)

Agenda Item, Discussion, Outcomes and Action Points

Preliminary Business

ICB/03/2401 Welcome, Introductions and Apologies

All those present were welcomed to the meeting and advised that this was a meeting held in public. The meeting was declared quorate. Apologies for absence were noted as above.

ICB/03/25/02 Declarations of Interest

There were no declarations of interest in relation to the agenda.

ICB/03/25/03 Chairs announcements

All NHS Chairs and Chief Executives were required to attend a meeting in London on 13th March 2025 with current NHSE Chief Executive and new interim Chief Executive. During the meeting, Chairs and Chief Executives were informed of the current state of finances of the country and the impacts this has on NHS expenditure in 2025/26. The Executive team were working on plans.

Since the last Board meeting, the ICB successfully undertaken the recruitment process for a new Chief Executive. Following a robust national recruitment process, Cathy Elliot was the successful candidate and will commence in post at the beginning of June.

Neil Large, Non-Executive Member has now left the ICB having taken on the appointment of Interim Chair of the Countess of Chester Hospital. The Chair expressed thanks to Neil Large for all of the support provided to the Board and colleagues since the ICB was established in 2022. Following on from this, the ICB has progressed the appointment of an additional Non-Executive Member for an interim period of six months, the Chair welcomed Mike Burrows.

ICB/03/25/04 Experience and achievement story

A short video was shared in relation to cancer patient's anxieties prior and following scans.

Leadership Reports

ICB/03/25/05 Report of the ICB Chief Executive

NHSE announcement – colleagues will have heard the announcement from the Prime Minister regarding the intent to abolish NHSE within the next two years and bring its function into the Department of Health and Social Care, and that combined headcount of both organisations is expected to be cut by 50%. Additionally, confirmation was received that all Integrated Care Boards (ICB) will need to reduce their running – both management and programme costs by 50% by Quarter 3 2025/26. Since the announcement no further details have been received, however, ICBs were here to stay. This was an unsettling time for the Board and for the staff and this will be managed in the most effective way as possible. The NHS has undergone significant changes over the years.

Requirement to extend Joint Controller Agreement with NHSE in relation to delegation of specialised commissioning – the ICB have received a letter from NHSE requiring the ICB to extend the Joint Controller Agreement in relation to NHSE providing the administrative and management services for specialised services by NHSE regional teams until 30th June 2025, pending these staff

moving across to be employed by NHS Lancashire and South Cumbria ICB. A further update on the workforce arrangements beyond July 2025 will be shared with the Board during Quarter 1 of 2025/26.

Staff survey – the national NHS staff survey 2024 results were published on 18th March 2025. A more detailed report on the results for the ICB and the Cheshire and Merseyside system will be presented to the Board in May 2025, in summary the latest staff survey results for the ICB indicate largely stable scores across themes with modest fluctuations. The results were positive given staff were across 20 locations.

Progress with FTSU has been made, however, the evidence as to how as an organisation learning was being shared was to be sought. Within Primary Care there is a dataset to help assess variation and this will be completed within Places – a report had been drafted by Healthwatch and how it feels in those Places for GP access. Report is to be presented to a future Board meeting.

Changes to the GPs national contract for 2025-26 – at the end of February 2024, NHSE announced the changes to the GP Contract for 2025-26, this was a positive movement for GPs across the patch.

Neighbourhood Health – the Neighbourhood Health Guidelines 2025/26 were published by NHSE on 30th January 2025 to help ICBs, local authorities and health care providers continue to progress neighbourhood health in 2025/26 in advance of the publication of the 10 Year Health Plan which was expected to be published in May.

A steering group has been established to look after the six core component parts, Place Directors and teams were working on how to map services and provisions along with the geography. A self-assessment is to be produced at Place level with the report to come back to a future Board. From a Warrington Place perspective an integrated neighbourhood team programme was in place to enable modern general practice a strong community service.

Long Covid – following the update to Board in January 2025 in relation to the cessation of the national ring-fenced allocation used to fund local Long Covid services and the decision of the Executive team, the ICB was currently undertaking the review of future options for ensuring appropriate support was available to patients with Long Covid. An options appraisal and recommendation will be brought back to May Board for a decision to be made.

With regards to Long Covid a point was raised in relation to ensuring there was representation on the panel. Data to be pulled and shared with the Board.

Gluten free report is to be presented at May's Board.

Vaccination – behavioural insight work has commenced with an in-depth report to be presented to a summer Board. A screening immunisation oversight group has been set up, vaccination rates have fallen across both staff and population health, important to work together across the North-West to identify the bets services for the population and staff.

The Board:

- **Noted the contents of the Chief Executive Report**
- **Approved the recommendation for the Chief Executive confirming in writing to NHS England the approval of NHS Cheshire and Merseyside to extend the current Joint Controller agreement until the staff transfer from NHS England to the North West ICBs on 1st July 2025**

ICB/03/25/06 Report of the ICB Director of Nursing and Care

The Director of Nursing and Care provided the Board with an update in relation to.

- Paediatric Audiology Services
- Partnership for Inclusion of Neurodiversity in Schools (PINS)

- Patient Safety – System Priorities Development

Paediatric Audiology Services
NHSE's Newborn Hearing Screening Programme (NHSP) recently completed an analysis of data for every baby born in England from 2018-2023, this identified four Trusts, covering five services that reported significantly fewer cases of permanent childhood hearing impairment than expected.

A thorough investigation of the services identified systemic issues, including poor quality practices, inadequate staff training, substandard data and report management, inconsistencies in care, ineffective peer review processes and a lack of UK accreditation service improving quality in psychological services accreditation.

In response to these findings, national recommendations were issued to ICBs to assess compliance with established standards and best practices.

Following a stage 1 desktop review of service data by NHSE each service was provided with an assurance level. The ICB has seven site visits that will be completed by the end of Quarter 1 of 2025/26, the visits will include ICB Quality Leads, local Commissioning Leads and Subject Matter Experts (SMEs) that have been identified through NHSE. The first visit was completed for the service at Wirral University Teaching Hospital on 14th March 2025

Areas for improvement will be monitored through an improvement plan presented at local quality contract meetings. Subsequent visits are proposed through April and May 2025 and will report full details via Quality and Performance Committee.

Assurance of the service is maintained with the service being sustained once the review concludes. Once the visits have been completed and all the recommendations have been received an action plan by each organisation will have to be followed, improvement plans are to be monitored with each organisation and be brought back to a future Board.

Partnerships for Inclusion of Neurodiversity in Schools (PINS)
The national PINS project is funded by the Department for Education and managed by NHSE. Within Cheshire and Merseyside (C&M), there are 37 primary schools across seven local authority areas involved in the project. The aim of the project is to support schools to develop their capacity to meet neurodiverse needs within mainstream primary schools, improving attendance, reducing exclusions and strengthening pupil wellbeing.

Patient Safety – System Priorities Development
In line with the patient safety strategic developments discussed through the previous Director of Nursing and Care report, the role of the ICB as system convenor allows for collective focus on priority areas for safety, both investigation and improvement.

As the safety priorities are defined, consideration of system stakeholder input into improvement was key with workshops planned to explore the role that all parties can have with regards to enhancing safety.

Action: Proposed System wide Safety Priorities to be brought for approval at the May Board.

Action: an update to come to the Board regarding the outcomes of the NHS England's newborn hearing and screening programme review and the subsequent improvement plans

The Board noted the report.

ICB/03/25/07 NHS Cheshire and Merseyside Finance Report Month 10

Month's 10 report provides an update to the Board on the financial performance of C&M ICS and highlights the following metrics – efficiency, productivity, and workforce.

As of 31st January 2025, the ICS system was reporting a year-to-date deficit of £109.7m against a planned year to date deficit of £62.4m resulting in an adverse year to date variance of £43.7m – this consists of both the ICB and the wider NHS provider positions.

The Month 10 of the risk adjusted forecast value of £72.6m variance against the plan of £150m for the financial year resulting in a £223.4m deficit.

ICBs overspending areas continue to be in relation to the cost of Continuing Health Care (CHC) and Mental Health packages, although, a trajectory of overspend has significantly improved following a review of the balance sheet and commitments. The pressure on prescribing budgets have remained largely unchanged for this month based on the latest prescribing data that was available and factoring in anticipated savings linked to the medicines waste campaign.

The year-to-date pressure was driven by the following issues.

- Continuing Healthcare – the continued pressures were linked to cost and volume of eligible CHC clients exceeding planning assumptions. An adverse variance of £23.4m was reported at Month 10, however, this was an improvement of £5.4m compared to Month 9. This was largely due to a review of the balance sheet including a review of packages that were open but not billed.
- Mental Health Services – the overspend was £21.8m reported at Month 10 of which £20m relates to packages of care. The variance from plan has remained worsened by £1m this month, however, this is a significant reduction in the trajectory of overspending observed in earlier months.

  The current forecast adverse variance to plan for Continuing Healthcare was £27.5m and £24.3m for complex packages of care. Within the report Appendix 1 outlined the details of the forecast variance by place and highlights the key drivers for the pressure.
- A pressure of £16m was reported on the prescribing budget at Month 10 based on November 2024 prescribing data. The forecast overspend on prescribing budgets was reported to be £19.7m which has remained unchanged since Month 9. The forecast anticipates savings will be made in the final two months of the year through the full delivery of remaining medicines efficiency plans and £5m savings generated through the medicines waste campaign.

The ICB continue to drive actions with partners to improve those positions. The ICB currently has its own recovery programme which continues to deliver actions to support the risk adjusted position. With regards to the provider positions, which have been largely consistent with previous reports were driven by several in-year factors specifically, cost of industrial action, pay award cost pressures, non-delivery of efficiency savings and several other organisational specifics which were detailed within the report.

Cash is a feature of the financial framework which is to be monitored moving into the new financial year as well as future financial years.

Month 11 performance position showed an improvement in the forecast outturn position whereby the ICB were reporting a £195.9m deficit compared to £223m. This was down to continued improvements in run rates both on the ICB side and provider positions but also additional resource that was received from NHSE during the period which allowed the ICB to improve the position to under £200m, resulting in a £45.9m variance against the original £150m.

The remaining actions will continue to be progressed in Month 12 to achieve the position in accordance with NHSE. Several weeks remained to conclude the year-end requirements on the annual report, annual accounts and the audit that will commence in April and May before signing off in June.

From a national perspective more work is to be completed on the medium- and longer-term plans as a system, identify opportunities to take costs out of the system, the ICB were a relatively large system

with around £7-8bn being spent locally. Work was ongoing as a community to identify the opportunities. Medium-term plan to be developed over the coming quarter.

It was highlighted that the system was being 'weaned' away from Covid levels with an attempt for a more rigorous financial plan. The ICB will have balanced the budget and delivered a small surplus. In terms of statutory financial duty and the statutory financial duties, the ICB were given a wider collaborative duty that was to enable the system to deliver a control total, the area in which the system has not delivered to a control total. The rules within the system were not always clear or whereby leverage sits at different points, agreeing a control total where the deficit falls under the ICBs remit of responsibility to have the system collaborating and working together – the ICB do not hold statutory and regulatory powers over NHS Trusts.

There was one Trust in the process of prioritising what to spend their residual cash on during March, which means they are unable to pay creditors. There is a strict cash regime into what organisations can draw down on. Difficult choices would then have to be made with regards to paying back government debt in the form of PDC and HMRC in terms of tax and national insurance along with payment to staff and other local suppliers. This was being experienced with a couple of Trusts, should the deficits continue, this will become in the near line of sight than it has been previously.

The Board are to understand how ready Trusts at a system level for 2025/26, how real are the CIP plans and demand management plans at Place level to help get through the 2025/26 financial year. The Chair asked the Director of Finance to lead this piece of work.

The Board noted the report.

ICB/03/25/08 NHS Cheshire and Merseyside Integrated Performance Report

The performance report details the overall view of delivery against the objectives set as part of the annual planning round, the report also provides the breakdown across provider and place with section five within the report detailing exceptions arriving from the report.

The ICB were approaching this year's planning round and finalising the plans for the upcoming year, there was often a point of reflection to look at demands seen during the previous period. The level of activity for planned care within the hospitals was 7.9% up from the previous year, communities has increase by 9% on the previous year and for GP appointments and wider primary care provision the activity was running 3% higher than the previous year along with a similar figure both in terms of paediatric and mental health touch points – a busy year in the context of what was being achieved in terms of continuous improvement.

Urgent care – there has been a reduction in patients attending A&E and walk-in centres, this has reduced by 4% over the course of the year. There was a strong correlation between improved access within primary care meaning those patients can attend a more appropriate setting pertinent to their clinical needs as opposed to an A&E, however, within urgent care settings the volumes of patients coming through A&E and being admitted into a form of bedded care and into social care has remained unchanged, demand in certain pathways particularly in social care has increased through this period.

It was encouraging to see in the sense of urgent and emergency care looking back at a challenged period experienced around winter each year, there has been a level of bounce back that was seen in January, A&E four-hour performance measure was 5% up on the same period last year. Heading into March in terms of recovery period it is expected there will be a 1% increase from where the ICB currently sit. In terms of ambulance category response times, there has been a five-minute improvement from this time last year. Bed occupancy, corridor times and the number of patients waiting to be discharged into a social setting has remained unchanged from last year. Whilst there are extensive improvement plans, organisations were keeping in line with the increased demand.

Elective – there has been a 15,000 decrease from the start of the year and for 65-week wait objectives there is expected to be around 250 patients whose treatment will be more than the target by year end.

Cancer – there have been significant achievements within cancer care.

Virtual wards – there remained a national target for virtual wards. Capacity occupancy level has been increased to 80% and has been unchanged since the start of the year. From next year there is to be an expansion from the new financial year.

Sickness – there was significant variation in terms of sickness across a broad range of Trusts, Chief People Officers monitor this and look at local initiatives. Mental health/stress related sickness, ambulance services have had an increase in musculoskeletal due to being in the ambulance for long periods of time.

Mersey Care – currently has a high level of sickness and were supporting staff in helping them come back to work, the Trust were understanding the data to identify the areas of focus. This was a whole trust approach, multi fasted approach and working on the culture of the organisation ensuring this is the best trust to work in. Discussions have been held with the University of Liverpool and looking at a different approach with trainees in terms of teach and treat which was in the early stages of thought process and possibilities – this was with psychology, physiotherapy and dental students.

Healthcare associated infections is to be one of the system safety priorities that will be brought to a future Board, a Healthcare Associated Infection Systemwide Group has been established in which all organisations will contribute to, this is featured within each quality and system improvement group – data is looked at nationally, regionally and locally.

There has been a general improvement with regards to A&E waiting times, however, there were significant outliers that have previously been discussed specifically East Cheshire, Mid-Cheshire and the Countess of Chester hospital. In terms of the Countess of Chester hospital a reset event was held in February which provided the ICB with a period of a week to understand the issues at play both within the community and within the A&E but also the flow through the hospital, following this there has been a comprehensive plan which has been an instrumental insight into understanding the achievements that can be realised within the hospital – for March there has been a 10% increase in the four-hour performance of the Countess of Chester and those long waiting times that were being experienced with patients often spending in excess of 72-hours waiting – real and extensive progress has been made.

East Cheshire system has historically had a difficult period and is the smallest hospital in terms of beds and has limited senior decision makers on a 24-hour basis, more recently the challenges have arisen with accessing social care and a different model that has been implemented around assessed discharge. A discussion is taking place to see whether the decision can be reversed and improved.

Action: revised dashboard to be presented to the system primary care committee, incorporating recent changes from the planning guidance and letters from the Secretary of State to general practice.

Action: future report to provide updates on the performance metrics and the impact of the virtual wards on cost-effectiveness, outcomes, and alignment with neighbourhood care mode

Action: provide updates on the impact of the hydration in care homes project and explore opportunities to broaden it out across wider area

The Board noted the report.

ICB/03/25/09 Consolidated Report of the ICB Directors of Place

Smoking during pregnancy was 10% higher in Halton and St Helens, work was being done with tobacco dependency services and maternity units, the rate is the lowest it has been. Case studies were being completed with pregnant smokers to understand what can be done.

Place Directors for Knowsley and Warrington provided updates to the Board.

Warrington
The partnership has restated its commitment to address poverty and raise awareness with regards to the challenges faced by the residents within the area. This was demonstrated at the recent Poverty Conference held on 4th February 2025 within the Warrington area. The conference brought together local organisations, charities, businesses and educational institutions to discuss issues and explore solutions.

Several key pledges were made during the conference, some of which were summarised as follows.

- Listening more attentively to the needs of communities
- Understanding the realities faced by the people served
- Emphasising person/family-centred approaches
- Working collaboratively across communities
- Building on the existing community ethos

The Poverty Truth Commission will launch in Spring 2025, the first step will involve recruiting Community Commissioners (those individuals who have lived experience of poverty) to share stories and inform decision making. Civic commissioners, including leaders from the council, health services, businesses and the voluntary sector will also be involved.

Halton
Halton's Core20Plus5 Connector Project continues to support a broad range of projects. Some female Connectors were supporting colleagues from C&M Women's Health and Maternity Programme to organise an International Women's Day event on 7th March 2025. The Connectors remain in high demand with other projects such as vaccine awareness and health literacy potentially developing.

Knowsley
Residents from Kirkby in Knowsley have created a brand-new cookbook with Mediterranean inspired diet to help try and curb the issue of obesity and the associated health risks such as fatty liver disease.

The cookbook was a collaboration between nutrition students from Liverpool John Moores University, local community groups and doctors and patients from the Millbrook Medical Centre in Kirkby. The cookbook has been backed by leading liver specialists from Aintree Hospital.

Liverpool
Progress with the BLINX PACO Pilot continues to gather pace. Clinical Safety DCB1060 (a clinical risk management standard that NHS organisations use to ensure the safety of health IT systems) has been completed at ICB level, two Liverpool practices have now gone live with the 'Digital Front Door' programme which enables patients to access online consultations, book appointments and access information. Feedback from patients in relation to their experience in relation to the 'Digital Front Door' has been positive.

St Helens
The Inequalities Commission met on 14th January 2025 with the new Independent Chair. Following the meeting, St Helens Place have continued to support the three main areas of Best Start in Life, food poverty and fuel poverty.

Sefton
National Hydration Pilot – scale and spread regionally

The Hydration team continue to focus on the roll out of care home training and UTI prevention and were expanding across Cheshire East and West, Halton, Liverpool and St Helens. The team has shared resources north-west wide via IPC programmes. The team were recognised as Team of the Quarter and presented at We are One on 26th February.

Wirral
The work, led by One Wirral Community Interest Company (CIC) provides a foundation for providing patients diagnosed with cancer, a robust pathway offer that meets their needs and can be personalised through a holistic needs assessment and care plan which then links to assets and services in the community to fulfil needs.

It was dioscussed that the Place Director report should be honed down for the next financial year to become more effective and efficient, reflecting the substantial effort required to produce it.

Erica supported this idea, emphasising the need to focus on themes and the impact of activities rather than providing extensive details.

Action: Sefton to provide assurance in the next report that they have worked through the needs of the population of Southport post-incident and have sufficient local Information Services.

Action: Place Directors and the board to consider how the Place Director report can be streamlined and improved for the next financial year, ensuring it effectively highlights key themes and impacts.

Action: Future report to come back to help Board understand the progress and impact of primary care network activities, ensuring alignment with broader neighborhood health models.

ICB Business Items and Strategic Updates

ICB/03/25/10 Cheshire and Merseyside Cancer Alliance Update

Jon Hayes, Managing Director and John McCabe, Medical Director of Cancer Alliance joined the meeting to share an update on cancer alliance.

The cancer alliance brings together healthcare providers, commissioners, patients, cancer research institutions and voluntary and charitable sector partners to improve cancer outcomes for the local population.

C&M cancer alliance was hosted by The Clatterbridge Cancer Centre on behalf of the C&M system and NHSE's national cancer programme.

The four key responsibilities were highlighted as follows.

- To deliver the NHS long term plan objectives for cancer including the ambition that by 2028 75% of cancers will be diagnosed at stages 1 and 2.
- To reduce unwarranted variation in care, access, patient experience and outcomes.
- To improve performance against cancer waiting time standards
- To support innovation and safeguard the long term sustainability of cancer services.

In terms of survival, C&M's one-year cancer survival rate has been better than England for several years. For the first time, the long term (five year) survival rate was higher than England.

In terms of cancer waiting times, 62-day cancer waiting time performance was amongst the best in England. C&M was already meeting the March 2026 planning ambition one year ahead of schedule. C&M latest performance was highlighted as follows.

- 28-day faster diagnosis standard – 75.5%
- 31-day cancer waiting time – 93.5%

- 62-day cancer waiting time – 74.9%

For incidence and prevalence, whilst the improvements in early diagnosis, survival and waiting times were encouraging, it remained true that proportionately more people get cancer in C&M than England. Cancer incidence remains 10% higher in C&M.

For patient experience, C&M were rated best Alliance in England for overall cancer care for the second year running – 2022, 9.12/10 and 2023 9.01/10.

With regards to patient safety, there is an alliance led process for sharing the learning from patient safety incidents involving cancer patients. For the C&M diagnostics programme, all Trusts have regular radiology events and learning meetings. The PACS cloud rollout in 2025 will enhance peer review capabilities and introduce RadAlert automated tracking of critical findings. AI for lung x-ray and CT in East Cheshire will be adopted elsewhere.

The look forward for the year ahead was highlighted to the Board.

- Publication of 10 year plan for health and cancer strategy
- Continued focus on improving early diagnosis and survival rates
- Greater focus on prevention and closing the gap on cancer incidence
- Continue to work with patients, carers and communities to improve outcomes and patient experience and reduce inequalities
- Driving improvements in cancer waiting times through greater efficiency and productivity

It was noted that good progress has been made, specifically with AI helping to read scans and, in the future, diagnosing skin cancers without the clinician officially diagnosing the patient.

With regards to Strategic Commissioning there were different parts of the system that contribute to cancer care.

The Board thanks Jon and John for the work of the Alliance and noted the report.

ICB/03/25/11 Liverpool Adult Acute and Specialist Providers Case for Change

James Sumner, Joint Chief Executive for LUFT and Liverpool Women's Hospital and Tim Gold Joint Chief Transformation Officer joined the Board to present LAASP case for change.

With regards to the estate across the Trusts, this was in largely in good order. For the Broadgreen site there were currently three organisations on one site – Broadgreen, Liverpool Heart and Chest Hospital and Mersey Care – the Joint Chief Executive noted that money is to be spent on the corridors and theatres, Aintree Hospital and Liverpool Women's site is in a good state.

There were opportunities for efficiencies and patient outcomes – i.e. the opportunity to use goodwill to engage in neighbourhoods. There was scale in improving innovation and the eco system within the city, a lot to offer that has been recognised nationally, ULHG will become the biggest anchored institution in the city.

Oversight governance is to be solidified, place-based governance and how place partnerships develop.

The board endorsed the case for change, emphasizing the need for clinical improvements, coherence of care pathways, and rapid progress towards a financially sustainable system.

James and Tim were asked to continue working at pace to cement and anchor these changes, with future governance and milestones to be agreed upon through meetings with chairs and chief executives.

The Board approved the Case for Change document and gave support for the LAASP Joint Committee to implement the LAASP Portfolio including development of a Strategic Outline Case and LAASP Financial Sustainability Plan.

ICB/03/25/12 Report on the October/November 2024 public engagement on Improving Hospital Gynaecology and Maternity Services in Liverpool

Case for change was approved in October and followed the six-week engagement period, for best practice an independent company called Hood and Woolf was brought in to analyse the materials that was gathered in the engagement events and an independent report was produced.

The engagement asked people to reflect on the case for change, share their experiences of hospital and gynaecology and maternity services within Liverpool and to highlight what was important to them as individuals.

The engagement questionnaire was completed by 913 people, 71 attended an engagement event two of which were online and four have been face to face.

Six community organisations ran engagement projects which included a focus on; pregnant women, mums, parents and families; those who are experiencing/have experienced homelessness, the South Asian community and Syrian, Yemeni, Somali and Kurdish communities.

The engagement materials were translated into 16 languages.

The Deputy Medical Director shared the questions asked with the Board.

Patient experience themes – those people who had experienced hospital gynaecology or maternity services or knew someone who had were asked to rate their experience. 56% described it as a positive experience, neutral responses accounted for 18% and negative feedback was reported by 25% of respondents. Feedback revolved around five key themes.

- Staff attitude and compassion
- Maternal and neonatal care quality
- Access and waiting times
- Staffing and expertise
- Scheduling and communication

Future priorities – respondents were asked to identify the three most important factors to them when considering the future of hospital gynaecology and maternity services in Liverpool. Five themes emerged in the feedback, and they were highlighted as follows.

- Patient experience
- Accessibility and equity of care
- Waiting times and appointment delays
- Patient safety
- Staff compassion and competence

The learnings for future engagement sessions were highlighted as follows.

- Consider making the questionnaire with provision for completion online, hard copy or over the telephone, the main data collection method, as it provides a clear structure for responses. Face to face activity would promote the questionnaire with the ability to work with individuals who may need support to complete it.
- Hold early briefing sessions with wider partners to provide an overview of the engagement and discuss how organisations can help share information with their staff and communities.
- Use unique QR codes for each different engagement material/type of activity so that effectiveness can be accurately tracked.

- Produce specific materials to support staff in helping promote the opportunity to get involved to patients and the public.

The Deputy Medical Director highlighted the next steps. Wider communications were issues to mark the publication of the engagement report, the engagement findings are to be used to inform the next stage of the Women's Hospital Services in Liverpool programme and in particular the options process. Headlines from the engagement report were shared with a group of Lived Experience Panel members at the beginning of March, other people were now being invited who have used gynaecology and maternity services to express and interest in joining the group. In the meantime, a call for panel members to get involved in the upcoming process has been put out.

Thanks were expressed to the Lived Experience panel, the group was around 25 volunteers who have come together since July 2024 and they are a group of people who have previous experience, current experience with family members. The panel have been critical in developing the approach and were critical in the next stage of the process to help support the options appraisal.

The Chief Executive noted the importance of the work and the relevance to strategic commissioning of the service in the future with relevant work being fed back to Quality Committees. There was an ask for the Board to have assurance on how this is being used and how the learning is shared.

There is a high-level indicative timeline for next steps, some specific with the 1st May and early June for two workshops bringing clinicians, Lived Experience Panel and other stakeholders to discuss hurdle criteria, evaluation criteria and developing long and short list of options with a view to have this completed by July. Costing and modelling work to be completed by August with this being brought into final options with a potential final option – public consultation is likely to not take place until early 2026, however, updates will be brought accordingly.

Action: **The Deputy Medical Director to Provide a detailed timeline and next steps for the women's services improvement project.**

The Board noted the report

ICB/03/25/13 NHS Cheshire and Merseyside 2025-26 Joint Forward Plan (Annual Refresh)

Each year the ICB has a statutory duty to publish the joint forward plan by the end of March. Appendix 1 within the report was the refresh delivery plan.

The full delivery plan and strategic tracker will be presented to Board in May, with an intent to develop and publish a refresh of the joint forward plan as a response to the NHS 10-year plan later this year, in line with national priority planning and system pressures and priorities the two key areas of focus were developed for 2024/25 which were achieving financial sustainability and improving urgent and emergency care performance. For 2025/26, the key areas of focus are neighbourhood health which will link in with population health.

There was a significant amount of work to be completed for 2025/26 with the focus being on population and neighbourhood health.

Action: The Assistant Chief Executive to present the full annual delivery plan and strategic tracker to a future meeting. This will include more detailed information on evolving the system, strategic commissioning roles, and building capabilities.

The Board:
• Approved the Joint Forward Plan refresh and authorised its publication

• Endorsed the proposal to provide the Board with an NHS Cheshire and Merseyside Integrated

Care Board Annual Delivery Plan and associated Annual Tracker for review and approval

• Endorsed the proposal that during 2025 the ICB will more fully review our Joint Forward Plan to ensure our plans are fully responsive to the priorities and opportunities outlined in the NHS 10 Year Plan

ICB/03/25/14 NHS Cheshire and Merseyside Financial Plan 2025-2026

The purpose of the report was to provide the Board with an update on the work that has been undertaken to develop the ICB financial plan for 2025/26 financial year in accordance with the national NHSE planning deadlines.

The paper provides an overview of the latest position that was reported to NHSE but were based on the assumptions that have driven the plan and the risks that sit in and around the planning assumptions, at the time of writing the report was forecasting a break-even plan for 2025/26 financial year. Returns were due on 27th March.

The C&M system has been set a maximum deficit control total of £178m for the upcoming financial year.

C&M ICB's opening recurrent allocation for the 2025/26 financial year is £7.54bn. This is a net increase of £366m and consists of the following adjustments.

- Allocation growth £295m which is to cover inflation and activity increases
- Convergence £29.3m due to being over target allocation
- Running cost reduction £3.4m this was to meet 30% running cost allocation reductions
- Discharge funding £24.6m this was now recurrent and added to the baseline
- Service development funding £79.9m, this was also now recurrent and added to baseline
- Other – corneal tissue £283k, optical coherence tomography £365k.

In terms of ICB financial plans, based on comparing against the 2025/26 resource envelope, the ICB financial planning position for 2025/26 was currently set at a break-even position with a summary of the ICB financial plan by spend and was totalling £8.07bn.

Cash releasing efficiency savings – NHS planning guidance assumes a minimum efficiency requirement of 2%, however, the ICB is starting 2025/26 from a significant recurrent underlying deficit position and must offset the negative impact of 2025/26 convergence/deficit repayment.

Current ICB plans include a savings target of £98.3m which equates to circa 5.8% of influenceable spend plus the required savings required for running costs.

A series of other demand management/cost avoidance activities were also planned for the 2025/26 financial year in order to support delivery of the financial position and will help constrain growth in expenditure and to realise opportunities as identified from the recent ICB recovery programme.

Additional national allocations of £131m has been received for 2025/26 to reflect national priorities. The basis for the allocation was highlighted as follows.

- Estates safety - £18m allocated for significant and high-risk backlog with an additional allocation to address maternity compliance in WHH.
- Diagnostics - £3.5m has been allocated to CDC, audiology and echo.
- Elective - £19.8m has been allocated for schemes to improve productivity within the elective pathway.
- Urgent pathway - £20m to address the existing UEC projects
- RAAC - £61.7m as per nationally determined schemes
- Mental health - £8m to support reducing out of area placements

The ICB was strengthening its governance with regards to saving programmes for the 2025/26 financial year, considering the learning over the last 12 months and the learning from the recovery programme and external support that has been received. A newly formed Financial Control and Oversight Group will meet for the first time in April, the group will receive regular updates on the ICB savings programme that reports into FIRC committee, and this will be strengthened by the support from the ICB's new Chief System Improvement and Delivery Officer from the beginning of April.

Action: Director of Finance to provide an update on the financial plan and the ICS position in the next board meeting.

The Board were asked to.

- Note the progress being made on revenue and financial plans for 2025/26 and the current forecast of a break-even position for the ICB.
- Note the requirement for the C&M system to meet the system control total of a maximum £178m deficit.
- Note that further updates will be provided to the ICB Board in line with planning requirements and will include a wider assessment of risks and mitigations in respect of delivery of the 2025/26 ICS financial position.

Specialised Commissioning – additional allocation is received into the ICB, and this is based on an agreed set of services for the organisation to commission ensuring close working relationships with specialised commissioning colleagues and neighbouring ICBs. Expenditure plans for the upcoming financial year were being worked on as there were risks and issues within the specialised commissioning contracts. Joint Committee to be held in April between the three ICBs and the North-West team to review programmes and priorities.

With regards to the proposed budget there were areas to be improved upon, i.e., virtual wards and health inequalities.

Piece of work to be completed on what defines prevention which is being led by the Director of Population Health.

The Board noted the report.

ICB/03/25/15 Supporting Care Leavers into Employment

Paul Martin, Head of Workforce Programmes joined the meeting to present supporting care leavers into employment.

The report addresses the issue of supporting care leavers into meaningful employment across C&M. The report outlines current initiatives, challenges and proposals for creating structured employment opportunities, strengthening workplace support and ensuring leadership accountability to embed care leavers as a priority group in NHS workforce policies.

There were currently 5,510 care leavers, 27% were over the age of 16, 56% were male and 44% were female, 14% were BAME and 86% were white. There was currently a high prevalence of disability and neurodiversity with many care leavers having SEND with higher rates of autism, ADHD and mental health challenges. The barriers faced by care leavers were highlighted as follows.

- Care leavers often face disrupted education, financial hardship, leading to lower academic attainment, higher unemployment and greater mental health challenges.
- Many carers experience housing instability and limited career guidance affecting long-term prospects.
- Some often lack access to support networks.

Care leavers often face challenges when it comes to NHS recruitment such as.

Recognition and policy gaps – care leavers were not formally recognised as a priority group in NHS recruitment and there was no national policy protection under the Equality Act 2010.

Employment barriers – there were strict reference requirements, restrictive job descriptions and often lack of tailored recruitment pathways limit access.

Career development and retention issues – the limited structured support often makes it difficult for care leavers to build long-term NHS careers.

Prioritising care leavers in workforce strategy – this is to be embedded as a priority group in recruitment and career development policies.

Improving recruitment pathways – guaranteed interviews are to be introduced, ring-fenced placements and tailored apprenticeship schemes.

Executive and national leadership – an Executive Champion for care leavers is to be appointed and an advocate for formal national recognition.

The key current initiatives were highlighted as follows.

- SPECTRA 25/7 partnership – 25 care leavers will be recruited into NHS employment; candidates were currently being shortlisted for 18 positions across the ICS.
- Medical student mentoring – Alder Hey and Liverpool/Edge Hill universities were piloting a mentoring scheme for up to 30 care experienced medical students to address professional pathway challenges.

The next steps were highlighted to the Board.

- Formal policy recognition – care leavers to be endorsed as a priority across C&M.
- Data collection and monitoring – self-identification in ESR to be enabled to track care leaver employment and retention needs.
- Expand key initiatives – scale up programmes across Trusts and build a community of practice and support network for care leavers and hiring managers.
- Executive leadership and governance – appoint an Executive Champion to oversee inclusion strategies and workforce support.
- Advocate for national recognition – care leavers to be formally recognised as a protected group under NHS workforce policies and the Equality Act 2010.

Delivery plan and understanding the cost associated with this and how the actions are to be tracked was requested.

Associate Directors of Quality at the nine Places support a corporate parenting board and work in partnership with the Directors of Children's Services, important to ensure children's and young person's voices are heard, this was currently ongoing.

It was noted that care workers were being supported too late in Liverpool, important to look to support children from the age of 14 as they begin to think of their career choices.

Trajectories and progress made to come back to a future Board meeting. It was agreed that the Director of Nursing and Care would become the Executive Champion. Delivery plan and budget to be presented to the Board prior to approval.

Action: Chief People Officer to develop a delivery plan and budget for the care leavers recruitment initiative and provide a report back to Board.

The Board supported the recommendations within the report o:

- **Recognising care leavers as a priority group in recruitment policies.**

- **Enable self-identification in the NHS Electronic Staff Record (ESR) to track employment trends.**
- **Strengthen recruitment pathways with guaranteed interviews and ring-fenced placements.**
- **Appoint an Executive Champion for Care Leavers to lead workforce inclusion**
- **Expand mentorship and career coaching to improve retention.**
- **Advocate for national policy change to formally recognise care leavers in NHS workforce planning.**

Meeting Governance

ICB/03/25/16 Minutes of the Previous Meeting: 30th January 2025

The Minutes of the previous meeting held on 30th January 2025 were accepted and recorded as a true and accurate record.

ICB/03/25/17 Board Action Log

NHS C&M Quality and Performance Report – an update is to come back to the next Board and to be understood through the committee report.

NHS C&M Integrated Performance Report – report to be presented to Board Development in April with a formal report to come back to May's Board.

Operating Model – report to be presented to May's Board.

Reflection and Review

ICB/03/25/18 Closing remarks and review of the meeting

The Chair closed the meeting.

CLOSE OF MEETING

Date of Next Meeting:
Thursday 29th May 2025, 9am-4.30pm, TBC.

Consent Items

ICB/013/25/19 Board Decision Log

The Board Decision Log was noted.

ICB/03/25/20 NHS Cheshire and Merseyside Green Plan 2025-28

The Board approved the NHS Cheshire and Merseyside Green Plan 2025-28

ICB/03/25/21 Emergency Preparedness Resilience and Response Core Standards 2024-25 Assurance Report

The Board noted the contents of the report and noted the significant improvement on the 2023/24 self-assessment compliance rating.

ICB/03/25/22 ICB Committees Chair Reports

The Board noted the ICB Committee Chair highlight reports and approved recommendation from the Audit Committee for the ICB Board to approve the minor amendments to and the adoption of the updated ICB Scheme of Reservation and Delegation (SORD) and ICB Operational SORD.

ICB/01/25/23 Confirmed Minutes of ICB Committees

- Audit Committee – December 2024
- Children and Young Peoples Committee – November 2024
- Finance, Investment and Our Resources Committee – January 2025 and February 2025
- Quality and Performance Committee – January 2025 and February 2025
- System Primary Care Committee – December 2024

CLOSE OF MEETING

Date of Next Meeting:
Thursday 27th February 2025, 9am-4.30pm, Liverpool Venue TBC.

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

Action Log 2023 - 2025

Updated: **22.05.25**

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status	Recommendation to Board
IBC-AC-22-69	25/01/2024	**NHS C&M Quality and Performance Report**	Board to receive information on secondary prevention measures in primary care (link to QOF)	Clare Watson	Mar-25	*Discussion ongoing with Performance team regarding access to reportable data that can be included within the integrated performance report. Data metrics will be agreed at System Primary Care Committee and then update to be provided to the Board*	ONGOING	
ICB-AC-80	27/03/2025	**Integrated Performance Report**	Revised dashboard to be presented to the system primary care committee, incorporating recent changes from the planning guidance and letters from the Secretary of State to general practice.	Anthony Middleton			ONGOING	
ICB-AC-81	27/03/2025	**Integrated Performance Report**	Future report to provide updates on the performance metrics and the impact of the virtual wards on cost-effectiveness, outcomes, and alignment with neighbourhood care mode	Anthony Middleton			ONGOING	
ICB-AC-82	27/03/2025	**Integrated Performance Report**	Provide updates on the impact of the hydration in care homes project and explore opportunities to broaden it out across wider area	Anthony Middleton			ONGOING	
ICB-AC-83	27/03/2025	**Director of Nursing Report**	Proposed System wide Safety Priorities to be brought for approval at the May Board.	Chris Douglas		Copming to July Board	ONGOING	
ICB-AC-84	27/03/2025	**Director of Nursing Report**	An update to come to the Board regarding the outcomes of the NHS England's newborn hearing and screening programme review and the subsequent improvement plans	Chris Douglas			ONGOING	
ICB-AC-85	27/03/2025	**Place Director Report**	Sefton to provide assurance in the next report that they have worked through the needs of the population of Southport post-incident and have sufficient local Information Services.	Deborah Butcher			ONGOING	
ICB-AC-86	27/03/2025	**Place Director Report**	Place Directors and the board to consider how the Place Director report can be streamlined and improved for the next financial year, ensuring it effectively highlights key themes and impacts.	Place Directors			ONGOING	
ICB-AC-87	27/03/2025	**Place Director Report**	Future report to come back to help Board understand the progress and impact of primary care network activities, ensuring alignment with broader neighborhood health models	Clare Watson & Alison Lee			ONGOING	
ICB-AC-88	27/03/2025	**Improving Hospital Gynaecology and Maternity Services in Liverpool**	The Deputy Medical Director to Provide a detailed timeline and next steps for the women's services improvement project.	Dr Fiona Lemmens			ONGOING	
ICB-AC-89	27/03/2025	**Joint Forward Plan Annual Refresh**	The Assistant Chief Executive to present the full annual delivery plan and strategic tracker to a future meeting. This will include more detailed information on evolving the system, strategic commissioning roles, and building capabilities.	Clare Watson			ONGOING	
ICB-AC-90	27/03/2025	**NHS Cheshire and Merseyside Financial Plan 2025-2026**	Director of Finance to provide an update on the financial plan and the ICS position in the next board meeting.	Mark Bakewell			ONGOING	
ICB-AC-91	27/03/2025	**Supporting Care Leavers into Employment**	Chief People Officer to develop a delivery plan and budget for the care leavers recruitment initiative and provide a report back to Board.	Mike Gibney			ONGOING	

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

29 May 2025

CONSENT ITEMS

All these items have been read by Board members and the minutes of the May 2025 Board meeting will reflect any recommendations and decisions within, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting.			
AGENDA NO	**ITEM**	**Reason for presenting**	**Page No**
ICB/05/25/23	Board Decision Log **(CLICK HERE)**	For information	-
ICB/05/25/24	Q4 2024-2025 Board Assurance Framework	No changes to the risks scores as presented to January 2025 Board. For assurance	**Page**
ICB/05/25/24	Q4 2024-2025 Corporate Risk Register	For assurance	**Page**
ICB/05/25/23	**Confirmed Minutes of ICB Committees** **Click on the links below to access the minutes:** • Audit Committee – March 2025 **(CLICK HERE)** • Finance, Investment and Our Resources Committee – March 2025 **(CLICK HERE)** • Finance, Investment and Our Resources Committee – April 2025 **(CLICK HERE)** • Quality and Performance Committee – March 2025 **(CLICK HERE)** • Quality and Performance Committee – April 2025 **(CLICK HERE)** • System Primary Care Committee – Feb 2025 **(CLICK HERE)** • Women's Hospital Services in Liverpool Committee – March 2025 **(CLICK HERE)**	For assurance	**Page**

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

29 May 2025

Board Assurance Framework 2024-2025 and Quarter Four Update Report

Agenda Item No: ICB/05/25/24

Responsible Director: Clare Watson, Assistant Chief Executive

Board Assurance Framework 2024-2025 and Quarter Four Update Report

1. Purpose of the Report

1.1 The purpose of the report is to present the quarter four update of the Board Assurance Framework (BAF).

2. Executive Summary

2.1 The 2024-25 BAF and principal risks were approved by the Board in July 2024. The principal risks are those which, if realised, will have the most significant impact on the delivery of the ICB's strategic objectives.

2.2 There are currently 10 principal risks, including 1 critical risk, 5 extreme risks and 4 high risks. Of these, all are at the agreed target for 2024-25 including 4 risks where increases to the target score were approved by the Board during the year. The principal risks and target scores will be refreshed for 2025-26 both to reflect current priorities and strategic challenges and with the aim of moving closer to the ICB risk appetite.

2.3 The critical risk is:

- P5 - Lack of Urgent and Emergency Care capacity and restricted flow across all sectors (primary care, community, mental health, acute hospitals and social care) results in patient harm and poor patient experience, currently rated as critical (20).

2.4 There have been no changes since the January 2025 Board meeting. A summary of the movements over the course of the year is provided in section 9 of the report.

2.5 The report and appendices set out the controls that are in place, an assessment of their effectiveness and further control actions planned in relation to all principal risks. Planned assurances have been identified in relation to each principal risk and these are provided through the work of the Committees and through Board reports over the course of the year.

2.6 Acceptable assurance is available in relation to 5 of the principal risks but further assurance is required in respect of the remaining 5 and further details are provided in section 9.9 and appendix two.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- **NOTE** the current risk profile, progress in completing mitigating actions, assurances provided and priority actions for the next quarter; and consider any further action required by the Board to improve the level of assurance provided or any new risks which may require inclusion on the BAF.

4. Reasons for Recommendations

4.1 The Board has a duty to assure itself that the organisation has properly identified the risks it faces and that it has processes in place to mitigate those risks and the impact they have on the organisation and its stakeholders. The Board discharges this duty as follows:

- identifying risks which may prevent the achievement of its strategic objectives
- determining the organisation's level of risk appetite in relation to the strategic objectives
- proactive monitoring of identified risks via the BAF and Corporate Risk Register
- ensuring that there is a structure in place for the effective management of risk throughout the organisation, and its committees (including at place)
- receiving regular updates and reports from its committees identifying significant risks, and providing assurance on controls and progress on mitigating actions
- demonstrating effective leadership, active involvement and support for risk management.

5. Background

5.1 As part of the annual planning process the Board undertakes a robust assessment of the organisation's emerging and principal risks. This aims to identify the significant external and internal threats to the achievement of the ICB's strategic goals and continued functioning. The principal risks identified for 2024-25 were approved for adoption by the Board in July 2024 and form the basis of the Board Assurance Framework reported quarterly to the Board.

5.2 The ICB must take risks to achieve its aims and deliver beneficial outcomes to patients, the public and other stakeholders. Risks will be taken in a considered and controlled manner, and the Board has determined the level of exposure to risks which is acceptable in general, and this is set out in the core risk appetite statement.

5.3 The Risk Management Strategy incorporates the board assurance arrangements and sets out how the effective management of risk will be evidenced and scrutinised to provide assurance to the Board. The Board

Assurance Framework (BAF) is a key component of this. The Board is supported through the work of the ICB Committees in reviewing risks, including these BAF risks, and providing assurance on key controls. The outcome of their review is reported through the reports of the committee chairs and minutes elsewhere on the agenda.

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

Objective One: **Tackling Health Inequalities in access, outcomes and experience**
Objective Two: **Improving Population Health and Healthcare**
Objective Three: **Enhancing Productivity and Value for Money**
Objective Four: **Helping to support broader social and economic prosperity**

6.1 The BAF supports the objectives and priorities of the ICB through the identification and effective mitigation of those principal risks which, if realised, will have the most significant impact on delivery.

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

7.1 The Annual Delivery Plan sets out linkages between each of the plan's focus areas and one or more of the BAF principal risks. Successful delivery of the relevant actions will support mitigation of these risks.

8. Link to meeting CQC ICS Themes and Quality Statements

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

8.1 The establishment of effective risk management systems is vital to the successful management of the ICB and local NHS system and is recognised as being fundamental in ensuring good governance. As such the BAF underpins all themes, but contributes particularly to leadership, specifically QS13 – governance, management and sustainability.

9. Risks

9.1 The quarter 4 BAF is summarised in the heat map below:

ID	Risk	Inherent			Current (Q4)			Target 2024-25			Risk Appetite (Optimal)	
		L	I	R	L	I	R	L	I	R	Rating	Timescale
P1	Health inequalities	4	5	**20**	3	5	**15**	3	5	**15**	High (8)	2027-28
P3	Elective care	5	5	**25**	3	5	**15**	2	5	**15**	Moderate (5)	2026-27
P4	Major quality failures	3	5	**15**	2	5	**10**	2	5	**10**	Moderate (5)	2026-27
P5	Urgent & emergency care	5	5	**25**	4	5	**20**	3	5	**20**	Moderate (5)	2026-27
P6	Primary care access	5	4	**20**	3	4	**12**	3	4	**12**	Moderate (6)	2025-26
P7	Statutory financial duties	5	5	**25**	4	4	**16**	4	4	**16**	High (8)	2026-27
P8	Provider sustainability	4	4	**16**	3	4	**12**	3	4	**12**	Moderate (6)	2026-27
P9	ICS workforce	4	4	**16**	4	4	**16**	4	4	**16**	Moderate (6)	2026-27
P10	Focus on long term strategy	4	4	**16**	3	3	**9**	3	3	**9**	Moderate (6)	2025-26
P11	Digital infrastructure	5	4	**20**	4	4	**16**	4	4	**16**	High (8)	2025-26

9.2 There are no changes proposed from the quarter 3 position. Over the course of 2024-25:

- The risk scores have reduced for P6 (from 16 to 12) and P7 (from 20 to 16) in line with the target scores for the year, with further reductions projected in future years in line with target scores

- The target risk scores were increased, with the approval of the Board, for P3 (from 10 to 15), P5 (from 15 to 20), P7 (from 15 to 16) and P9 (from (12 to 16). In the case of P3 and P5 this reflected that despite the mitigating action being taken, it was going to take longer than initially anticipated to achieve a reduction. The target for P7 was adjusted reflecting that the potential impact had reduced due to an improving financial position. The increased target for P9 reflected funding decisions to manage the ICB financial position with a result that planned mitigating action was paused.

9.3 A summary of the principal risks and high-level mitigation strategies is provided at appendix one. Further detail in respect of each risk, including the assessment and scoring rationale, current controls and assessment of their effectiveness, gaps identified, planned actions and progress, assurances provided and a current position statement in relation to progress towards target, is provided in the individual risk summaries at appendix two.

9.4 There are currently 10 principal risks, including 1 critical risk, 5 extreme risks and 4 high risks. Of these, all are at the agreed target for 2024-25 including 4 risks where increases to the target score were approved by the Board during the year. The principal risks and target scores will be refreshed for 2025-26 both to reflect current priorities and strategic challenges and with the aim of moving closer to the ICB target scores

9.5 The majority of the planned actions are on track, but there are five actions assessed as problematic - delivery remains feasible, actions not completed, awaiting further interventions. These are:

9.5.1 In relation to P4 – major quality failures, embedding NHS Impact approach.

9.5.2 In relation to P4 – major quality failures, continue to develop BI capability to support intelligence led approach.

9.5.3 In relation to P7 – statutory financial duties, action to conclude and secure agreement to the medium-term financial strategy. This reflects the scale of the challenge and the work still to complete in testing and finalising delivery metrics, timescales and quantifying associated financial impact for recovery programmes.

9.5.4 In relation to P8 – provider sustainability, oversight of ECT Sustainable Hospitals Programme delivery and milestones, as the programme is currently paused.

9.5.5 In relation to P8 – provider sustainability, due to the current ICB financial position the next steps in options appraisal for catheter laboratory optimisation have been paused.

9.6 As progress is made in implementing and strengthening controls, with resulting reductions in the level of risk, the focus will shift to assuring that key controls are embedded and effective in continuing to mitigate the risk to an acceptable level. The ICB's committees provide scrutiny and challenge of risk independent of the management line and are an important source of 2nd line assurance to the Board. Their discussion and decisions in relation to BAF risks were summarised in the chair's highlight reports considered by the Board on 30/01/25, 27/03/25 and appearing elsewhere on this agenda.

9.7 In addition the following assurance reports have been provided to the Board during quarter four:

9.7.1 Director of Nursing Report – 30/01/25, 27/03/25 (P4)
9.7.2 Integrated Performance Report – 30/01/25, 27/03/25 (P3, P4, P5, P6, P9)
9.7.3 Finance Report – 30/01/25, 27/03/25 (P7)
9.7.4 Reforming Elective Care for Patients in Cheshire and Merseyside – 30/01/25 (P3)
9.7.5 Cheshire and Merseyside Cyber Security Update – 30/01/25 (P11)
9.7.6 Data Into Action - Progress update – 30/01/25 (P1, P7, P11)
9.7.7 Cheshire and Merseyside Cancer Alliance Update – 27/03/25 (P1, P3)
9.7.8 Liverpool Adult Acute and Specialist Providers Case for Change – 27/03/25 (P3, P4, P7, P8, P9)
9.7.9 Report on the October/November 2024 public engagement on Improving Hospital Gynaecology and Maternity Services in Liverpool – 27/03/25 (P4, P8)

9.7.10 NHS Cheshire and Merseyside 2025-26 Joint Forward Plan (Annual Refresh) – 27/03/25 (P10)

9.7.11 NHS Cheshire and Merseyside Financial Plan 2025-2026 – 27/03/25 (P7)

9.8 A summary of the assurance ratings for each of the principal risks is provided below:

ID	Risk	Committee	Current Score (Q3)	Controls					Assurance Rating
				Policies	Processes	Plans	Contracts	Reporting	
P1	Health inequalities	S&T	**15**	**G**	**G**	**G**	**G**	**G**	**Acceptable**
P3	Elective care	Q&P	**15**	**G**	**A**	**G**	**G**	**G**	**Acceptable**
P4	Major quality failures	Q&P	**10**	**A**	**A**	**A**	**G**	**G**	**Acceptable**
P5	Urgent & emergency care	Q&P	**20**	**G**	**A**	**A**	**G**	**A**	**Partial**
P6	Primary care access	SPCC	**12**	**G**	**A**	**A**	**G**	**G**	**Acceptable**
P7	Statutory financial duties	FIRC	**16**	**G**	**G**	**A**	**A**	**G**	**Partial**
P8	Provider sustainability	S&T	**12**	**G**	**G**	**A**	**A**	**A**	**Partial**
P9	ICS workforce	FIRC	**16**	**A**	**A**	**A**	**G**	**A**	**Partial**
P10	Focus on long term strategy	Execs	**9**	**G**	**G**	**A**	**A**	**G**	**Acceptable**
P11	Digital Infrastructure	S&T	**16**	**A**	**A**	**A**	**A**	**A**	**Partial**

9.9 There are a number of risks assessed as having only partial assurance - some confidence in delivery of existing mechanisms / objectives, some areas of concern. These are:

P5 where key performance measures indicate that, despite existing controls, service delivery is not yet meeting required national and local standards.

P7 where additional assurance is required that there is an agreed and approved ICS medium-term financial strategy to address the financial deficit.

P8 where additional assurance is required that there is a credible case for change and sustainable transformation plans in relation to a number of fragile services.

P9 where further assurance is required regarding action planned to address priority gaps in control with the reduced resource available.

P11 where additional assurance is required regarding organisation and system level cyber security compliance and risk, and robust plans to address any identified gaps.

Further detail is provided in the risk summaries at appendix two.

10. Finance

10.1 There are no financial implications arising directly from the recommendations of the report. However, the report does cover a number of financial risks which are described in section 9 and detailed in the appendices.

11. Communication and Engagement

11.1 No patient and public engagement has been undertaken.

12. Equality, Diversity and Inclusion

12.1 Principal risks P3, P4, P5, P6, P8 and P9 have the potential to adversely impact on equality, diversity and inclusion in service delivery, outcomes or employment. The mitigations in place and planned are described in more detail in the risk summaries at appendix two.

12.2 Principal risk P1 has the potential to impact on health inequalities. The mitigations in place and planned are described in more detail in the risk summaries at appendix two.

13. Climate Change / Sustainability

13.1 There are no identified impacts in the BAF on the delivery of the Green Plan / Net Zero obligations.

14. Next Steps and Responsible Person to take forward

14.1 Following preliminary discussions at the recent Board development session, the Board, supported by the Executive Team, will complete a review of the principal risks reflecting the updated annual plan and any significant external and internal threats to the achievement of the ICB's strategic goals and continued functioning. The scheduled review of the risk appetite will take place alongside this.

14.2 The outcome of these reviews will be used to frame the Board Assurance Framework going forward into 2025-26. It is planned to bring this to the meeting in July 2025 for approval.

15. Officer contact details for more information

Matthew Cunningham
Associate Director of Corporate Affairs & Governance
NHS Cheshire and Merseyside ICB

16. Appendices

ALL APPENDICES CAN BE ACCESSSED BY CLICKING HERE

Appendix One: Board Assurance Framework Summary
Appendix Two: BAF Risk Summaries

Board Assurance Framework 2024/25 – Quarter 4 review

Appendix One – Summary

Principal Risks	Responsible Committee & Executive	Inherent Risk Score (LxI)	Current Risk Score (LxI)	Change from previous quarter	Target Risk Score 2024-25	Priority Actions / Assurance Activities
Strategic Objective 1: Tackling Health Inequalities in Outcomes, Access and Experience						
P1: The ICB is unable to meet its statutory duties to address health inequalities	Strategy & Transformation Committee Clare Watson	**4x5=20**	**3x5=15**	No change	**3x5=15**	Assurance on progress and effectiveness of delivery of All Together Fairer: Our Health and Care Partnership Plan. Focus remains the building of the foundations that would lead to a reduction in health inequalities over the longer term.
Strategic Objective 2: Improving Population Health and Healthcare						
P3: Acute and specialist providers across C&M may be unable to reduce backlogs for elective and cancer care, due to capacity constraints related to industrial action or other supply side issues or the impact of winter Urgent and Emergency Care pressures. This may result in inability to meet increased demand, increase in backlogs of care, resulting in poor access to services, increased inequity of access, and poor clinical outcomes	Quality & Performance Committee Anthony Middleton	**5x5=25**	**3x5=15**	No change	**3x5=15**	Further action to strengthen controls. Key actions are the Elective Recovery Team and increasing diagnostics capacity through Community Diagnostic Centres and elective capacity through elective hubs.

P4: Major quality failures may occur in commissioned services resulting in inadequate care compromising population safety and experience	Quality & Performance Committee Chris Douglas / Rowan Pritchard-Jones	**3x5=15**	**2x5=10**	No change	**2x5=10**	Significant controls in place. Priority will be to continue to embed and strengthen controls and provide assurance on continuing effectiveness of control framework.
P5: Lack of Urgent and Emergency Care capacity and restricted flow across all sectors (primary care, community, mental health, acute hospitals and social care) results in patient harm and poor patient experience	Quality & Performance Committee Anthony Middleton	**5x5=25**	**4x5=20**	No change	**4x5=20**	Urgent Care Recovery Programmes in 5 areas are focused on the key objective of eliminating corridor care in 24-25, as well as reducing the number of hospital attendances and admissions and improving discharge pathways and processes.
P6: Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population	Primary Care Clare Watson	**5x4=20**	**3x4=12**	No change	**3x4=12**	Assurance on progress and effectiveness of delivery of Primary Care Access Recovery Plan and Dental Improvement Plan.
Strategic Objective 3: Enhancing Quality, Productivity and Value for Money						
P7: The Integrated Care System is unable to achieve its statutory financial duties	Finance, Investment & Our Resources Committee Mark Bakewell	**5x5=25**	**4x4=16**	No change	**4x4=16**	Key aim of Recovery Programme is to improve use of resources. Key further action is to secure agreement to the Medium-Term Financial Strategy.
P8: The ICB is unable to resolve current provider service sustainability issues resulting in poorer outcomes for the population due to loss of services	Strategy & Transformation Committee Rowan Pritchard-Jones	**4x4=16**	**3x4=12**	No change	**3x4=12**	Further action to implement and strengthen controls. Ongoing action to progress the development of case for change across multiple programmes.

P9: Unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic objectives.	Finance, Investment & Our Resources Committee Chris Samosa	**4x4=16**	**4x4=16**	No change	**4x4=16**	Further action to implement and strengthen controls. Key actions are to develop and enhance system workforce planning and scaling up of Peoples Services.
Strategic Objective 4: Helping the NHS to support broader social and economic development						
P10: ICS focus on responding to current service priorities and demands diverts resource and attention from delivery of longer-term initiatives in the HCP Strategy and ICB 5-year strategy on behalf of our population.	ICB Executive Graham Urwin	**4x4=16**	**3x3=9**	No change	**3x3=9**	Assurance on progress and effectiveness of delivery of All Together Fairer and Joint 5-Year Forward Plan.
P11: The ICB is unable to address inadequacies in the digital infrastructure and related resources leading to disruption of key clinical systems and the delivery of high quality, safe and effective health and care services across Cheshire and Merseyside.	Strategy & Transformation Committee Rowan Pritchard-Jones	**5x4=20**	**4x4=16**	No change	**4x4=16**	Further action to implement and strengthen controls. Key actions are C&M wide baseline analysis and benchmarking, identifying and progressing opportunities for collaboration and standardisation, and identifying and addressing supply chain risks.

Appendix Two – BAF Risk Summaries

ID No: P1	Risk Title: The ICB is unable to meet its statutory duties to address health inequalities
Risk Description (max 100 words)	Longstanding social, economic and health inequalities across Cheshire and Merseyside, when comparing outcomes both between different communities in our area and the national average for HI. Population health and wellbeing is shaped by social, economic, and environmental conditions in which people are born, grow, live, and work. This can only be addressed through collective systemwide effort and investment across the partnership, our communities, the NHS, Local Government, and Voluntary and Private sectors. This risk relates to the potential inability of the ICB to secure the necessary investment and influence priorities across multiple organisations, agencies and communities covered by the ICB.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Clare Watson	Prof. Ian Ashworth	Assistant Chief Executive	Strategy & Transformation

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Tackling Health Inequality, Improving Outcomes and Access to Services	Transformation	C – beyond 12 months	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	02/04/25	16/06/25

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	4	3	3	3	3	3	31/03/25	Our longer-term ambition is to moderate to a (2x4=8) level of risk but will only be achievable over 3-4 years due to resource allocation and capacity. This equally applies to systemwide inequalities due to financial pressures and capacity.
Impact	5	5	5	5	5	5		
Risk Score	20	15	15	15	15	15		

Rationale for score & progress in quarter (max 300 words)	There is potential for a major reduction in health outcomes and/or life expectancy and major increase in the health inequality gap in deprived areas or for socially excluded groups (impact 5). Current controls are effective in reducing the likelihood, but this is still possible (3). There have been delays in mitigating action due to financial constraints and any further delay is likely to increase the risk score to 20 (critical). Planned mitigation is focused on delivering the All Together Fairer: Our Health and Care Partnership Plan, including securing health inequalities investment allocation. The planned actions will be affected by the ICB financial review, some delay to some aspects of work, will be applied to support the 2024-25 financial challenges. The delay would be for the remainder of this financial year. As a result, the completion dates for All Together Fairer and Health Inequalities approaches with place-based partnerships and implementation of Population Health sub-groups have been delayed. Our focus remains on the building of the foundations that would lead to a reduction in health inequalities and contribute to our ambition of a score of 8, but this is now expected to take longer over the next 3-4 years. It is vital that the ICB Recovery Programme consistently reviews opportunities to reduce demand and avoidable admissions, whilst acting on reducing the impact of health care inequalities, as well as considers the implications of any decommissioning on the Health Inequalities resources, in relation to the associate populations. We will also need to assess the impact of the NHSE changes and the implications for the Population Health Programme, this would likely be better known by the QT1 reporting period.

Current Key Controls		**Rating**
Policies	Constitution, membership & role of HCP Partnership Board, 'All Together Fairer;(Marmot Review)' Core 20+5 Stocktake, Prioritisation Framework, Public Engagement / Empowerment Framework.	**G**
Processes	Strategic planning, consultation & engagement, financial planning, Population Health Partnership group support, advice, and scrutiny of the Population Health Programme.	**G**
Plans	***All Together Fairer: Our Health and Care Partnership Plan,*** HCP Interim Strategy, 5 Year Joint Forward Plan, Health Inequalities Funding (including SDF now in baseline) secure for 25-26 programme, Joint Health, and Wellbeing Strategy achieved.	**G**
Contracts	NHS Trust contracts (including contract schedule to support reducing health inequalities)	**G**
Reporting	C&M HCP Partnership Board, Population Health Partnership Group, Place-Based Partnership Boards all established for 2024-25. The Strategy & Transformation Committee ceased December 2024, the ICB governance review will determine the new reporting structure for the Population Health Partnership. ICB Board reporting in 2024-25 sustained.	**G**
Gaps in control		
Gaps in controls A reduced investment in Health Inequalities funding in year 2024/25 from the ICB has led to a delay in some programme commencement dates until April 2025. The programme will need to assess the impact of the NHSE changes and the implications for the Population Health Programme plan. This would likely be better known by the QT1 reporting period.		

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Finalise Joint 5-year Forward Plan aligned to All Together Fairer	[redacted]		Neil Evans	01/10/24	**Complete**
Secure ICB ring-fenced Health Inequalities budget allocation			Clare Watson	31/03/25	**Complete**
Agree All Together Fairer and Health Inequalities approaches with place-based partnerships (incl allocation, guidance & reporting established for 2024-25).			Ian Ashworth	31/03/25	**Complete**
Implement Population Health Group sub-groups aligned to population health programme plan on a page were completed for 2024-25.			Population Health Consultants	31/03/25	**Complete**
Development of performance framework, underpinning data & intelligence to enable demonstration of progress completed for All Together Fairer Programme in 2024-25.			Cerriann Tunnah	31/03/25	**Complete**
NHSE recurrent funding secured for both the Familial Hypercholesterolemia and CVD Prevention services – confirmed at S&TC.			Julie Kelly	21/11/24	**Complete**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme, or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Assurance Rating**
ICB Board approval to Joint 5 Year Forward Plan	October 2024	1/10/24	**Acceptable**
Progress reports to C&M HCP Board on delivery & implementation of programmes and projects.	Quarterly	26/09/24	
Progress reports to Strategy & Transformation Committee on delivery & implementation of programmes maintained through to December 2024 when the committee ceased.	Bi-monthly	Bi-monthly Apr to Dec	
Core20+5 Health Inequalities Stocktake for NHSE/I reported to Population Health Partnership Group & C&M HCP Board.	Quarterly	QT 1 to 3 submitted QT4 in	

		production for submission 28/4/25	

Gaps in assurance

- Limitations on scale and pace of investment due to challenging financial environments for all partners, and the Population Health Programme.
- Population Health Group Sub-Groups completed for 2024-25. A review of the population health programme plan on a page for 2025-26 will determine if any other subgroups will be required.
- Strategy & Transformation Committee ceased December 20245. New governance reporting will need to be identified for 2025-26.

Actions planned	Owner	Timescale	Rating
Secure ICB ring-fenced Health Inequalities budget allocation – 2025-26	Clare Watson	31/03/25	**Complete**
Review of Programme reporting metrics and Impacts	Ceriann Tunnah	31/03/25	**Complete**
Develop assurance role of Population Health Group Sub-Groups	Ian Ashworth	31/03/25	**Complete**
Revised governance arrangements to be approved by ICB Board.	Clare Watson	31/05/25	**On Track**

ID No: P3	**Risk Title: Acute and specialist providers across C&M may be unable to reduce backlogs for elective and cancer care, due to capacity constraints related to industrial action or other supply side issues or the impact of winter Urgent and Emergency Care pressures. This may result in inability to meet increased demand, increase in backlogs of care, resulting in poor access to services, increased inequity of access, and poor clinical outcomes**
Risk Description (max 100 words)	The COVID 19 pandemic generated significant backlogs due to reduced capacity and people delaying seeking healthcare interventions, exacerbating existing inequalities in access to care and health outcomes. Supply side constraints, including industrial action, and urgent and emergency care pressures, impact on the available capacity in the system to tackle the longest waits. This risk relates to the potential inability of the ICB in this context to deliver these plans against national targets for recovery of electives, diagnostics and cancer services, which may result in patient harm and increased health inequalities.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Anthony Middleton	Andy Thomas	Finance	Quality & Performance

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improving Population Health and Healthcare	Performance	A – within the next quarter	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	29/04/2025	16/06/2025

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	**5**	**3**	**3**	**3**	**3**	**3**	31/3/25	The ICB has a low tolerance for risks impacting patient safety and the aim is to reduce to a moderate/low level acknowledging that this will take 2-3 years to achieve in line with national improvement trajectories.
Impact	**5**	**5**	**5**	**5**	**5**	**5**		
Risk Score	**25**	**15**	**15**	**15**	**15**	**15**		

Rationale for score & progress in quarter (max 300 words)	There is potential for multiple deaths or irreversible health effects, or harm to more than 50 people, and gross failure to meet national standards (impact 5). Current controls are effective in reducing the likelihood to possible (3). Elective Recovery, Diagnostics and Cancer Programmes are focused on increasing activity, faster diagnosis and treatment and reducing long waits. As a result of lost opportunities due to industrial action, recent cyber-attacks and urgent care pressures it is not now anticipated that a reduction in the score will be achieved by year-end and the target score was increased from 10 to 15 in quarter 3. Latest reported performance indicates that whilst cancer and diagnostics performance has been robust, the wider challenges in elective care means that 65 week waits will not have been eliminated by year end 2024/25.

Current Key Controls		Rating
Policies	NHS Long Term Plan, NHS Operational Planning Guidance, NHS elective recovery plan published February 2022 '**Delivery plan for tackling the COVID-19 backlog of elective care'**	**G**
Processes	System level operational planning, performance monitoring, contract management, system oversight framework, diagnostics mutual aid	**A**
Plans	C&M Operational Plan, Elective Recovery Programme and Plans, Diagnostics Programme and Plans including Community Diagnostics Centres, Cheshire & Merseyside Cancer Alliance work programme, Place Delivery Plans, Winter Plan, EPRR	**G**
Contracts	NHS Standard Contract – contracting round for 23/24 concluded	**G**
Reporting	Programme level reporting, Quality & Performance Committee, Primary Care Committee, ICB Board, Regional Elective Board (chaired by NHSE)	**G**

Gaps in control
Scale and frequency of potential future industrial action unknown and may impact on workforce capacity.

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
CMAST Elective Recovery Improvement Programme	Reduce	Target impact remains same	Anthony Middleton	2024/25	**On Track**
Increase diagnostics capacity through CDCs and elective capacity through elective hubs	Reduce	As above	Anthony Middleton	2024/25	**On Track**
Cancer Alliance targeted investment and support to priority cancer pathways	Reduce	As above	Anthony Middleton	2024/25	**On Track**
Delivery of cancer alliance strategic intelligence plan alongside ICB, reduce, reduce, 25/26.	Reduce	Reduce	Anthony Middleton	2025/26	**On Track**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Assurance Rating**

Performance reporting to Quality & Performance Committee & ICB Board	Monthly & bi-monthly	Monthly & bi-monthly	**Acceptable**
Programme delivery reporting to Strategy & Transformation Committee, ICB Board	Bi-monthly	Bi-monthly	
Children and Young People's Elective Wait Recovery: accelerated delivery proposal	-	26/9/24	

Gaps in assurance
All Trusts were committed to eliminate waits over 65 weeks by September (extended to December 2024) per 24-25 operational plans, however it is noted that certain specialties are particularly pressured, including ENT, T&O, Plastics and Gynaecology, and that there are a small number of Trusts who are going to be unable to achieve this due to levels of capacity issues, resources and operational pressures. Further detail is provided in the Integrated Performance Report. Each of the "breach" patients are validated and tracked on a daily and weekly basis, and we are looking at additional opportunities for mutual aid and shared support between the trusts.

Actions planned	**Owner**	**Timescale**	**Rating**
Weekly patient tracking list meetings all trusts	Anthony Middleton (via CMAST)	2024-25	**On Track**
C&M Elective Recovery Mutual Aid Team broker mutual aid	Anthony Middleton (via CMAST)	2024-25	**On Track**

ID No: P4	Risk Title: Major quality failures may occur in commissioned services resulting in inadequate care compromising population safety and experience
Risk Description (max 100 words)	The ICB has a statutory responsibility to improve the quality of commissioned services and safeguard the most vulnerable, the quality governance framework that has been established supports early identification and triangulation of risks to quality and safety. This risk pertains to the potential failure of the established framework, with the consequence of a major impact on the safety and experience of services by our population.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Chris Douglas / Rowan Pritchard-Jones	Kerry Lloyd	Nursing & Care / Medical	Quality & Performance

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improving Population Health and Healthcare	Quality	B – within the financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	02/04/25	16/06/25

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	3	2	2	2	2	2	31/3/25	The ICB has a low appetite for risk that impacts on patient safety. Our longer-term aspiration remains to reduce further to a moderate (1x5=5) level.
Impact	5	5	5	5	5	5		
Risk Score	15	10	10	10	10	10		
Rationale for score & progress in quarter (max 300 words)	There is potential for multiple deaths, permanent injuries or irreversible health effects, or harm to more than 50 people, totally unacceptable quality of clinical care, and gross failure to meet national standards (impact 5). Current controls are effective in reducing the likelihood, to unlikely (2). Good progress has been made in establishing the quality oversight framework providing a firm foundation for identifying emerging concerns and appropriate intervention. The increased focus on the resources available and our need to increase our productivity in 2024-25 makes it increasingly important to mitigate any potential impact to the quality and safety of commissioned services, and as a result it is anticipated that progress in further reducing this risk will be limited during the current financial year.							

Current Key Controls	Rating

Policies	Clinical Quality Strategy, National Quality Board guidance on risk management and escalation, Safeguarding legislation and policy alignment, Patient Safety policy alignment, including Patient Safety Incident Response Framework	**A**
Processes	System Quality Group, Emerging Concerns Group, Clinical Effectiveness Group, Multi- agency safeguarding boards/partnerships, Infection Prevention Control/Anti-Microbial Resistance Board, Place based quality partnership groups & serious incident panels, Quality Assurance Visits, Rapid Quality Reviews, Independent Investigations & other reviews and responses to national enquiries and investigations. System Wide Clinical Risk and Consensus Group created (Winter Safety). Development of Quality Statements to support 2025/26 Commissioning Intentions.	**A**
Plans	Development of Clinical and Care Professional Leadership Framework & Associated Steering Group, Approach to NHS Impact	**A**
Contracts	Place based quality schedule within NHS standard contract, Development of standardised C&M quality schedule, Service specifications, Safeguarding commissioning standards	**G**
Reporting	System Oversight Board, Quality & Performance Committee ICB Board, National quality reporting	**G**

Gaps in control

Need to ensure NHS Impact & PSIRF are embedded and extended
Development of data and intelligence platforms to identify and triangulate quality concerns / failures.

Actions planned	**Expected outcome**		**Owner**	**Timescale**	**Rating**
	Likelihood	**Impact**			
Closedown Serious Incident Framework	Reduce	Maintain	Richard Crockford	30/06/25	**On Track**
Continuous review and alignment of quality reporting requirements	Reduce	Maintain	Chris Douglas	2024-26	**On Track**
Embedding NHS Impact approach	Reduce	Maintain	Fiona Lemmens	2024-26	**Problematic**
Extending and embedding PSIRF	Reduce	Maintain	Richard Crockford	2024-25	**Completed**
Continue to develop BI capability to support intelligence led approach	Reduce	Maintain	Becky Williams	2024-26	**Problematic**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Assurance Rating**
Quality reporting to Quality & Performance Committee & ICB Board	Monthly	Monthly & bi-monthly – Apr 24 to Mar 25	**Acceptable**
Executive Director of Nursing & Care report to ICB	Bi-monthly	Bi-monthly – Apr 24 to Mar 25	
Regional quality group reporting	Bi-monthly	Bi-monthly – Apr 24 to Mar 25	
Gaps in assurance			
Work to strengthen quality, safety and experience reporting through intelligence led approach			

Actions planned	Owner	Timescale	Rating
Continue to develop ability to be intelligence led	Chris Douglas / Rowen Pritchard Jones	2024-26	**On Track**
Strengthen approach to the use of patient experience insight and feedback to ensure the early identification of negative impact on patient experience	Kerry Lloyd	2024-26	**On Track**

D No: P5	Risk Title: Lack of Urgent and Emergency Care capacity and restricted flow across all sectors (primary care, community, mental health, acute hospitals and social care) results in patient harm and poor patient experience.
Risk Description (max 100 words)	The wider urgent and emergency care system, spanning all sectors, is under significant pressure with similar demand, capacity and flow challenges impacting on the ability of patients to access the right urgent or emergency care at the right time in the right place. Within the acute sector, high bed occupancy, driven by delayed discharges and longer stays, results in reduced flow from emergency departments, which in turn impacts waiting times in ED and ambulance response times. Such delays may result in patient harm and poor patient experience, and increased health inequalities.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Anthony Middleton	Claire Sanders	Finance	ICB Executive

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improving Population Health and Healthcare	Quality	A – within the next quarter	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	02/04/25	16/06/25

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	5	4	4	4	4	4	31/3/25	The ICB has a low tolerance for risks impacting patient safety and the aim is to reduce to a moderate/low level acknowledging that this will take 2-3 years to achieve.
Impact	5	5	5	5	5	5		
Risk Score	25	20	20	20	20	20		
Rationale for score & progress in quarter (max 300 words)	There is potential for multiple deaths, permanent injuries or irreversible health effects, or harm to more than 50 people, totally unacceptable quality of clinical care, and gross failure to meet national standards (impact 5). Current controls are effective in reducing the likelihood, but this is still likely (4). Urgent Care Recovery Programmes in 5 areas are focused on the key objective of eliminating corridor care in 24-25, as well as reducing the number of hospital attendances and admissions and improving discharge pathways and processes. The planned actions are currently on track, but as a result of current demand levels, it was not possible to achieve a reduction in the score by year-end and the target score was increased from 16 to 20 in quarter 3.							

Current Key Controls		Rating
Policies	NHS Delivery plan for recovering urgent and emergency care services. Winter letter. SCC Review of Standards. Revised OPEL frameworks (Acute, Community, Mental Health and NHS 111)	**G**
Processes	System Coordination Centre, System wide operational planning, NHS Oversight Framework.	**A**
Plans	UEC Recovery Programme at scale workstreams and UEC Recovery plan of each of the 5 localities , C&M Operational Plan.	**A**
Contracts	NHS Standard Contract	**G**
Reporting	UEC Recovery and improvement Group, Strategy & Transformation Committee, Quality & Performance Committee, ICB Board	**A**

Gaps in control

Scale and frequency of future industrial action is unknown and likely to continue to impact on workforce capacity.
Demand exceeds planned capacity levels in a range of sectors, and fuller understanding of demand and capacity across all sectors is required.
Variation in processes C&M wide, e.g. application of patient choice, discharge processes.
Revaluation of NEPTS is required as part of procurement process.

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
At scale work stream admission avoidance	Reduce	Reduce	Tony Mayer	2024-26	**On Track**
At scale work stream ambulance improvement	Reduce	Reduce	Claire Sanders	2024-26	**On Track**
At scale work stream acute discharge	Reduce	Reduce	Dan Grimes	2024-26	**On Track**
At scale work stream acute length of stay	Reduce	Reduce	Dan Grimes	2024-26	**On Track**
At scale work stream oversight resilience	Reduce	Reduce	Claire Sanders	2024-26	**On Track**
Urgent Care Improvement Programme – North Mersey	Reduce	Reduce	Leigh Thompson	2024-26	**On Track**
Tier 1 rapid improvement offer from National UEC/ECIST	Reduce	Reduce	Claire Sanders	30/04/25	**On Track**
Urgent Care Improvement Programme – Mersey and West Lancashire	Reduce	Reduce	Mark Palethorpe & Jenny Wood	2024-26	**On Track**

Urgent Care Improvement Programme – Cheshire	Reduce		Laura Marsh & Dan Grimes	2024-26	**On Track**
Urgent Care Improvement Programme – Warrington and Halton	Reduce		Carl Marsh	2024-26	**On Track**
Urgent Care Improvement Programme – Wirral	Reduce		Simon Banks	2024-26	**On Track**
UEC Clinical Risk and Consensus Group	Reduce		Rowan Pritchard-Jones	2024-26	**On Track**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Assurance Rating**
UEC Recovery and Improvement Group	Monthly	Monthly Apr 24 to Mar 25	**Partial**
Recovery Programme delivery reporting to Recovery Committee & ICB Board	Monthly & bi-monthly	26/9/24	
Performance reporting to Quality & Performance Committee & ICB Board	Monthly & bi-monthly	Monthly & bi-monthly Apr 24 to Mar 25	
Gaps in assurance			
Performance against the majority of urgent and emergency care measures is below target and England average.			

Actions planned	**Owner**	**Timescale**	**Rating**
Urgent Care Improvement Programmes (as above)	Place Directors (as above)	2024-26	**On Track**

ID No: P6	Risk Title: Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population
Risk Description (max 100 words)	This risk relates to the potential inability of the ICB to ensure that local plans are effective in delivering against national targets for recovery of primary care access, which may result in poorer outcomes and inequity for patients and loss of stakeholder trust and confidence in the ICB.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Clare Watson	Chris Leese & Tom Knight	Assistant Chief Executive	SPCC

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improving Population Health and Healthcare	Primary Care	A – within the next quarter	Principal	Manage

Date Raised	Last Updated	Next Update Due
10/05/23	02/04/25	16/06/25

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	5	4	3	3	3	3	31/03/25	The aim is to reduce to a moderate level of risk over the 2024-26 lifetime of access recovery / improvement plans.
Impact	4	4	4	4	4	4		
Risk Score	20	16	12	12	12	12		
Rationale for score & progress in quarter (max 300 words)	There is potential for significant reduction in health outcomes and/or life expectancy, significant increase in health inequality gap in deprived areas or socially excluded groups, adverse public reaction and significant impact on trust and confidence of stakeholders (impact 4). Current controls are effective in reducing the likelihood to possible (3). Ongoing delivery of Primary Care Access Recovery and Dental Improvement Plans is on target and currently achieving the target risk score of 12. From a Primary Medical perspective, the ongoing collective action by GP practices could drive up the score during the remainder of the year if patients are becoming impacted. There will be Place variation with the scoring. In addition, there is also a potential impact on community pharmacies due to the collective action which will also be monitored and could impact the score during the remainder of the year. A risk for the Collective Action has been agreed by the System Primary Care Committee and is currently escalated to the Corporate Risk Register. Primary Medical the new operation planning guidance sets out an expected framework to improve access and support better demand management/increased capacity. Coupled							

	with this is a requirement in the new planning guidance to ensure access to urgent dental care as well as routine access for adults and children.

Current Key Controls		Rating
Policies	NHS Long Term Plan, NHS Operational Planning Guidance, National Stocktakes and Guidance in relation to Primary Care, Primary Care Access Recovery Plan,	**G**
Processes	System and place level operational planning, performance monitoring, contract management, system oversight framework, place maturity / assurance framework.	**A**
Plans	Primary Care Strategic Framework version 1, Developing Primary Care Access Recovery Plan, System Development Funding Plan, Dental Improvement Plan 25/26, ICS Operational Plan, Place Level Access Improvement Plans x 9. June 2025 submission Primary Medical contract oversight plan.	**A**
Contracts	GMS PMS APMS Contracts, Local Enhanced/Quality Contracts, Directed Enhanced Services – Primary Care Networks – Enhanced Access, GDS&PDS Contracts	**G**
Reporting	System Primary Care Committee, NW Regional Transformation Board, Quality & Performance Committee, ICB Board, HCP Board. Place Primary Care forums. Local Dental improvement plan delivery board	**G**

Gaps in control

Primary Care Strategic Framework version 2 to be completed & formally signed off.
Primary medical June plan (in development) and operational consistency between Places to deliver new single framework
Primary Care dentistry have a resourcing issue may be a challenge in terms of delivery
Awaiting 10 year plan to inform a refresh of overall Primary medical access plans

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
June oversight plan			Chris Leese	June 2025	**On Track**
Refresh of Access Recovery and Improvement Plans, following release of 10 year plan, and ongoing delivery			Chris Leese	August 25 & Ongoing	**On Track**
Delivery of Dental Improvement Plan 2024-26			Tom Knight	2024-26	**On Track**
Collective action EPRR process in place			EPRR Team/Chris Leese	2024-25	**Complete**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Committee Rating**
Reporting on delivery to System Primary Care Committee & ICB Board	Quarterly	04/25 06/25 08/25 10/25 12/25	**Acceptable**
Performance Reporting to ICB Board	Bi-monthly	Bi-monthly Apr 25 to Mar 26	
Gaps in assurance			

Actions planned	Owner	Timescale	Rating

ID No: P7	Risk Title: The Integrated Care System is unable to achieve its statutory financial duties
Risk Description (max 100 words)	There is a substantial underlying financial gap across the Cheshire and Merseyside healthcare system between current spending levels and the national formula-based allocation. If the ICB is unable to secure agreement to and deliver a long-term financial strategy which eliminates this gap whilst also enabling delivery of statutory requirements and strategic objectives, then it will fail to meet its statutory financial duties. This is further exacerbated by the relative' distance from target, convergence adjustments for both core ICB allocations and specialised services and inflationary pressures anticipated in the short -medium term above funding settlements.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Mark Bakewell	Rebecca Tunstall	Finance	Finance, Investment & Our Resources

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Enhancing Quality, Productivity and Value for Money	Finance	B – within financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	02/04/25	16/06/25

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	5	4	4	4	4	4	31/03/25	The ICB is willing to pursue higher levels of risk while maintaining financial sustainability and efficient use of resources. The aim is to reduce to a moderate level over the 3-year financial plan.
Impact	5	5	5	4	4	4		
Risk Score	25	20	20	16	16	16		

Rationale for score & progress in quarter (max 300 words)	There is potential for a significant financial loss, and impact on trust and confidence of stakeholders (impact 4). The scale of the financial gap means that the likelihood is currently likely (4). The potential impact has reduced due to an improving financial position and the year-end target score was amended from 15 to 16 to reflect this. Planned actions to secure ICS wide agreement and NHSE approval to a Medium-Term Financial Strategy are in progress. The longer-term aim is to reduce to a moderate level over the lifetime of the medium-term financial strategy. A medium-term financial model has been shared with the Board which sets out the financial challenge and drivers of the deficit. The medium-term financial strategy will be developed as the associated transformation and commissioning strategies are progressed.

Current Key Controls		Rating
Policies	Standing Financial Instructions, Scheme of Reservation & Delegation, Delegation Agreements (ICB / Place), Financial Policies	**G**
Processes	Financial planning	**G**
Plans	ICS Financial Plan 2024/25, Medium Term Financial Strategy	**A**
Contracts	NHSE/I Funding allocations (Revenue & Capital), NHS Standard Contracts	**A**
Reporting	ICB Executive Team, Finance Investment and Resources Committee, ICB Board, NHSE/I	**G**

Gaps in control
Medium Term Financial Strategy including Recovery Plan to be agreed.

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Conclude 24-25 contracts	Reduce	Reduce	Claire Wilson	31/07/24	**Complete**
Develop Medium Term Financial Strategy including Financial Recovery Plan	Reduce	Reduce	Mark Bakewell	30/09/24	**Problematic**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Committee Rating**
ICB Board approval of Medium-Term Financial Strategy	September 24		**Partial**
System Financial Report to ICB Board	Bi-monthly	25/7/24, 26/9/24, 28/11/24, 30/1/25, 27/3/25	
NHSE ICB Assessment	Annual (July)		
Gaps in assurance			
ICS Medium Term Financial Strategy including Recovery Plan yet to be agreed			

Actions planned	Owner	Timescale	Rating
Secure approval to Medium Term Financial Strategy	Mark Bakewell	30/09/24	**Problematic**

ID No: P8	Risk Title: The ICB is unable to resolve current provider service sustainability issues resulting in reduced quality and effectiveness of services and poorer outcomes for the population
Risk Description (max 100 words)	There are significant service sustainability challenges across the Cheshire and Merseyside system, including significant clinical risk and challenges identified by the Liverpool Clinical Services Review, and Trusts at SOF3, and a number of fragile hospital and other services across C&M. This risk concerns the potential inability to maintain services in their current configuration and inability to deliver the necessary transformational business cases in relation to our most challenged services.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Rowan Pritchard Jones	Fiona Lemmens/Leigh Thomson/ Mark Wilkinson	Medical	Transformation

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Enhancing Quality, Productivity and Value for Money	Transformation	C – beyond financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	02/04/25	16/06/25

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	4	3	3	3	3	3	31/03/25	The ICB has a low appetite for risk that impacts on patient outcomes. Our longer-term ambition is to moderate to (2x3=6) level of risk but will only be achievable over 2-3 years.
Impact	4	4	4	4	4	4		
Risk Score	16	12	12	12	12	12		
Rationale for score & progress in quarter (max 300 words)	There is potential for major effect on quality of clinical care and non-compliance with national standards posing significant risk to patients, and significant impact on trust and confidence of stakeholders (impact 4). Current controls are maintaining the likelihood at possible (3). Strategic transformation programmes have been established to address service sustainability issues and work will continue to develop case for change and consultation proposals during 2024-25 but are not expected to be complete or impact on the risk level until 2025-26 and beyond. Progress has been made on key programs over the last quarter: • SCT options appraisal now completed and preferred option identified , Stage 2 assurance meeting passed. Outcome of options appraisal and public consultation plans being presented to ICB board in May 25							

Commented [FL1]: this will need to be updated to reflect the new oversight and assurance framework OAF. It will Trusts as OAF 3-5

Commented [DB2R1]: Is the new framework effective from 2025-26? If so then I think we leave as is for Q4 and update it in the 2025-26 risk description.

	• Womens Services in Liverpool public engagement report now been through committee and ICB board. Options appraisal process commenced. Clinical workshops planned for 1st may and 6th June 25. • Clinical reference group for LAASP established with ICB representation. • Planning for future actions for SCT underway including presentation of outcome of options appraisal to ICB board in May, planning for public consultation, and rapid review of obstetric services at Ormskirk site being undertaken by the C&M LMNS • Womens Services planning for future actions including CRGs to meet in May and June, after which modelling and options analysis will take place, and ongoing internal safety improvement plan work as part of LAASP work

Current Key Controls		**Rating**
Policies	NHSE Major Service Change Guidance, NHSE Standard Operating Framework	**G**
Processes	NHSE Major Service Change Process	**G**
Plans	C&M Clinical Improvement and NHS Impact programme, Liverpool Place provider collaboration on urgent care pathways, CMAST Clinical Pathways Programme, Shaping Care Together Programme in Sefton Place, ECT/Stockport Foundation Trust (SFT) Programme in East Cheshire Place, Women's Services Programme in Liverpool Place	**A**
Contracts	Provider contracts held at Place. NHSE Specialist Commissioning Contracts held at NHSE region	**A**
Reporting	Provider Boards and internal governance arrangements, Programme Boards, Liverpool Provider Joint Committees, ICB Women's Services Committee, ICB Strategy & Transformation Committee, ICB Board	**A**
Gaps in control		
Progression through programme plans including where appropriate business case development, consultation and approval of key strategic transformation programmes is required to improve controls.		

Actions planned	**Expected outcome**		**Owner**	**Timescale**	**Rating**
	Likelihood	**Impact**			
Continuous Improvement Approach	Maintain	Maintain	Fiona Lemmens	2024-25	**On Track**
Oversight of Shaping Care Together Programme delivery and milestones	Maintain	Maintain	Deb Butcher, Fiona Lemmens, Clare Watson	2024-25	**On Track**

Commented [FL3]: will need updating when new committee structure agreed.

Commented [DB4R3]: Changes wont be approved until July Board so suggst leave as is until then

Oversight of ECT Sustainable Hospitals Programme delivery and milestones	Maintain	Maintain	Mark Wilkinson, Fiona Lemmens, Clare Watson	2024-25	**Problematic**
Oversight of Liverpool Clinical Services Review Programme delivery and milestones	Maintain	Maintain	Tony Leo	2024-25	**On Track**
Oversight of Womens Services in Liverpool Programme delivery and milestones	Maintain	Maintain	Fiona Lemmens, Chris Douglas	2024-25	**On Track**
Oversight of CMAST programmes	Maintain	Maintain	Fiona Lemmens	2024-25	**On Track**
Commence stage 2 of the EIA process	Maintain	Main		2024-25	**On Track**
Establish a joint HOSC with local authority leads	Maintain	Maintain		2024-25	**On Track**
Commenced drafting the Pre consultation Business Case	Maintain	Maintain		2024-25	**On Track**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Assurance Rating**
Continuous Improvement updates to ICB Executives Committee	As required		**Partial Assurance**
Shaping Care Together Programme Board updates to Strategy & Transformation Committee and ICB Board	Bi-monthly	Board – 25/7/24 & 28/11/24	
ECT Sustainable Hospitals Programme Board updates to Strategy & Transformation Committee	Quarterly		
LCSR Programme updates to One Liverpool Board and Strategy & Transformation Committee	TBC	Board – 27/3/25	
Womens Services in Liverpool Programme updates to ICB Women's Services Committee	Quarterly	3/7/24 & Board – 9/10/24, 27/3/25	
Recovery Programme delivery reporting to Recovery Committee & ICB Board	Fortnightly and Month Bi-Monthly	May 24 – Mar 25 (fortnightly) & Board –	

Commented [FL5]: not sure which programme this refers to??

Commented [DB6R5]: It was added when you did the Q3 review in December?

Commented [FL7]: can you check with Matthew Cunningham on this point please. I think it might be complete

Commented [DB8R7]: Gavin can you check with Matthew please

Commented [FL9]: no sure which piece of work this refers to. I think it is SCT in which case it is on track.
tracy jeffes in Sefton team can update on SCT progress

Commented [DB10R9]: Gavin can you check with Tracy please

Commented [FL11]: will need updating with new committee structure. This applies to others in this section too

Commented [DB12R11]: As above I think this should wait until post July Board approval

Commented [FL13]: we dont have recovery committee anymore.

Commented [DB14R13]: As it existed for part of 24-25 think we should leave as is for Q4 and amend on 25-26 risk

		30/5/24, 26/9/24	
CMAST programme updates to Strategy & Transformation Committee and Board	Quarterly	Board – 25/7/24	

Gaps in assurance
Issues in relation to affordability and timescales will need to be addressed in pre consultation business cases for key programmes. The impact of the current ICB financial situation and associated planning processes on the various transformation processes remains uncertain.

Actions planned	Owner	Timescale	Rating
Shaping Care Together (SCT) – conclude public engagement, analyse feedback and conclude options appraisal process.	Deb Butcher, Fiona Lemmens, Clare Watson	2025-26 Q1	**On Track**
Women's services in Liverpool programme - conclude public engagement, analyse feedback and commence options appraisal process	Fiona Lemmens, Chris Douglas	2025-26 Q2	**On Track**
All other programmes – oversight and assurance of milestone progress	Mark Bakewell, Mark Wilkinson, Fiona Lemmens, Clare Watson, Chris Douglas	2025-26 and beyond	**On Track**
Establishment of the Hospital group Model in Liverpool supports the internal work on short term patient safety improvement plans		2025-26 and beyond	**On Track**
During the options appraisal process the NW Clinical Senate raised concerns about impact on sustainability and safety of obstetric and neonatal services at the Ormskirk site. As a result the C&M LMNS are undertaking a rapid review at the request of MWL Trust.			**On Track**

Commented [FL15]: there is a new action to go in here. During the options appraisal process the NW Clinical Senate raised concerns about impact on sustainability and safety of obstetric and neonatal services at the Ormskirk site. As a result the C&M LMNS are undertaking a rapid review at the request of MWL Trust.
it is on track to report in MAy

ID No: P9	Risk Title: Unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic objectives
Risk Description (max 100 words)	Ensuring that we have a workforce with the necessary skills and experience, and that is reflective of our local population, is essential to the delivery of our strategic objectives. The C&M system has significant workforce challenges including recruitment, retention and sickness absence.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Mike Gibney	Sarah Smith	Nursing & Care	Finance, Investment & Our Resources

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Enhancing Quality, Productivity & Value for Money	Workforce	B – within financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	02/04/25	16/06/24

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	4	4	4	4	4	4	31/03/25	Our longer-term ambition is to moderate to a (2x3=6) level of risk but will only be achievable over 2-3 years due to resource allocation and capacity.
Impact	4	4	4	4	4	4		
Risk Score	16	16	16	16	16	16		
Rationale for score &	There is potential for a major effect on quality of clinical care and significant financial loss (impact 4). Current controls are maintaining the likelihood at likely (4). Workforce Recovery Programme, supporting the implementation of the C&M Workforce							

progress in quarter (max 300 words)	Plan in 2024-25, is focused on identifying opportunities to optimise our resources to support a reduction in workforce costs whilst not compromising quality of care and the patient experience. Financial constraints have limited ability to increase workforce planning capacity but realignment of existing Peoples Team resources will enable a more limited work programme in the short term. Due to resource constraints, it is not now anticipated that a reduction in likelihood to possible (3) will be achieved by year-end and the target score was increased to 16 in quarter 2, with further reductions over a 2-3 year period dependent on resources.

Current Key Controls		Rating
Policies	Provider Recruitment & Selection, Apprenticeship, Retention Strategies.	A
Processes	Organisational development, workforce planning, PDR, training & development, communication & engagement, recruitment, demographic profiling, international recruitment, apprenticeship levy, C&M retention forum, NHSE/HEI supply data	A
Plans	C&M People Plan, NHS People Promise, provider workforce plans	A
Contracts	TRAC, ESR, Occupational Health, Payroll, EAP	G
Reporting	WRES, WDES, Staff survey, reporting to People Board. System workforce dashboard (manual).	A

Gaps in control

Financial constraints have limited / deferred investment in workforce development capacity

While manual System Workforce dashboard has been developed, need still exists for broader automated options.

Limited maturity of collaborative working at system level

Inconsistent workforce planning process/methodology across the system

Insufficient links to educational institutions and local authorities

Technology and inconsistent use of workforce systems across the region (ESR, ERoster, TRAC, NHS jobs, OH system)

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Develop and enhance workforce planning capabilities across the system	Reduce	Maintain	Emma Hood	30/09/24	Complete
Scaling of Peoples Services	Reduce	Maintain	Sarah Smith	Review Apr 25	On Track
Plans to further develop and enhance workforce planning capabilities across the system as resources and capacity allow	TBC	TBC	TBC	2025-26	TBC

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	Planned Date /Frequency	Date/s provided	Assurance Rating
Integrated Quality & Performance Reports to ICB Board	Bi-monthly	Bi-monthly Apr 24 to Mar 25	Partial Assurance
System workforce reporting to People Board	Quarterly		
NHS Equality Diversity and Inclusion Improvement Plan updates	Quarterly		
WRES & WDES reporting	Annual		

CQC Well Led review	Annual		
Gaps in assurance			
CQC approach to assessing integrated care systems is still evolving.			
Actions planned	Owner	Timescale	Rating
Respond to CQC framework	Clare Watson	2024/25	On Track

ID No: P10	Risk Title: ICS focus on responding to current service priorities and demands diverts resource and attention from delivery of longer-term initiatives in the HCP Strategy and ICB 5-year strategy on behalf of our population
Risk Description (max 100 words)	Delivery of our shared aims, strategy and 5-year plan is dependent on collective ownership and collaborative effort by communities and organisations across Cheshire & Merseyside. The ICB has a key role in system leadership and promoting greater collaboration across the NHS and with local partners. This risk relates to the potential that focus on responding to current service priorities and demands diverts resource and attention from delivery of longer-term initiatives in the HCP Strategy and ICB 5-year strategy on behalf of the population.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Graham Urwin	Clare Watson	Assistant Chief Executive	ICB Executive

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Helping the NHS to support broader social & economic development	Transformation	C – beyond financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	02/04/25	16/06/25

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	4	3	3	3	3	3	Achieved	Interim target score achieved based on what is feasible for 2024/25. Our longer-term aim is to limit to a moderate level of risk, but this is unlikely before 2025/26.
Impact	4	3	3	3	3	3		
Risk Score	16	9	9	9	9	9		
Rationale for score & progress in quarter (max 300 words)	The current national and local quality, safety, performance and financial pressures during the post COVID recovery period gives rise to potential for significant reduction in health outcomes and/or life expectancy and significant increase in health inequality gap in deprived areas or socially excluded groups, criticism or intervention by NHSE and significant impact on trust and confidence of stakeholders (impact 4). This is mitigated by a refreshed Joint Forward Plan which includes a focus on urgent care and financial recovery during 24/25 which also need to reflect impacts on Core20+5 populations and our strategic ambitions. A revised HCP Strategy has been approved which aligns the HCP to the All Together Fairer plan to address health inequalities. In support of this a delivery plan has been developed together with a plan for investment into health inequalities which was presented to the Health and Care Partnership in July 2024 with a focus on smoking, healthy weight and housing, building on previous commitments, for example children and young people schemes. It is recognised							

	that in the short term the level of resources available for this wider focus on longer term population health investments is constrained and may limit further progress in reducing this risk during the current financial year.

Current Key Controls		Rating
Policies	Constitution & membership of ICB Board & HCP, Public Engagement / Empowerment Framework, Prioritisation Framework.	**G**
Processes	Strategic planning, communication & engagement, programme & project management, culture & organisational development, Provider Collaboratives, C&M and sub-regional networks	**G**
Plans	HCP Strategy 2024-29, Joint 5-year Forward Plan 2024-29, Joint Health & Wellbeing Strategies x 9 places, Operational Plan, Communications & Engagement Plan, Provider Collaborative Business Plans, Financial Plan.	**A**
Contracts	MOU with NHSE for system oversight is in development	**A**
Reporting	C&M HCP Partnership Board, Place-based partnership boards & H&WB Boards, ICB Board	**G**

Gaps in control
ICB operating model under review – timescale deferred in line with NHSE operating model review

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Refocus HCP Strategy 2024-2029 aligned to 'All Together Fairer'	Maintain	Maintain	Neil Evans & Ian Ashworth	30/08/24	**Complete**
Complete JFP 2024-29 *(delayed Board approval until post General Election)*	Maintain	Maintain	Neil Evans	31/07/24	**Complete**
Develop an update to propose a refreshed ICB operating model	Maintain	Maintain	Clare Watson	30/01/25	**On Track**
Identify ICB health inequalities funding that will be overseen by the HCP Committee to support delivery of Marmot the C&M All Together Fairer strategy and ambitions. To be presented to July HCP Meeting	Maintain	Maintain	Ian Ashworth	31/07/24	**Complete**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Assurance Rating**
Approval of updated HCP Strategy (To be approved by HCP – August) & Joint Forward Plan 2024-29 (ICB Board - July)	July 2024	Board 25/7/24 & 26/9/24 HCP 1/10/24	**Acceptable Assurance**
Reporting on progress of delivery plans during 2024-25 (ICB Board and delegated Board Committee)	In line with delivery dates in plan		
Joint Overview & Scrutiny of HCP Strategy and Joint Forward Plan	As required		
NHSE Systems Oversight Framework	Quarterly Review with NHS England		
Gaps in assurance			
JFP requires annual refresh and needs to reflect both short and longer term (five year) description of ICB priorities.			

Actions planned	Owner	Timescale	Rating
Seek approval to updated HCP Strategy and JFP	Clare Watson	31/08/24	**Complete**
Development of ICB Integrated Business Plan to describe delivery of Joint Forward Plan and ICB Corporate, Operational and Financial Planning priorities	Neil Evans	31/08/24	**Complete**
Development of MOU with NHS England in relation to system oversight operating model	Clare Watson/Anthony Middleton	31/08/24	**Complete**

ID No: P11	Risk Title: The ICB is unable to address inadequacies in the digital infrastructure and related resources leading to disruption of key clinical systems and the delivery of high quality, safe and effective health and care services across Cheshire and Merseyside.
Risk Description (max 100 words)	The ICB is responsible for leading ICS-wide cyber security. C&M is a complex system including the ICB, all 16 NHS providers, 349 GP practices and other related health and care services. Risks may arise from a Cyber security attack (either direct to one or more organisations or to one of their suppliers), lack of investment in resilient infrastructure and / or lack of appropriately skilled staffing. This could lead to possible financial and / or data loss, disruption to the delivery of patient care and/or damage to the reputation of one or more organisations in Cheshire and Merseyside.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Rowan Pritchard-Jones	John Llewelyn	Medical	Strategy & Transformation

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Tackling Health Inequality, Improving Outcomes and Access to Services Enhancing quality, productivity and value for money	Transformation	B – within the financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
27/6/24	02/04/25	16/06/25

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	5	4	4	4	4	4	31/3/25	The ICB has a low tolerance for risks impacting patient safety. The aim is to moderate to a (2x8) over two years as resources and capacity allow.
Impact	4	4	4	4	4	4		
Risk Score	20	16	16	16	16	16		
Rationale for score & progress in quarter (max 300 words)	There is the potential for patient harm, major effect on quality of clinical care, significant financial loss, significant loss of trust and confidence of stakeholders and adverse national media (impact 4). Current controls are sufficient to reduce the likelihood to likely (4). The possibility of a cyber-attack cannot be completely removed, and a residual risk will remain, but the implementation of the 5-Year Cheshire and Merseyside Cyber Security Strategy aims to reduce likelihood to unlikely (2) over the lifetime of the strategy. It is anticipated that limited investments possible in 2024-25 will maintain the risk at the current level. In year funding secured through national cyber resilience fund and that will fund the delivery of priorities in the programme. New programme manager appointed for the Cyber Strategy delivery. We anticipate a further round of funding next year and this year's programme will build the business case to support securing further funding. Issues in relation to cyber security							

	manager vacancy but this is being mitigated through support from our IT providers. Anticipate this risk level will be maintained for the remainder of the year but controls should reduce likelihood but is always subject to new threats arising.

Current Key Controls		Rating
Policies	IT Security Policy (individual IT Service providers and organisations); IT Umbrella Policy, NHS England's CareCERT process, National Cyber security policy for England, What Good Looks Like success criteria, technical & data architecture standards, IT policies, information governance policies.	**A**
Processes	Cyber security systems & processes, Security audits & penetration tests, Digital maturity assessment, DSPT assessment & submissions, Cyber Associates Network, ICB monitoring of system wide cyber security standards. Clear incident management and support in major incidents agreed with ICB providers	**A**
Plans	ICS Cyber Security Strategy, Digital and Data Strategy 2022-2025, Investment (280k) & delivery plan in 2024/25, Cyber incident / Business continuity plan. National funding £620k revenue & £640k capital	**A**
Contracts	Cyber security monitoring tools inc. IT Health and Cynerio, IT provider contracts, data sharing agreements	**A**
Reporting	Digital Services Delivery Board (ICB infrastructure only), Digital Transformation & Clinical Improvement Assurance Board, Strategy & Transformation Committee	**A**

Gaps in control

ICS / ICB Capacity and investment to respond to continuously evolving threat – funding streams delayed by a year with consequent impact on control action timescales
Gaps in ICB cyber leadership (Head of Cyber Security) and out of hours response capacity.
Lack of organisational & system level monitoring and reporting of standards, compliance & risks.
Further work required to raise awareness and understanding of cyber security at Board level & for all staff.

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Cyber Security training for ICB Board	Reduce	Maintain	RPJ / JL	30/06/25	**On Track**

Further desktop Cyber exercise	Reduce	Maintain	JL / SP / MIAA	21/11/24	**Complete**
Benchmarking BAF/digital/cyber risks and associated processes across all healthcare organisations in Cheshire and Merseyside	Reduce	Maintain	JL / SP / MIAA	31/07/25	**On Track**
Develop a process for the transparent governance of provider level risks	Reduce	Maintain	JL / SP / MIAA	31/07/25	**On Track**
Define clear incident management and support in major incidents with ICB providers	Maintain	Reduce	CTO	30/09/24	**Complete**
Explore opportunities for collaboration across NW ICBs for Cyber security delivery model	Reduce	Maintain	JL / SP / MIAA	30/09/25	**On Track**
Explore opportunities to improve collaboration and sharing of Cyber resource across the Cheshire and Merseyside system	Reduce	Maintain	JL / SP / MIAA	30/09/25	**On Track**
Investigate and conclude upon the need for third party incident response capacity creating a business case for investment if deemed appropriate.	Reduce	Maintain	JL / SP / MIAA	30/09/25	**On Track**
Explore opportunity to standardize cyber tooling across C&M and procure at scale	Reduce	Maintain	JL / SP / MIAA	31/03/26	**On Track**
Analyse & map across C&M organisations, critical service/supply chain security assurances and gaps. Identify significant exposure points and report with recommended actions	Reduce	Maintain	JL / SP / MIAA	31/03/26	**On Track**
Work with ICB procurement & IG to create standard security and assurance procurement & contracts requirements & share across all organisations within the ICS.	Reduce	Maintain	JL / SP / MIAA	31/03/26	**On Track**
Undertake a skills survey across Digital teams within the ICS, analysing data to identify gaps in organisations and across the footprint and build out a training needs assessment based upon the outcomes.	Reduce	Maintain	JL / SP / MIAA	31/03/26	**On Track**
DSPT becomes aligned to Cyber assessment framework in 24/25	Reduce	Maintain	JL / SP / MIAA	31/03/26	**On Track**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Committee Rating**
Cyber dashboard reporting to Digital Services Delivery Board / S&T Committee / Board	Quarterly (from Sept 24)		**Partial**
S&T Committee and Board approval of ICS Cyber Security Strategy	March 2024	28/03/24	

Penetration testing – IT Providers and Trusts	March 2025 Annual		
Cyber Essentials accreditation – IT Providers and Trusts	Annual		
MIAA audit of DSPT in line with the mandated scope set out in the DSPT Independent Assessment Guide reported to Audit Committee	Annual	25/06/24	
2024-25 delivery plan progress reports	September 2024 Quarterly	Board – 30/1/25	
Approval of delivery plans for future years.	April 2025 Annual		

Gaps in assurance
No oversight of compliance with cyber security standards at organisation and system level across C&M Funded delivery plans beyond 2024-25 yet to be established

Actions planned	**Owner**	**Timescale**	**Rating**
Develop cyber dashboard to provide oversight of compliance with key Cyber standards at organisation level	JL / SP / MIAA	31/07/25	**On Track**
Formalise Cyber risk reporting to the Board	JL / SP / MIAA	31/03/25	**Complete**
Review provider SLA's and existing Cyber investment to realign to requirements in the Cyber strategy.	JL	30/09/25	**On Track**

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

29 May 2025

ICB Corporate Risk Register – Quarter Four

Agenda Item No: ICB/05/25/25

Responsible Director: Clare Watson, Assistant Chief Executive

Corporate Risk Register – Quarter Four

1. Purpose of the Report

1.1 The purpose of the report is to present the Corporate Risk Register (CRR) for review by the Board.

2. Executive Summary

2.1 The ICB's Corporate Risk Register comprises those risks escalated from Committee and Directorate risk registers as having a current score of 15+.

2.2 There are currently 13 risks on the CRR at appendix one, including 6 critical risks and 7 extreme risks. The most significant risks are:

- QU09 – East Cheshire Trust Summary Hospital Mortality Index (SHMI) is above the expected range which could be an indicator of sub-optimal care of patients resulting in avoidable harm, currently rated as critical (20).
- QU05 - Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm, currently rated as critical (20).
- WSC6 - If patient safety, quality risks and clinical issues in the current women's services model of care cannot be sufficiently mitigated, avoidable patient harm and poorer patient outcomes are likely, currently rated as critical (20).
- PF1 - Common risk across places in relation to urgent care flow, including 'no criteria to reside', with a potential impact on safety and quality of care, currently rated as critical (20).
- QU08 - Reduced standards of care across all sectors due to insufficient capacity and limited monitoring systems leading to avoidable harm and poor care experience, currently rated as critical (20).
- F8/9 - As a result of increasing demands, inflationary pressures and restricted options / inability to deliver recurrent efficiency savings, there is a risk of significant overspends against the Place budget which may affect the ICB's ability to meet statutory financial duties, currently rated as critical (20).

2.3 Further details of the mitigation strategies are provided in section 9 below and in the individual risk summaries at appendix three. All of the risks on the CRR have been subject to scrutiny and review by the relevant ICB Committee and further information is included in the highlight reports elsewhere on the agenda.

2.4 Since the January 2025 report:

- a review of primary care risks has been undertaken to develop risks based on agreed key strategic objectives and risk themes applicable across the 4 contractor groups. As a result the Primary Care Committee are

recommending that risks PC1 and PC8 are closed as they have been subsumed into more specific risks. The detailed assessment of 9 risks applying across some or all of the 4 contractor groups is currently underway but it is not anticipated that any will meet the criteria for escalation to the CRR when existing controls are taken into account.

- QU08 - Reduced standards of care across all sectors due to insufficient capacity and limited monitoring systems leading to avoidable harm and poor care experience has increased from extreme (16) to critical (20) as a result of an increased risk in Wirral.
- F8/9 - As a result of increasing demands, inflationary pressures and restricted options / inability to deliver recurrent efficiency savings, there is a risk of significant overspends against the Place budget which may affect the ICB's ability to meet statutory financial duties has increased from extreme (16) to critical (20) as a result of an increased risk in Wirral.
- there has been movement in the risk scores for some places as indicated in Appendix two.

2.5 Two further quality and performance risks have been identified for escalation by specific places, which potentially also apply across other places. These are listed below and will be assessed by each place and subject to review and agreement by the Quality and Performance Committee.

- CEOps1 (Cheshire East) – Current investment levels within CE Place preventing delivery of the C&M standardised contract proposal for Talking Therapies contracts, leading to failure to perform against Access, Waiting time and Recovery Rate targets, leading to poor patient experience and potential harm, currently rated as extreme (15).
- WiP006 (Wirral) – Risk that the high prevalence of C Difficile infections in the Wirral system impacts on the quality of patient care and exacerbates operational pressures, currently rated as extreme (16).

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- **NOTE** the Corporate Risk Register, progress in completing mitigating actions, further action planned, and assurances provided; and consider any further action required by the Board to improve the level of assurance provided.

4. Reasons for Recommendations

4.1 The Board has a duty to assure itself that the organisation has properly identified the risks it faces and that it has processes in place to mitigate those risks and the impact they have on the organisation and its stakeholders. The Board discharges this duty as follows:

- identifying risks which may prevent the achievement of its strategic objectives
- determining the organisation's level of risk appetite in relation to the strategic objectives
- proactive monitoring of identified risks via the Board Assurance Framework and Corporate Risk Register
- ensuring that there is a structure in place for the effective management of risk throughout the organisation, and its committees (including at place)
- receiving regular updates and reports from its committees identifying significant risks, and providing assurance on controls and progress on mitigating actions
- demonstrating effective leadership, active involvement and support for risk management.

5. Background

5.1 The ICB's Corporate Risk Register comprises those risks escalated from Committee and Directorate risk registers as having a current score of 15+.

5.2 The Corporate Risk Register is distinct from the BAF as it reflects the significant risks escalated up from across the organisation for the attention of the Board (bottom up). These require additional scrutiny and potentially cross organisational response by virtue of their potential to disrupt achievement of the ICB's strategic and operational objectives. The scale of the corporate risk register reflects the current risk environment and covers the full scope of organisational activity. The BAF in contrast reflects a smaller number of principal risks (6-10) identified by the Board as the significant strategic challenges to delivery of the ICB's strategic objectives (top down).

5.3 The Corporate Risk Register has been compiled from current Committee and Directorate Risk Registers and provides an update on the report presented to the Board in January 2025.

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

Objective One: **Tackling Health Inequalities in access, outcomes and experience**
Objective Two: **Improving Population Health and Healthcare**
Objective Three: **Enhancing Productivity and Value for Money**
Objective Four: **Helping to support broader social and economic**

6.1 The CRR supports the objectives and priorities of the ICB through the identification and effective mitigation of the most significant risks across the organisation which, if realised, may impact on delivery.

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

7.1 The effective mitigation of the most significant risks across the organisation supports the achievement of the Annual Delivery Plan.

8. Link to meeting CQC ICS Themes and Quality Statements

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

8.1 The establishment of effective risk management systems is vital to the successful management of the ICB and local NHS system and is recognised as being fundamental in ensuring good governance. As such the CRR underpins all themes, but contributes particularly to leadership, specifically QS13 – governance, management and sustainability.

9. Risks

9.1 There are currently 15 risks on the CRR, including 4 critical risks and 11 extreme risks. A summary of the current and proposed mitigations in respect of each risk is set out below with further detail provided in the individual risk summaries at appendix three.

9.1.1 **QU09 - East Cheshire Trust Summary Hospital Mortality Index (SHMI) is above the expected range which could be an indicator of sub-optimal care of patients resulting in avoidable harm,** currently rated as critical (20). Actions planned to increase control have been completed or are now established as on-going control measures. The impact continues to be monitored but the data is not yet available to confirm that the control measures are effective and as a result the Quality and Performance Committee are currently unable to support a reduction in score.

9.1.2 **QU05 - Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm**, currently rated as critical (20). The mitigation strategy includes a range of place level service and pathway improvement programmes in collaboration with partners, supported by the ICB at scale priority workstream.

9.1.3 **WSC6 – In relation to women's services, if patient safety, quality risks and clinical issues in the current women's services model of care cannot be sufficiently mitigated, avoidable patient harm and poorer patient outcomes are likely**, currently rated as critical (20). Consideration was given to a reduction to 15 but following discussion it

was confirmed it remains at 20. Current controls include oversight by LMNS and local CQPGs and the Patient Safety Incidence Response Framework. Key further action is the clinical design work for medium and long term in the programme plan.

9.1.4 **PF1 - Common risk across places in relation to urgent care flow, including 'no criteria to reside', with a potential impact on safety and quality of care**, currently rated as critical (20). Current controls include the ICB System Coordination Centre, performance and contract monitoring, and recovery plans. Key further actions include the implementation of the UEC Recovery Programme and Place Improvement Plans.

9.1.5 **WSC3 - Failure to secure the required financial resources for the transformation of women's hospital services in Liverpool, combined with revenue implications, will negatively impact on the successful delivery of proposals**, currently rated as extreme (16). The C&M system is already financially challenged and therefore the risk score reflects that new expenditure and investment may not be possible in the current financial climate; this is as much about the wider availability of public sector capital as the C&M situation. A Finance and Estates Group is due to be established in January 2025 (as part of the emerging Programme governance and reporting arrangements). Further actions include baseline mapping to support the design phase and finance and estates modelling to support the options development – the latter action has a longer-term timescale of January – June 2025.

9.1.6 **14DR - There is a risk of the ICB's critical information systems suffering a failure due to a cyber security attack leading to possible financial / data loss, disruption to services and patient care and/or damage to the reputation of the organisation**, currently rated as extreme (16). Current controls include a range of policies, cyber security software systems and associated processes to detect and prevent potential attacks. Further planned actions include delivery of the system wide Cyber Security Strategy, improvements to supplier management and continued training and awareness raising.

9.1.7 **WSC4 - If the programme is unable to deliver an agreed a model of care, women's hospital services in Liverpool may not be able to meet clinical service specifications and could become clinically unsustainable leading to a loss of services; this could lead to further negative impacts on other providers across C&M and the north-west region**, currently rated as extreme (15). A 'Clinical Leaders Group (CLG)' has been established to support the programme board. The CLG is leading the model of care work on behalf of Programme Board, with Specialised Commissioning and Clinical Network Leads also involved in the design work. Capital and revenue implications of the

future model of care, interim model of care and counterfactual case are to be formulated by the Finance and Estates Group from January 2025.

9.1.8 **T2 - Impact on health outcomes and inequalities through limited Access to Specialist Weight Management Services across Cheshire and Merseyside and litigation in non-compliance with NICE Technology Appraisals in relation to GLP1 Weight Loss Drugs**, currently rated as extreme (16). This is currently being mitigated through interim measures to delay withdrawal of services in Liverpool, St Helens and Halton. Further actions include an interim ICB commissioning policy for referral to digital providers and planning to adopt forthcoming NHSE and NICE guidance.

9.1.9 **QU04 - Delays in recruitment to fill gaps in the Safeguarding Service may lead to failure to provide statutory functions and meet core standards resulting in patient harm**, currently rated as extreme (15). Current controls include working across place footprints and prioritising statutory duties. Further actions include the commencement of a talent pipeline / career path for Designated Nurses.

9.1.10 **QU08 - Reduced standards of care across all sectors due to insufficient capacity and limited monitoring systems leading to avoidable harm and poor care experience**, currently rated as critical (20). Risk score across the ICB has reduced from 25 down to 20. Plans to address gaps in controls have progressed, with work on-going to establish reporting dashboards to support assurance and oversight. ICB Business Intelligence Team have developed Power BI tools to facilitate this work and are now reporting a progress update whereby the Quality Dashboard is ready to be tested and, if successful, rolled out.

9.1.11 **F8/9 - Common risk across places that as a result of increasing demands, inflationary pressures and restricted options / inability to deliver recurrent efficiency savings, there is a risk of significant overspends against the Place budget which may affect the ICB's ability to meet statutory financial duties**, is currently rated as critical (20) in Wirral. Current controls include delegated budgets, budgetary control and expenditure approvals process, financial recovery programmes and efficiency schemes, and financial monitoring and reporting. Key further action is being taken to address cost pressures in relation to CHC and prescribing, and to develop longer-term financial plans delivering recurrent efficiencies.

9.1.12 **HPDAF2 / WiPDAF2 - Halton / Wirral health and care system is unable to meet the needs of children and young people with complex and/or additional needs leading to long term health issues, increased inequalities and demands on services**, both currently rated as extreme (16). Current controls include SEND strategies, policies and action plans, NHS and local authority contracts, and oversight by

improvement and partnership boards. Key further actions comprise delivery of improvement actions in collaboration with local partners.

9.2 All committees and sub-committees of the ICB are responsible for ensuring that risks associated with their areas of responsibility are identified, reflected in the relevant corporate and / or place risk registers, and effectively managed. Each of these risks has been scrutinised and reviewed by the relevant ICB Committee. Risks considered and actions / decisions taken are detailed in the highlight reports elsewhere on the agenda.

9.3 A summary of the assurance ratings for each of the risks escalated to the CRR is provided below:

ID	Risk	Committee	Current Score (Q3)	Controls					Assurance Rating
				Policies	Processes	Plans	Contracts	Reporting	
WSC3	Women's Services investment	Women's	**16**	**G**	**G**	**G**	**G**	**G**	**Partial**
QU09	ECT SHMI	Q&P	**20**	**G**	**G**	**G**	**A**	**G**	**Partial**
14DR	Cyber attack	S&T	**16**	**A**	**A**	**A**	**A**	**A**	**Partial**
WSC4	Women's Services model of care	Women's	**15**		**G**	**G**		**G**	**Partial**
T2	Weight management	S&T	**16**	**G**	**A**	**R**	**A**	**A**	**Partial**
QU04	Safeguarding capacity	Q&P	**15**	**G**	**A**	**G**	**G**	**G**	**Partial**
QU05	Neurodevelopmental assessments	Q&P	**20**	**A**	**G**	**A**	**G**	**A**	**Partial**
QU08	Standards of care	Q&P	**16**	**A**	**A**	**A**	**A**	**A**	
WSC6	Women's Services safety and quality	Women's	**20**	**G**	**G**	**G**	**G**	**G**	**Acceptable**
F8/9	Place cost pressures / efficiencies	FIRC	**16**	**G**	**A**	**A**	**A**	**G**	**Partial**
PF1	Place NCTR / UEC	Q&P	**20**	**G**	**A**	**A**	**G**	**A**	**Partial**
HPDAF2	Halton CYP complex needs	Q&P	**16**	**A**	**R**	**A**	**A**	**R**	**Partial**
WiPDAF2	Wirral CYP complex needs	Q&P	**16**	**G**	**A**	**A**	**G**	**G**	**Partial**

9.4 Sources of assurance in relation to key controls are detailed in the individual risk summaries in appendix three.

10. Finance

10.1 There are no financial implications arising directly from the recommendations of the report. However, the report does include financial risk F8, which is described in section 9 above and detailed in the appendices.

11. Communication and Engagement

11.1 No patient and public engagement has been undertaken.

12. Equality, Diversity and Inclusion

12.1 Risks QU05, WSC3, WSC4, WSC6, WiPDAF2 and HPDAF2 have the potential to impact on equality, diversity and inclusion in service delivery, outcomes or employment. The mitigations in place and planned are described in more detail in the risk summaries at appendix three.

11.2 Risks QU09, QU08, QU15, T2, WiPDAF2 and HPDAF2 have the potential to impact on health inequalities. The mitigations in place and planned are described in more detail in the risk summaries at appendix three.

13. Climate Change / Sustainability

13.1 There are no risks currently on the CRR which impact on the delivery of the Green Plan / Net Zero obligations.

14. Next Steps and Responsible Person to take forward

14.1 Senior responsible leads and operational leads for each risk will continue to develop and improve the controls in line with the targets and progress the mitigation actions described in section 9 above and in the individual risk summaries at appendix three. Updates will be provided through the regular CRR report to the Board.

12. Officer contact details for more information

Matthew Cunningham
Associate Director of Corporate Affairs & Governance
NHS Cheshire and Merseyside ICB

13. Appendices

ALL APPENDICES CAN BE ACCESSSED BY CLICKING HERE

Appendix One: Corporate Risk Register
Appendix Two: Place Risk Distribution
Appendix Three: Risk Summaries

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Appendix One

Corporate Risk Register – May 2025

Risk ID	Risk Title	Committee	Senior Responsible Owner	Inherent Risk Score (LxI)	Current Risk Score (LxI)	Previous Risk Score (LxI)	Target Score	Risk Proximity
Assistant Chief Executive Directorate								
PC1	Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & Dental Services) **RECOMMENDED FOR CLOSURE**	SPCC	Clare Watson	**16**	**16**	**16**	9	A – Within 3 months
PC8	Potential Collective Action and GPs working to contract only in response to the 24/25 Contract Offer, impacting on patient care and access to services. **RECOMMENDED FOR REPLACEMENT**	SPCC	Clare Watson	**15**	**15**	**16**	12	B – Within 12 months
Finance Directorate								
WSC3	Failure to secure the required financial resources for the transformation of women's hospital services in Liverpool, combined with revenue implications, will negatively impact on the successful delivery of proposals.	Women's Services	Mark Bakewell	**16**	**16**	**16**	8	C – Beyond 12 months
Medical								
QU09	East Cheshire Trust Summary Hospital Mortality Index (SHMI) is above the expected range which could be an indicator of sub-optimal care of patients resulting in avoidable harm.	Quality & Performance	Rowan Pritchard-Jones	**20**	**20**	**20**	10	A – Within 3 months
14DR	There is a risk of the ICB's critical information systems suffering a failure due to a cyber security attack leading to possible financial / Data loss, disruption to services and patient care and/or damage to the reputation of the organisation	Strategy & Transformation Committee	John Llewellyn	**16**	**16**	**16**	12	A – Within 3 months

Risk ID	Risk Title	Committee	Senior Responsible Owner	Inherent Risk Score (LxI)	Current Risk Score (LxI)	Previous Risk Score (LxI)	Target Score	Risk Proximity
WSC4	If the programme is unable to deliver an agreed a model of care, women's hospital services in Liverpool may not be able to meet clinical service specifications and could become clinically unsustainable leading to a loss of services; this could lead to further negative impacts on other providers across C&M and the north west region	Women's Services	Christine Douglas	**15**	**15**	**15**	10	C – Beyond 12 months
T2	Impact on health outcomes and inequalities through limited Access to Specialist Weight Management Services across Cheshire and Merseyside and litigation in non-compliance with NICE Technology Appraisals in relation to GLP1 Weight Loss Drugs	Strategy & Transformation	Fiona Lemmens	**16**	**16**	**16**	9	A – Within 3 months
Nursing and Care								
QU04	Delays in recruitment to fill gaps in the Safeguarding Service may lead to failure to provide statutory functions and meet core standards resulting in patient harm	Quality & Performance	Christine Douglas	**20**	**16**	**16**	8	A – Within 3 months
QU05	Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm	Quality & Performance	Christine Douglas	**20**	**20**	**20**	8	A – Within 3 months
QU08	Reduced standards of care across all sectors due to insufficient capacity and limited monitoring systems leading to avoidable harm and poor care experience	Quality & Performance	Christine Douglas	**25**	**20**	**16**	10	A – Within 3 months
WSC6	If patient safety, quality risks and clinical issues in the current women's services model of care cannot be sufficiently mitigated, avoidable patient harm and poorer patient outcomes are likely	Women's Services	Christine Douglas	**20**	**20**	**20**	8	A – Within 3 months

Risk ID	Risk Title	Committee	Senior Responsible Owner	Inherent Risk Score (LxI)	Current Risk Score (LxI)	Previous Risk Score (LxI)	Target Score	Risk Proximity
Place Directorates								
F8/9	As a result of increasing demands, inflationary pressures and restricted options / inability to deliver recurrent efficiency savings, there is a risk of significant overspends against the Place budget which may affect the ICB's ability to meet statutory financial duties.	Finance, Investment & Our Resources	Place Directors	**25**	**20**	**16**	12	B – Within 12 months
PF1	Demand, capacity and flow challenges across the wider urgent and emergency care system, spanning primary care, community and mental health care and social care, resulting in high levels of NCTR patients could result in risk of patient harm and poor experience of care	Quality & Performance	Place Directors	**25**	**20**	**20**	15	A – Within 3 months
WiPDAF2	Wirral health and care system is unable to meet the needs of children and young people with complex and/or additional needs leading to long term health issues, increased inequalities and demands on services	Quality & Performance	Simon Banks	**20**	**16**	**16**	8	C – Beyond 12 months
HPDAF2	Halton health and care system is unable to meet the needs of children and young people with complex and/or additional needs leading to long term health issues, increased inequalities and demands on services	Quality & Performance	Anthony Leo	**16**	**16**	**16**	12	C – Beyond 12 months
WiP006	Risk that the high prevalence of C.Difficile infections in Wirral System impacts on the quality of patient care and exacerbates operational pressures	Quality & Performance	Associate Director of Quality & Safety Improvement	**9**	**16**	**n/a**	Not Knows	C – Beyond 12 months

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Appendix Two

Place Risk Distribution – May 2025

Risk ID	Risk Title	Current Risk Score									
		ICB Wide	Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
F8/9	As a result of increasing demands, inflationary pressures and restricted options / inability to deliver recurrent efficiency savings, there is a risk of significant overspends against the Place budget which may affect the ICB's ability to meet statutory financial duties.	20↑	12	12		8	12	12	8	10	20
QU04	Delays in recruitment to fill gaps in the Safeguarding Service may lead to failure to provide statutory functions and meet core standards resulting in patient harm	16	16	12	8	16	12	9	9	9	8
QU05	Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm	20	16	12	12	12	16	16	20	16	16
QU08	Reduced standards of care across all sectors due to insufficient capacity and limited monitoring systems leading to avoidable harm and poor care experience	20	9	4	12	12	16		6	6	20
T2	Limited Access to Specialist Weight Management Services across Cheshire and Merseyside and non-compliance with NICE Technology Appraisals in relation to GLP1 Weight Loss Drug / Specific Place Risks in relation to potential loss of existing services	16			9		20		16		
PF1	Common place risk in relation to urgent care flow / 'no criteria to reside'	20	12	20		9	20		16	16	20

Appendix Three

Risk Summaries

ID No: WSC 3	**Failure to secure the required financial resources for the transformation of women's hospital services in Liverpool will negatively impact on the successful delivery of proposals.** The appraisal of options will consider relative capital costs / revenue implications and the deliverability of proposals in this context. It is likely that all proposals will require a level of capital funding. In addition, a dedicated programme budget is required that will include the budget for key programme roles and involvement activities.

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score	4	4	16	**Flat**
Current Risk Score	4	4	16	
Risk Appetite/Target Risk Score	2	4	8	

Senior Responsible Lead	Mark Bakewell	**Operational Lead**	Rob Nolan / Jen Huyton

Actions planned	Owner	Timescale	Progress Update
Agree programme budget / resourcing plan	CP	Sept 24	C&E budget and additional programme resources agreed.
Establish finance and estates group	MB / JH	Jan 25	Complete - To support options process. Meetings have been arranged on 28 January & 19th February 2025.
Undertake baseline financial mapping to support design phase	MB / JH	From Jan 25	Includes detailed financial analysis of the counterfactual case – from June 2025
Undertake finance and estates modelling to support options development	MB / JH	Jan - Jun 25	High level modelling to be undertaken to support long list evaluation – before June 2025. Discussions about resourcing this work required.
Support the development of the PCBC and SOC	MB / JH	Jul – Sept 25	Resource to be identified.

Agree programme budget requirements including resources for finance modelling.	RN	March 25	Finance and estates group to support.

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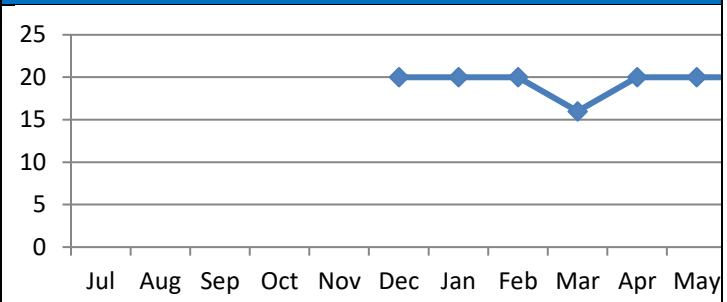
ID No: QU09	Risk Title: East Cheshire Trust Summary Hospital Mortality Index (SHMI) is above the expected range which could be an indicator of sub-optimal care of patients resulting in avoidable harm

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	4	5	20	
Current Risk Score	4	5	20	
Risk Appetite/Target Risk Score	2	5	10	

Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
20 ⇔	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Medical Director - Rowan Pritchard-Jones	ADQSI – East Cheshire	Medical	Quality & Performance

egic Objective	Function	Risk Proximity	Risk Type	Risk Response
ve population health	Quality	A – within next quarter	Corporate	Manage

Raised	Updated	Next Update Due
/2023	Nov-2024	Apr-2025

Risk Description [Description of risk and rationale for score – think about the cause, what this might lead to (the risk) and the consequences if this happens]

The SHMI is the ratio between the actual number of patients who die following hospitalisation at a trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers all deaths reported of patients who were admitted to non-specialist acute trusts in England and either die while in hospital or within 30 days of discharge. A 'higher than expected' SHMI should not immediately be interpreted as indicating bad performance and instead should be viewed as a 'smoke alarm' which requires further investigation. SHMI is not a direct measure of quality of care and cannot be directly used to identify avoidable deaths, however, it may be an indication of poor quality of care which could lead to increased avoidable harm and avoidable deaths.		
Current Controls		**Rating**
Policies	Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalization, England, May 2022 to April 2023; National Guidance on learning from deaths, National Quality Board, 2017; Acutely ill adults in hospital: recognizing and responding to deterioration NICE clinical guideline (CG50); Acute Kidney injury: prevention, detection, and management NICE (NG148); Sepsis: recognition, diagnosis and early management NICE (NG51); Intravenous fluid therapy in adults in hospital NICE (CG174); Acute Hospital Discharge '100 day challenge', Letter David Sloman July 2022; Hospital discharge and community support guidance, NHS England, July 2022	**G**
Processes	Rapid Quality Review (RQR) and subgroups **(RQR stepped down and now moved to bimonthly SHMI Quality Improvement Meeting)**; Quarterly mortality reports to East Cheshire Trust (ECT) Safety and Quality standards committee and ECT Board; Contract Quality and performance Meeting (CQPM) to monitor performance of NHS commissioned services; Reports to Cheshire and Merseyside Quality and Performance Committee Quality leads meetings and Quality and Performance Assurance Group at Place; C2Ai data is now being reported monthly. Analysis and case review of people who die out of hospital within 30 days of discharge has been completed. SHMI dashboard in development with ICB BI and Trust BI support.	**G**
Plans	CQPM workplan to ensure ongoing mortality/ SHMI reporting and oversight; ECT SHMI reduction action plan; ECT deteriorating patient group established; Winter Plan to support timely discharge and admission avoidance. SHMI driver diagrams and improvement plan. RQR SHMI Improvement Plan - developed and refined. Driver diagrams now in place	**G**
Contracts	NHS Cheshire and Merseyside ECT contract; Quality schedules- Mortality Reviews	**A**

Reporting	SHMI Quality Improvement Meeting reporting into NHS Cheshire and Merseyside Quality and Performance Committee; ECT reporting into Safety and Quality Standards Committee and ECT Board; Mortality and SHMI performance oversight through CQPM and Place Quality and Performance Assurance Group- escalations to NHS Cheshire and Merseyside Quality and Performance Committee made through Place Key Issues report	**G**

Gaps in control *[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]*

Mortality Reviews/Structured Judgement reviews (SJR) are being rolled out across medicine. Development of the SHMI dashboard is ongoing. Some assurance has been received around: coding of palliative care- this is being done in general practice. The analysis showed more work required to prevent dehydration of frail elderly and recognition and timely escalation of deteriorating patient. No care delivery issues identified with out of hospital care and support. The Trust regularly report to their board on learning from deaths. This is being strengthened as part of the improvement plan.

Actions planned	Owner	Timescale	Progress Update
RQR meetings to continue until assurance that the issues are understood and agreement of the improvement plan	Rowan Pritchard-Jones	November 2023	It was agreed in November to close down the rapid quality review meetings and replace them with a SHMI quality improvement meeting which will meet bimonthly. The first meeting was held on 15th December 2023. Completed- now had 2 SHMI quality improvement meetings. Next meeting April 2024
Quality improvement work around hydration and deteriorating patient to be progressed	Kate Daly-Brown	October 2023	Quality Improvement work agreed and commenced with medical wards. This is part of the SHMI Improvement Plan. Update provided at SHMI quality improvement meeting on 23rd Feb. Ward staff are actively engaged with quality improvement work.
Monthly data analysis/ scrutiny of report from C2Ai	John Hunter/ Rowan Pritchard-Jones	ongoing	Monthly reports are now being received, analysed and will inform the SHMI dashboard. Ongoing review monthly by Medical Director and John Hunter.

Assurances		
Planned	**Actual**	**Rating**
Need a regular focus and report to NHS Cheshire and Merseyside Quality and Performance Committee- frequency to be agreed	SHMI quality improvement meetings bimonthly to monitor progress against improvement plan. Updates will inform reports to Quality and performance Committee.	**A**
Ongoing oversight and scrutiny of improvement plan both within ECT and across the system at Place through CQPM	Regular reporting/ updates to CQPM, however, the oversight will be through SHMI quality improvement meetings until assurance of progress received.	

Gaps in assurance [areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]
Some assurance given around: Mortality review process being embedded in all divisions. Reporting of avoidable harm being routinely measured and reported (C2AI data) Evidence of Quality Improvement methodology relating to fundamentals of care. However, ongoing oversight is required until improvements are seen.

Actions planned	Owner	Timescale	Progress Update

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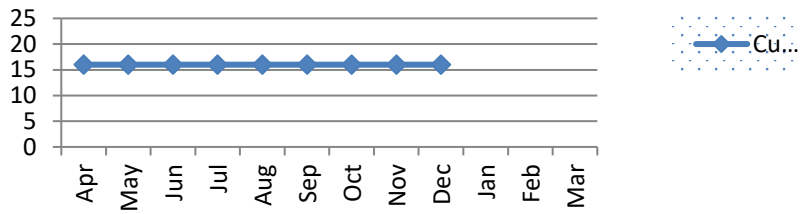
ID No:14DR	Risk Title: There is a risk of the ICB's critical information systems suffering a failure due to a cyber security attack leading to possible financial / Data loss, disruption to services and patient care and/or damage to the reputation of the organisation			
	Likelihood	Impact	Risk Score	Trend
Inherent Risk Score *[assess on 5x5 scale, this is the score without any controls applied]*	4	4	**16**	
Current Risk Score	4	4	**16**	
Target Risk Score	3	4	**12**	

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
John Llewellyn	Cathy Fox	Medical	Strategy & Transformation

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Tackling Health Inequality, Improving Outcomes and Access to Services Enhancing quality, productivity and value for money	Digital	A – within 3 months	Corporate	Manage

Date Raised	Last Updated	Next Update Due26/1/24
26/1/24	02/04/25	16/06/25

Risk Description (max 100 words)
The ICB is dependent on IT and information systems to deliver its statutory functions and strategic objectives. There is a significant threat of cyber-attack from a wide range of sources with NHS organisations being a potential target, and new types of threat emerging on a regular basis. This risk concerns the potential for a successful attack on the ICB's systems which could disrupt service delivery and patient care, and lead to data loss, financial loss and reputational damage.

Current Controls		Rating
Policies	IT Security Policy (individual IT Service providers and organisations); IT Umbrella Policy, NHS England's CareCERT process, National Cyber security policy for England, What Good Looks Like success criteria, technical & data architecture standards, IT policies, information governance policies.	**A**
Processes	Cyber security systems & processes, Security audits & penetration tests, Digital maturity assessment, DSPT assessment & submissions, Cyber Associates Network, ICB monitoring of system wide cyber security standards. Clear incident management and support in major incidents agreed with ICB providers	**A**
Plans	ICS Cyber Security Strategy, Digital and Data Strategy 2022-2025, Investment (280k) & delivery plan in 2024/25, Cyber incident / Business continuity plan. National funding £620k revenue & £640k capital	**A**
Contracts	Cyber security monitoring tools inc. IT Health and Cynerio, IT provider contracts, data sharing agreements	**A**
Reporting	Digital Services Delivery Board (ICB infrastructure only), Digital Transformation & Clinical Improvement Assurance Board, Strategy & Transformation Committee	**A**
Gaps in control		
ICS / ICB Capacity and investment to respond to continuously evolving threat – funding streams delayed by a year with consequent impact on control action timescales Gaps in ICB cyber leadership (Head of Cyber Security) and out of hours response capacity. Lack of organisational & system level monitoring and reporting of standards, compliance & risks. Further work required to raise awareness and understanding of cyber security at Board level & for all staff.		

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Cyber Security training for ICB Board	Reduce	Maintain	RPJ / JL	30/06/25	**On Track**
Further desktop Cyber exercise	Reduce	Maintain	JL / SP / MIAA	21/11/24	**Complete**
Benchmarking BAF/digital/cyber risks and associated processes across all healthcare organisations in Cheshire and Merseyside	Reduce	Maintain	JL / SP / MIAA	31/07/25	**On Track**
Develop a process for the transparent governance of provider level risks	Reduce	Maintain	JL / SP / MIAA	31/07/25	**On Track**
Define clear incident management and support in major incidents with ICB providers	Maintain	Reduce	CTO	30/09/24	**Complete**

Explore opportunities for collaboration across NW ICBs for Cyber security delivery model	Reduce	Maintain	JL / SP / MIAA	30/09/25	**On Track**
Explore opportunities to improve collaboration and sharing of Cyber resource across the Cheshire and Merseyside system	Reduce	Maintain	JL / SP / MIAA	30/09/25	**On Track**
Investigate and conclude upon the need for third party incident response capacity creating a business case for investment if deemed appropriate.	Reduce	Maintain	JL / SP / MIAA	30/09/25	**On Track**
Explore opportunity to standardize cyber tooling across C&M and procure at scale	Reduce	Maintain	JL / SP / MIAA	31/03/26	**On Track**
Analyse & map across C&M organisations, critical service/supply chain security assurances and gaps. Identify significant exposure points and report with recommended actions	Reduce	Maintain	JL / SP / MIAA	31/03/26	**On Track**
Work with ICB procurement & IG to create standard security and assurance procurement & contracts requirements & share across all organisations within the ICS.	Reduce	Maintain	JL / SP / MIAA	31/03/26	**On Track**
Undertake a skills survey across Digital teams within the ICS, analysing data to identify gaps in organisations and across the footprint and build out a training needs assessment based upon the outcomes.	Reduce	Maintain	JL / SP / MIAA	31/03/26	**On Track**
DSPT becomes aligned to Cyber assessment framework in 24/25	Reduce	Maintain	JL / SP / MIAA	31/03/26	**On Track**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Committee Rating**
Cyber dashboard reporting to Digital Services Delivery Board / S&T Committee / Board	Quarterly (from Sept 24)		**Partial**
S&T Committee and Board approval of ICS Cyber Security Strategy	March 2024	28/03/24	
Penetration testing – IT Providers and Trusts	March 2025 Annual		
Cyber Essentials accreditation – IT Providers and Trusts	Annual		
MIAA audit of DSPT in line with the mandated scope set out in the DSPT Independent Assessment Guide reported to Audit Committee	Annual	25/06/24	
2024-25 delivery plan progress reports	September 2024 Quarterly	Board – 30/1/25	

Approval of delivery plans for future years.	April 2025 Annual		

Gaps in assurance			
No oversight of compliance with cyber security standards at organisation and system level across C&M Funded delivery plans beyond 2024-25 yet to be established			
Actions planned	**Owner**	**Timescale**	**Rating**
Develop cyber dashboard to provide oversight of compliance with key Cyber standards at organisation level	JL / SP / MIAA	31/07/25	**On Track**
Formalise Cyber risk reporting to the Board	JL / SP / MIAA	31/03/25	**Complete**
Review provider SLA's and existing Cyber investment to realign to requirements in the Cyber strategy.	JL	30/09/25	**On Track**

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ID No: WSC 4	**If the programme is unable to deliver an agreed a model of care, women's hospital services in Liverpool may not be able to meet clinical service specifications and could become clinically unsustainable leading to a loss of services; this could lead to further negative impacts on other providers across C&M and the North West region.** Without an agreed clinical model of care that meets the required commissioning specifications, there is a risk that complex services requiring specialist multidisciplinary support may be de-commissioned or lost from Liverpool. For example LWFT already has to send pregnant women with complex cardiac conditions to Manchester for co-located specialist care, and may not be able to continue as the Maternal Medicine Centre for C&M without the required infrastructure, expertise and support. A snowball effect may follow the loss of any complex obstetrics and gynaecology services from Liverpool due to the loss of reputation and consequent difficulties with recruitment and retention of senior medical staff. This could significantly affect higher risk obstetric services in Liverpool and would necessitate a region-wide clinical reconfiguration. Any major impact on obstetrics services in Liverpool would also create a higher residual level of risk for women experiencing acute emergencies.

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score	3	5	15	**Flat**
Current Risk Score	3	5	15	
Risk Appetite/Target Risk Score	2	5	10	

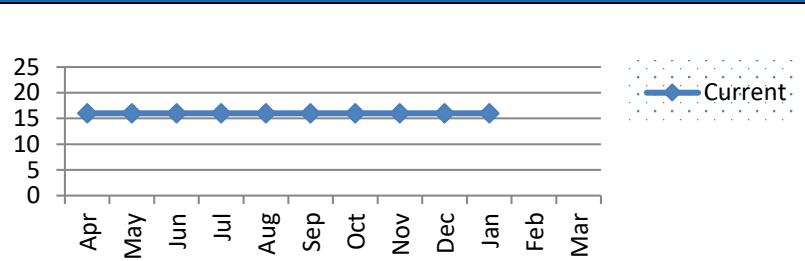
Senior Responsible Leads	James Sumner	**Operational Leads**	Mandish Dhanjal / Chris Dewhurst / Fiona Lemmens

Actions planned	Owner	Timescale	Progress Update
Clinical Leaders Group (CLG) to lead model of care work on behalf of programme board.	CLG	Autumn 24	Engagement event 2 (design) planned for December 2024.
Specialised commissioning and clinical network leads to be involved in design	CLG	Autumn 24	Included in invitations.
Clinical engagement event 2 – model of care – planned for December	CLG	Dec 24	Complete
Finance, estates, workforce and digital workstreams to support model of care design and modelling work	CP	From Jan 25	Finance and estates group mobilised.

Capital and revenue implications of future model of care, interim model of care and counterfactual case (do nothing) to be worked up	Finance group	From Jan 25	High level modelling to be undertaken to support long list evaluation – before June 2025. Discussions about resourcing this work required.
Support for model of care from Liverpool and C&M NHS leaders to be sought	FL / CD / JS	Spring / Summer 25	

NHS
Cheshire and Merseyside

ID No: T2	Risk Title: Impact on health outcomes and inequalities through limited Access to Specialist Weight Management Services across Cheshire and Merseyside and litigation in non compliance with NICE Technology Appraisals in relation to GLP1 Weight Loss Drugs

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	4	4	16	
Current Risk Score	4	4	16	
Risk Appetite/Target Risk Score	3	3	9	

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Fiona Lemmens	Neil Evans	Medical / ACE	Strategy and Transformation

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improve Population Health	Quality	A – within 3 months	Corporate	Manage

Date Raised	Last Updated	Next Update Due
January 2024	10/04/25	30/04/25

Risk Description *[Description of risk and rationale for score – think about the cause, what this might lead to (the risk) and the consequences if this happens]*

Across Cheshire and Merseyside we have nine separately commissioned Specialist Weight Management Services (referred to as Tier 3). These services are included in the current NICE Guidance (CG189) and provide specialist support to patients with complex support needs in relation to weight management, including being a mandated part of the pathway for people seeking/requiring bariatric surgery or prescribing of GLP1 Weight Loss Drugs.

Historically services in Liverpool, Knowsley, Halton and St Helens have been commissioned by the Local Authorities however in line with statutory responsibility sitting with the NHS the Local Authorities have served notice on this provision (other than Knowsley where this hasn't impacted in 2024-25). Interim ICB funding arrangements have been required to maintain interim skeleton services. Non recurrent funding has been committed to avoid total absence of services in these Places in 2025-26.

In the other five Places we have minimal service access levels and variable funding and service models and across all 9 Places need/demand far outstrips capacity leading to extended waits and acceptance criteria thresholds being raised well above recommended NICE standards, as well as being inconsistent.

No service is currently providing access to GLP1 medication (TA 664 and TA875 and TA1026) and the capacity and the prescribing costs are currently assessed as unaffordable in Cheshire and Merseyside and would require significant investment. On March 27th NHS England published an interim commissioning policy for TA1026 which includes primary care prescribing and a national funding allocation for a small cohort of patients to be prescribed GLP1 based on a clinical prioritisation criteria within the commissioning policy. Prescribing of Tirzepatide should have commenced in SWMS on 24th March and in Primary Care settings from 23rd June 2025.

The picture described above is not unique to Cheshire and Merseyside and the ICB is working with NHS England (Obesity Team) and peer ICBs to identify approaches that may allow development of Tier 3, wider weight management services and prescribing of GLP1 medications. At present the ICB is developing an implementation plan to reflect the financial allocation and NICE guidance, commissioning policy which is due to be presented to the Executive Committee during April for discussion and agreement as to the way forwards.

During September 2024 ICBs across England were made aware that a company (Oviva) had been awarded a contract by an ICB in the South West which the Provider said fell within the “Right to Choose” contracting requirements as a digital provider of SWMS. NHS England have investigated and during October confirmed they believe this to be correct. This means patients from anywhere in England can be referred to the provider. Due to the absence of local capacity and no service prescribing GLP1 this has led to significant levels of enquiries from the Public and GPs requesting referrals to the Provider. At present this has been limited as we have issued a holding position to GPs pending the ICB Contracting Team validating the nature/compliance of the Oviva contract. The provider has been communicating intensively with both public and GPs to make them aware of the service and we are aware that some referrals have been made.

An interim ICB commissioning policy has been approved and published. This outlines parameters for referral criteria to digital providers in order to prioritise referrrals to those with greatest clinical need. We are in discussions with Oviva in relation to a number of invoices (circa £65k Sept to Dec) in relation to patients they are already treating, including an audit of compliance). The C&M Policy now need revising when the NICE guidance and NHS England Commissioning Policy is published in Quarter 4. A meeting has been arranged (April 2025) between NHS England and ICBs to agree a consistent approach to contracting with Right to Choose providers of Obesity services.

Current Control		Rating
Policies	NICE Obesity: identification, assessment and management Guidance (Updated July 2023); Technology Appraisal for Provision of Obesity Drugs; (CG189, TA 664 and TA875 and pending TA11156)	**G**
Processes	C&M Tier 3 Weight Management Group, including provider representation NHS England led Obesity Working Group and aligned ICB Working Group commencing work Sept 2024 supporting by NHS Confederation.	**A**
Plans	Development of a business case to invest in SWMS and delivery of NICE TA, this is dependent on confirmation national funding will be available to support the NICE TA.	**R**

Contracts	Nine separate contracts across 6 Providers all with different specifications	**A**
Reporting	The plans outlined below were reported to Board in January 2024 and Executive Team March 2024 but plans have been delayed due to identification of a future funding source and delays in the updates to NICE guidance.	**A**

Gaps in control *[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]*

No C&M wide minimum service specification for the provision of Tier 3 Weight Management Services. Non compliance with NICE guidance (including Technology Appraisals) and implementation would require significant investment.

Actions Planned	Owner	Timescale	Progress Update
A full review of the pathway and delivery of Specialist Weight Management Services is underway C&M	Neil Evans	Complete	Summary of current services captured
Development and adoption of a minimum Cheshire and Merseyside service specification for the provision of Tier 3 services.	Neil Evans/Adam Major	May 25	Workshop held in March outlining model, including ICB, LA, Providers and service users. Implementation is constrained by financial investment required so approach will be determined by Executive Committee/Board decision on preferred approach.
Implementation of GLP1 through funding ringfenced for Tirzepatide roll out	Neil Evans/Adam Major	April 25	Options appraisal and service model to be developed in line with NICE guidance, Technology Appraisals and NHS England Commissioning Policy. Proposals to be considered by Executive Committee during April.
Development of interim plans in the four Places where Local Authorities are withdrawing from commissioning services	Neil Evans and Place nominated leads"	June 25	Interim arrangements have been established in each Place but will need to be reviewed as plans on Tirzepatide and SWMS services are confirmed at C&M wide footprint. **Tony Mcleod, Danielle McCulloch, Neil Meadowcroft and Judith Neilson*
Validate Oviva contract with BNSSG ICB as complying with Right to Choose requirements. Based on the outcome of this work we will consider options to manage the scale of referrals e.g. compliance with locally defined clinical criteria.	Adam Major	May 25	Contract has been validated as meeting Right to Choose so commissioning policy and communications to be developed and approval sought from ICB Executive Team.

Assurances

Planned	Actual	Rating
The development of a robust options appraisal presenting options on how we can fully or partially mitigate the risks in relation to health outcomes, inequalities and litigation.	Whilst we now have confirmation of the national funding associated with the NICE TA for Tirzepatide implementation, this is lower than our modelling predicted but should enable some	**Partial**

	mitigation of the risk by enabling progress against the actions identified.	
Mitigating the financial impact of Oviva being a Right to Choose Provider.	Interim steps put in place through a C&M commissioning policy and audit of compliance with Oviva. NHS England are coordinating ICBs to work collectively in relation to Right to Choose provision.	**Partial**

Gaps in assurance *[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]*

NHS England confirmation of the funding availability and details of the national commissioning policy for Tirzepatide leave a significant gap between modelled need for GLP1 drugs and funding to implement viable solutions. To reduce the financial exposure to this will mean we could not comply fully with the NICE Technology appraisals for any GLP1 drug for weight loss.

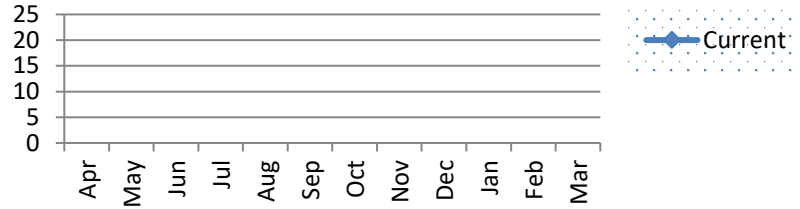
Four of our Places continue to fund services non recurrently and without available funding all of C&M has very limited capacity in SWMS services.

The national policy guidance around Right to Choose leaves limitations on the legal robustness of our mitigations on Oviva. We have informally discussed with NHS England and a legal firm working with ICBs elsewhere in the country and this has reaffirmed that the steps we have taken may not fully mitigate the financial risk.

Actions planned	Owner	Timescale	Progress Update
See above actions			

NHS
Cheshire and Merseyside

ID No: QU04	Risk Title: Designated Safeguarding workforce			
	Likelihood	Impact	Risk Score	Trend
Inherent Risk Score				
Current Risk Score	4	4	16	
Target Risk Score	4	3	12	



Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
		Nursing and Care	SOB

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
	Statutory Safeguarding		Clinical	

Date Raised	Last Updated	Next Update Due
	09/05/2025	09/06/2025

Risk Description (max 100 words)

Risks Title: Inequity in availability of designated safeguarding professional capacity & administrative functions within Place across Cheshire & Merseyside ICB

Cause:

1. Legacy workforce arrangements and lack of sufficient capacity to meet the needs of the population.
2. Variance within Place of equitable access to safeguarding administrative support

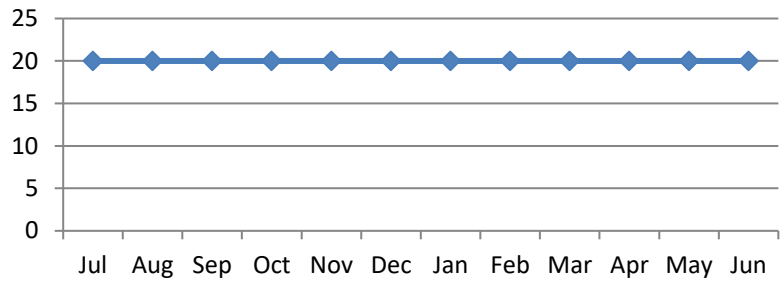
Consequence:

1. Designated professionals unable to perform to the required level of competence (in developing and shaping strategic response at Place)
2. Direct impact on wellbeing of designated professionals and wider Place teams, leading to burnout and absenteeism
3. Governance and reporting arrangements of incidents not fully embedded from Place to ICB oversight with increased risk of inability to adhere to reporting requirements (SOP) due to fragility of the administrative workforce
4. Risk to ICB organisation reputation and relationships with partner agencies

Current Controls		Rating
Policies		
Processes	1) Business continuity remains in place for safeguarding functions using a two-cluster approach 2) Mapping of current roles and functions undertaken by each administrative function at place (for those without dedicated function, understanding of how those functions are currently covered) 3) Development and implementation of the ICB Safeguarding Statutory Safeguarding Review Tracker in November 2024. The dashboard was developed by BI who can run quarterly reports for oversight of safeguarding statutory reviews across C&M. This is overseen by the Safeguarding Learning and Development Group	
Plans	1) Scoping options for Cheshire and Merseyside safeguarding model to ensure equitable distribution of assets (immediate and mid-term approach) completed and presented to Executive team. 2) Recruit to whole time equivalent vacant roles (statutory functions) – complete by Qtr. 1 2025/26 3) Governance and single line of sight reporting from Place into LSP agreed during Qtr. 4 (2024/25) but requires further shaping during Qtr. 1 (2025/26) 4) Review JDs and job plans for Designated Doctors within their Place held SLA with provider trusts to ensure equity in approach/provision 5) Designated Doctor for Child Death recruited to (funding available for 3 of the 6 sessions required for Merseyside) – Qtr. 1 (2025/26) 6) TNA and training plan for designated professionals completed (and implemented) 7) Scope options for a once and well approach (*one safeguarding inbox per cluster area to manage queries and oversight of safeguarding alerts	

NHS
Cheshire and Merseyside

ID No: QU05	Risk Title: Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	5	4	20	
Current Risk Score	5	4	20	
Risk Appetite/Target Risk Score	2	4	8	

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Christine Douglas	Julie Hoodless	Nursing and Care	Quality & Performance

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improve population health	Quality	A – within next quarter	Corporate	Manage

Date Raised	Updated	Next Update Due
01/03/2023	May-2025	Jul-2025

Risk Description [Description of risk and rationale for score – think about the cause, what this might lead to (the risk) and the consequences if this happens]

ASD and ADHD services have suffered from demand outstripping capacity causing significantly long waiting times. There is a risk of harm due to the significant, adverse impact of long waiting times on children, young people and adults with suspected Autism and/or ADHD. The impact includes:

1. Crisis leading to poorer individual outcomes and avoidable acute and mental health hospital admissions.
2. Increased risk of self-harm and suicide (people with Autism are 16 times more likely die because of suicide than the general population).
3. Poorer mental health and wellbeing outcomes and greater risk of school exclusion and family breakdown.
4. Perpetuating the risk of health inequalities for people with neurodevelopmental and other co-existing conditions including learning disabilities.

There is a financial risk due to the increased costs/ spend in the system due to the increasing demand. There is an increase in non-contract spend on private providers as more people seek access via Right to Choose and opt out of long NHS waiting lists.

Current Controls		Rating
Policies	Autism Assessment Framework; The assessment pathways for Autism and ADHD are governed by NICE Clinical Guidelines. Autism: CG128 (CYP) and CG142 (Adults) and ADHD: CG72; Transforming Care Programme.	**A**
Processes	CQPGs/ CQPMs to monitor performance of NHS commissioned services; Reports to Cheshire and Merseyside Quality and Performance Committee; Close working with Parent Carer Forums at Place - co-production. Performance reports presented to Quality and Performance Committee; Quality and Performance Groups at Place; LD focus area at Cheshire and Merseyside System Quality Group- April 2023; Quality schedules - long wait harm reviews	**G**
Plans	Cheshire Neurodevelopmental Clinical Network - strategic plans and implementing best practice; ASD/ ADHD included in SEND improvement plans at Place; Quality schedules - long wait harm reviews	**A**
Contracts	0-18 diagnostic pathways sit in Alder Hey block contract, additional capacity is subcontracted to Healios, non-diagnostic ASD support is via contract with Addvanced Solutions. 18+ ADHD diagnostic pathway is via contract with Cheshire & Wirral Partnership Trust, non-diagnostic support is via contract with Ladders for Life. Adult ASD diagnostic pathway is via contract with Mersey Care.	**G**
Reporting	Quality and Performance reported through: CQPG/ CQPM, Quality and Performance Groups at Place/ C&M Quality and Performance Committee, SEND/ LA reporting - SEND scorecards and dashboards at Place. Reporting from SEND Sub-Group to System Oversight Board (SOB)	**A**

Gaps in control *[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]*

C&M ICB Commissioners developing joint and strategic approach to commissioning for Autism and ADHD; Increased investment for both assessment and evidence-based support required - but difficult in current financial climate.

Actions planned	Owner	Timescale	Progress Update
Multiple strategic actions across health & education and to reduce waiting times.	TP Programme Leads/ Transformation ADQs	October 2025	Management of this risk requires cross-working between the Nursing & Care Directorate, specifically the Special Educational Needs & Disabilities (SEND) Collaborative Unit cross-working with colleagues in the Transformation & Partnership Directorate. The ICB Head of SEND attends the ND pathway Oversight Group chaired by Laura Marsh, leading ND pathway roll-out, to ensure that waiting times for the population are targeted from both commissioning and quality perspectives.

Assurances

Planned	Actual	Rating
NHSE Baseline assessment of demand, data, demographics etc.	Q&P key issues reporting- monthly standard agenda item	**G**
Performance is reported into all Trust CQRMs, Quality & Performance meetings at Place and SEND Partnership Board Performance Group (Place SEND governance)	Performance data for all age ASD and ADHD diagnostic pathways is available and reported Performance data for support services is available and reported	**A**

	SEND summary report presented to Q&P Committee following risk review at the SEND Oversight Group	G

Gaps in assurance [areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]			
Quality & Performance Committee require regular reporting for oversight and assurance.			
Actions planned	**Owner**	**Timescale**	**Progress Update**
SEND Lead to provide focus report to Q&P Committee (frequency to be agreed)	Julie Hoodless	Q4 24/25	Completed. Governance structure in support of Q&P Committee means that a summary report from the SEND Oversight Group is presented to the Committee. Action to be closed & removed from July 2025 risk summary.

ID No: WSC6	**If patient safety, quality risks and clinical issues in the current model of care cannot be sufficiently mitigated, avoidable patient harm and poorer patient outcomes are likely, with a greater impact on the socially deprived and those from ethnic minority groups.** The case for change sets out the clinical risks the programme is seeking to resolve. These risks are driving the Women's Hospital Services Programme to find solutions that enable the long-term clinical sustainability of these services, as well as identifying short and medium term solutions to reduce clinical safety and quality risks and support the stability of services.

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score	4	5	20	**Flat**
Current Risk Score	4	5	20	
Risk Appetite/Target Risk Score	2	4	8	

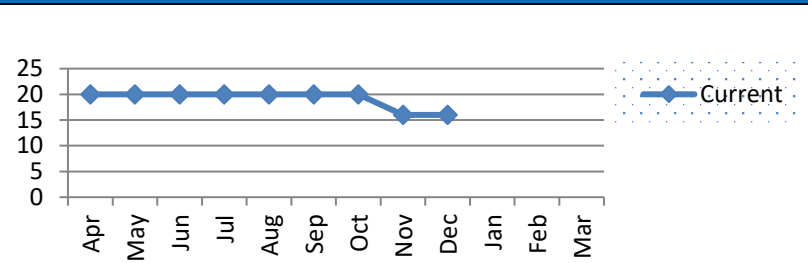
Senior Responsible Leads	Christine Douglas / James Sumner	**Operational Leads**	Chris Dewhurst / Natalie Hudson / Oliver Zuzan / Jenny Hannon

Actions planned	Owner	Timescale	Progress Update
Deliver LWFT improvement plan that includes short term actions and mitigations.	JS	From Feb 24	Work continuing. Delay to blood transfusion robot purchase now resolved. Deteriorating patent collaborative work underway. Routine reporting to Committee.
Clinical design work for medium and long term in programme plan for autumn – now winter.	CP	From Dec 24	Complete - Clinical engagement event 2 – model of care – planned for December
Health inequalities in outcomes to be a key factor in design work.	CP	From Dec 24	Complete - Also included in case for change.
Insights from hard-to-reach groups and equalities groups to be reflected in design work.	CP	From Dec 24	Public engagement feedback / VCFSE orgs feedback / Lived Experience Panel feedback to be considered in design process. Case for change engagement report to be completed by February 2025.

Cross reference care model design with trust internal improvement plan (with alignment to trust risk register).	JS / CD	From February 2025	

NHS
Cheshire and Merseyside

ID No: F8	Risk Title: As a result of increasing demands, inflationary pressures and restricted options / inability to deliver recurrent efficiency savings, there is a risk of significant overspends against the Place budget which may affect the ICB's ability to meet statutory financial duties.

	Likelihood	Impact	Risk Score	Trend
Inherent Risk Score *[assess on 5x5 scale, this is the score without any controls applied]*	5	5	25	
Current Risk Score	5	4	16	
Target Risk Score	4	3	12	

Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
12	12	15	8	12	12	8	8	16

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Place Directors	Place ADOFs	Place Directorate	Finance, Investment & Our Resources

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Enhancing Quality, Productivity and Value for Money	Finance	B – within 12 months	Place	Manage

Date Raised	Last Updated	Next Update Due
April 2024	01/05/25	01/06/25

Risk Description (max 100 words)
The potential for significant overspends against place budgets is a risk in common escalated by multiple places, driven by increasing demand, inflationary pressures, and restricted options, delays in or inability to deliver efficiency savings. Taken collectively this may affect the ICB's ability to meet statutory financial duties.

Current Controls	Rating

Policies	ICB SORD, SFIs, detailed financial policies	**G**
Processes	Budget setting, financial monitoring & control, appointment of / allocation to budget holders / managers	**A**
Plans	Annual financial plan & place allocations, recovery & efficiency plans	**A**
Contracts	Contracts with NHS & other providers	**A**
Reporting	Place SLT & Finance Groups, Finance, Investment and Our Resources Committee, ICB Board	**G**

Gaps in control

Nationally prescribed budget setting assumptions insufficient to meet anticipated costs e.g. inflation
Inherent or inherited deficit positions in some places require recovery plans / recurrent efficiency savings
Unanticipated increases in demand and / or costs
Gaps / delays / reductions in planned efficiencies

Actions planned	Owner	Timescale	Progress Update
Oversight of financial position & efficiency delivery	Place SLTs	2024-25	
Place based financial / recovery plans	Place ADoFs	2024-25	
Place based actions as indicated by specific place risks	Place ADoFs	2024-25	

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances		
Planned	**Actual**	**Rating**
Finance Reports to Finance, Investment & Resources Committee	Monthly – April to December 2024	**Partial Assurance**
Finance Reports to ICB Board	25/7/24, 26/9/24, 28/11/24	

Gaps in assurance
Month 6 position indicated deficits for all 9 places, totaling £29.6m.

Actions planned	Owner	Timescale	Progress Update
Place based financial / recovery plans	Place ADoFs	2024-25	
Place based actions as indicated by specific place risks	Place ADoFs	2024-25	

NHS
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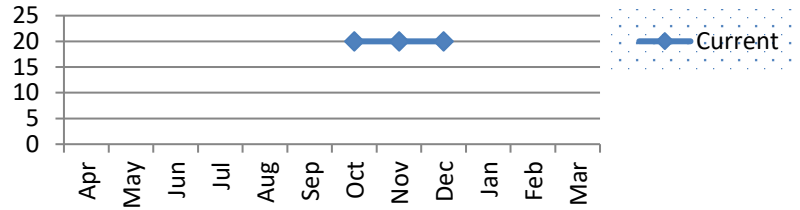
ID No: PF1	Risk Title: Demand, capacity and flow challenges across the wider urgent and emergency care system, spanning primary care, community and mental health care and social care, resulting in high levels of NCTR patients could result in risk of patient harm and poor experience of care

	Likelihood	Impact	Risk Score	Trend
Inherent Risk Score *[assess on 5x5 scale, this is the score without any controls applied]*	5	5	25	
Current Risk Score	4	5	20	
Target Risk Score	3	5	15	

Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
12	20		9	20		16	16	20

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Place Directors	ADTPs	Place Directorate	Quality & Performance

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Tackling Health Inequalities in Outcomes, Access and Experience	Performance / Quality	A – within 3 months	Place	Manage

Date Raised	Last Updated	Next Update Due
Nov / Dec 2023	01/05/25	01/07/25

Risk Description (max 100 words)
The potential for patient harm and poor experience of care due to restricted patient flow across the integrated care system is a risk in common escalated by multiple places. This is driven by increased presentations at ED, and across the system combined with workforce capacity limitations, excess bed days due to no criteria to reside patients and higher levels of acuity, resulting in reduced flow from emergency departments into the acute bed base and is in turn impacting on waiting times in the Emergency Department (ED), compounding the need for corridor care, ambulance handover delays and failure to meet the 15-minute ambulance response time standard. Delays in

ambulance response times and delays in ED are associated with patient harm and poor patient experience, and increased health inequalities as people living in more deprived areas are more likely to present at EDs. Noting that this is a whole system issue spanning primary care, community and mental health care and social care is under significant pressure with similarly high levels of acute complex frailty demand, capacity limitations (particularly within sectors of the market such as domiciliary care and EMI Nursing Homes).

Current Controls		Rating
Policies	National Policy framework, standards & guidance applied at place via Discharge Policy, UEC Standards, Long waits guidance, Risk stratification, FNC / CHC framework, D2A guidance, SCC guidance, Fuller report, Choice Policy, OPEL Framework (Place action cards)	**G**
Processes	NHS Oversight Framework, national UEC tiering and associated support; ICB System Coordination Centre; programme, performance & contract management; system wide & place level planning & weekly / daily protocols & systems to monitor, manage and escalate patient flow issues	**A**
Plans	C&M Operational Plan, Winter Plan, Place Delivery Plans – 2024/25, System & Place UEC Recovery Programmes	**A**
Contracts	NHS Standard Contract	**G**
Reporting	Place oversight, SCC, UEC Recovery Programme, Quality & Performance Committee, ICB Board, regional/ national NHSE teams	**A**

Gaps in control

Demand and acuity exceed planned capacity levels in a range of sectors, and fuller understanding of demand and capacity across all sectors is required.
Workforce shortages in some sectors across multiple places, including industrial action.
Data Quality / Gaps to ensure all delays and numbers are recorded at place level & Quality dashboard.
Synthesis & consistency of policy into action / variations in process & offer
Local ability to influence root cause of some delayed discharge for Complex Patients/pathways

Actions planned	Owner	Timescale	Progress Update
UEC Recovery Programme	SROs	2024-25	Recovery programmes underway and on track including at scale workstreams, Liverpool, Mersey & West Lancashire, Cheshire, Warrington & Halton, Wirral
Place Delivery Plans / Improvement Plans	Place Directors	2024-25	Underway in all places

Place based actions as indicated by specific place risks	Place Directors & SLTs	2024-25	Updates provided via specific place risks

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

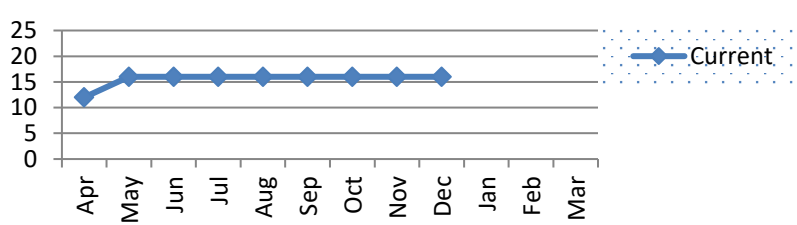
Assurances		
Planned	**Actual**	**Rating**
UEC Recovery Programme Board reports at system & place	Fortnightly reporting – April to Dec	**Partial**
Place Based Partnership Board reporting	Monthly / Bi-monthly reporting – Apr to Dec	
Integrated Performance Report to Q&P Committee & ICB Board	ICB Board – 30/5, 25/7, 26/9, 28/11	

Gaps in assurance
Performance against the majority of urgent and emergency care measures is below target and England average. Issues with quality of data identified on some place risks Requirement to review / further develop plans identified on some place risks

Actions planned	**Owner**	**Timescale**	**Progress Update**
Urgent Care Improvement Programmes at place	Place Directors	2024-25	Recovery programmes underway
Place based actions as indicated by specific place risks	Place Directors & SLTs	2024-25	Updates provided via specific place risks

NHS
Cheshire and Merseyside

ID No: PDAF 2	Risk Title: The Wirral health and care system is unable to meet the increasing needs of children and young people with complex and/or additional needs leading to long term health issues, increased inequalities and demands on services.

	Likelihood	Impact	Risk Score	Trend
Inherent Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	5	4	**20**	
Current Risk Score	4	4	**16**	
Target Risk Score	2	4	**8**	
Risk Appetite	Risk Appetite to be agreed across NHS C&M due to multiple places sharing the risk.			

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Place Director, NHS Cheshire and Merseyside	Joint Commissioning Lead for CYP, Wirral Council and NHS C&M	Transformation and Partnerships	Wirral Place Based Partnership Board

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Strategic Objective 1: Tackling Health Inequalities in Outcomes, Access and Experience	Quality, transformation and commissioning	C- Beyond financial year	Transformation and Partnership	Manage and mitigate

Date Raised	Last Updated	Next Update Due
25th August 2023	27/03/25	27/05/25

Linked Wirral Plan 2026 objective(s)	**Brighter Futures**: Working together for *brighter futures* for our children, young people and their families by breaking the cycle of poor outcomes for all regardless of their background.

	Safe and pleasant communities: Working for *safe and pleasant communities* where our residents feel safe and are proud to live and raise their families. **Active and healthy lives**: Working to provide happy, *active and healthy lives* for all, with the right care, at the right time to enable residents to live longer and healthier lives.

Risk Description
An Increased in demand and complexity of children and young people which since the pandemic which I outstripping capacity in current NHS and LA provision.

Linked operational risks	The operational Risk Registers are being developed.

Current Controls		**Rating**
Policies	HR Policies. Operational policies and SEND code of practice. CHC national framework. Safeguarding. Mental Health Act. Children's Act.	**Green**
Processes	CYP mental health escalation framework. DSD data base. Neurodevelopmental pathway. AACC Children's framework SEND Local Offer - SENDLO	**Amber**
Plans	SEND Written Statement of Action (WSOA) - Action Plan. CYP mental health transformation. SEND Improvement Plan	**Amber**
Contracts	NHS Standard Contract. Local Authority contract	**Green**
Reporting	Children, Young People and Education Committee. SEND Partnership Board. Health and Wellbeing Board. Wirral Place Based Partnership Board. Children Safeguarding Partnership. Quality and Performance Group. Contract meetings. Strategy and Transformation Group.	**Green**
Gaps in control		
Knowledge of future needs of population. Preparation for re-inspection of SEND with a view to progress against the Written Statement of Action (WSOA), and removal of the Improvement Notice by October 2025. Pathways and services for CYP with complex needs that provide alternatives to care, custody or inpatient admission through anticipatory care.		

Actions planned	Owner	Timescale	Progress Update
Demand modelling and provision agreement	Joint Commissioning Lead for CYP (Wirral Council and NHS C&M)	Aug 24 Oct 24 April 25 March 25	DBV and JSNA have given a better understanding of data. Review of service specifications to identify gaps in provision. Review of services – SALT, OT, ND pathway & EHWB. New model developed for ND Pathway & EHWB with new data sets to inform revised dashboard. **Complete** SALT waiting list management and EHCP provision business cases agreed, and implementation has begun (Aug 2024) – bi-weekly monitoring of progress in place. Trajectories have been developed that identify recovery timescales. DBV funding £200k to be invested in developing alternative health delivery models in the Graduated Approach to support early intervention and prevention and reduce escalation to specialist services.
Action planning for SEND reinspection and delivery of WSOA action plan.	Director, Children's Services (Wirral Council) and Associate Director, Quality and Patient Safety NHS C&M	Sept 2024 Dec 2024	QA process for WSoA – moving into Inspection preparation and readiness review against new framework. Ensuring collection of evidence that demonstrates positive outcomes and impact. New subgroups of SEND Partnership Board – continuous improvement, Performance management and WSoA will scrutinise and report on progress to SEND Partnership Board. Self-assessment produced that reflects multi-agency working.
Development of care pathways and provision and commissioning activity. 1. Central point of access (CPA) for emotional health & wellbeing needs CYP branded 'Branch'	Joint Commissioning Lead for CYP	Nov 2024	1. Alliance contract awarded start date April 2024. Digital Platform in development with digital agency Kaleidoscope. Branding 'Branch' coproduced with CYP. Full launch took place Nov 2024. **Complete**

2. Implementation of the ND model 3. Development of alternative health delivery models in universal settings (DBV) 4. Establishment of balanced system model for speech and language 5. Available provision for high-risk complex young people and associated integrated care planning.		Dec 2024 April 2025 March 25 April 24 March 2025	2. New model agreed and waiting to be implemented Business cases have been submitted for new model but paused due to ICB financial recovery. **Complete** New business case to be developed for next financial year 25/26.. 3. Funding bid agreed by DFE to develop an early intervention health delivery model which will increase early support in mainstream settings and promote inclusivity. 4. SALT system steering group in place with action plan and timescales agreed. Steering group part of DBV work. 5. DSD and MH gateway -combined to mitigate risks of duplication and gaps. And to proactively manage risks and jointly care plan. **Complete** Proposed development of provision to support high risk cases in progress. Lyndhurst ASD/LD provision underway.
Governance of quality, safety performance and risk of children and young people	Director, Children's Services (Wirral Council) and Associate Director, Quality and Patient Safety NHS C&M	Sept 2024	Review of children and young people's governance arrangements – bringing together performance, quality, risks and improvements from Public Health, ICB (Wirral Place) and LA Children's Services Revised Governance arrangements in place for SEND in light of Improvement notice (May 2024) **Complete**

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Assurances		
Planned	**Actual**	**Rating**
New SEND Performance Reporting framework and revised dashboard and SEND Partnership Board replacing Transformation Board	Established	**Reasonable**
SEND Strategy and Outcomes Framework	In progress	
Progress on CYP priorities from Health and Care Plan monitored through programme reporting to Strategy and Transformation Group	Programme reporting to Strategy and Transformation Group.	
Development of EHWB model and ND model	Completed	
Implementation of ND model	Planned delivery August 24 DELAYED	
Clearance of waiting times	Planned delivery June 24 DELAYED	
Governance arrangements	In place	
Priority area Identified locally and as part of NHS C&M recovery programme	Established- PID in place	

Gaps in assurance
Removal of WSOA by Office for Standards in Education, Children's Services and Skills (OFSTED). Improvement Notice issued May 2024.

Actions planned	Owner	Timescale	Progress Update
Implementation of ND pathway and clearance of waiting times	Commissioning Lead for CYP (Wirral Council and NHS C&M)	April 2025	Business cases submitted – paused due to ICB financial recovery. Front door will move to WUTH and WUTH to develop implementation and recovery plan – business case being prepared for Dec 2024 for next financial year 25/26. Bid submitted to TCP to support waiting list.
SEND Strategy and Outcomes Framework	Commissioning Lead for CYP (Wirral Council and NHS C&M)	Dec 2024	High-level outcomes and strategic priorities identified. Outcomes framework almost complete. Strategy due Dec 2024.
System meeting requirements to assure DFE for removal of Improvement Notice.	Director, Children's	October 2025	Monthly SEND Board established chaired by CEO.

	Services (Wirral Council) and Associate Director, Quality and Patient Safety NHS C&M		6 monthly progress meetings with DfE.

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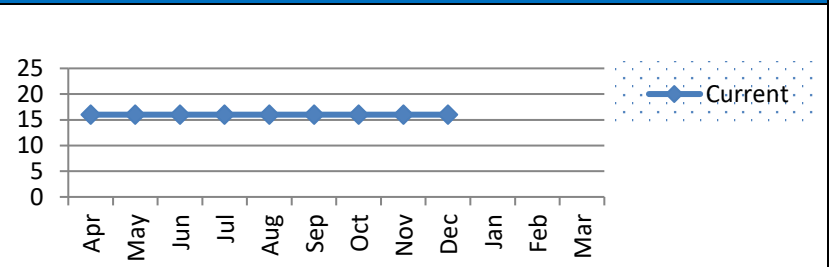
ID No: PDAF 2 Place Risk ID 150	Halton Place Partnership System is unable to meet the needs of children and young people with complex and/or additional needs leading to long term health and care issues, increased inequalities and demands on services.

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	4	4	16	
Current Risk Score	4	4	16	
Target Risk Score	3	4	12	

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Anthony Leo Place Director	Associate Directors of: Quality & Safety Improvement – Denise Roberts Transformation and Partnerships – Philip Thomas	Halton Place	SEND Improvement Board One Halton Partnership Board

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Tacking health inequalities in outcomes, access and experience in Halton	Quality & Safety Improvement Transformation and Partnerships	C beyond the financial year	Place	Manage

Date Raised	Last Updated	Next Update Due
07/12/23	April 2024	03/07/24
	26/06/24 – reviewed at SLT – no changes.	18/07/24
	18/07/24 – reviewed at SLT – no changes.	15/08/24

	15/08/24 – reviewed at SLT – no changes.	19/09/24
	19/09/24 – reviewed at SLT – no changes. A further in-depth PDAF review was undertaken at SLT PLT on 23/09/24 where it was agreed the PDAF risks would be re-drafted by Anthony Leo and Nigel Gloudon.	17/10/24
	24/10/24 – reviewed at SLT – no changes at present but will be updated in due course.	21/11/24.
	15/11/24 following discussion between Anthony Leo and Dawn Boyer, this risk has been updated as per Tony's comments below:- In relation to the risks re children, this is a **Place Partnership System** risk (not just ICB @ Halton Place). We believe this reflects the level of collective, shared risk across the Place Partnership System rather than the risk borne just by ICB @ Halton. As a system, there have been inadequate inspections for both SEND (All Health Partners & LA) and ILACS (mainly LA). The risk is that if the partners do not collectively address the issues, the partnership will not meet the needs of local CYP – that is a collective responsibility, not just ICB @ Halton Place.	19/12/24

	This risk and score need to remain please with the following amendment to the narrative. HPDAF2 – Halton Place Partnership System is unable to meet the needs of children and young people with complex and/or additional needs leading to long term health and care issues, increased inequalities and demands on services, currently rated as extreme (16) Risk title/description updated.	
	19/12/24 reviewed at SLT – no changes at present but will be updated in due course.	16/01/25
	10/01/25 Feedback from Philip Thomas:- Either the risk cannot be aggregated or if it is a single Place cannot comment on the risk rating – as it does not reflect that Place's risk. As it is down as 2 Place's Tony shouldn't be the sole SRO either I also think this is an issue not a risk	

Risk Description
Halton Place Partnership System is unable to meet the needs of children and young people with complex and/or additional needs leading to long term health and care issues, increased inequalities and demands on services.

Linked Operational Risks	

Current Controls		**Rating**
Policies	SEND Strategy Operational policies.	**Amber**

Processes	Outcomes Framework Communications and Engagement Plan Strategic Planning Process with Partners Business intelligence/data analysis Programme and Project Management Updated Joint Strategic Needs Assessment	**Red**
Plans	SEND Strategy SEND Priority Action Plan with identified SROs	**Amber**
Contracts	NHS Contracts Local Authority Contracts	**Amber**
Reporting	SEND Improvement Board Children's Safeguarding Partnership One Halton Partnership Board Health and Wellbeing Board Place Quality and Performance Group Contract Review Meetings	**Red**

Gaps in control

1. Strategic oversight and governance arrangements – to be embedded.
2. Efficient and high quality information gathering and sharing processes to ensure that children's and young people's needs are understood accurately and met more swiftly and effectively through coordinated approaches.
3. Effective joint commissioning of services to ensure that children, young people and their families receive sufficient support to have their needs met.
4. Early identification of needs and access to specialist health pathways, including the neurodevelopmental assessment pathway and speech and language therapy and the support available, while children and young people wait.
5. Timeliness of new EHC plans and updates to EHC plans following the annual review process, so that, if appropriate, children and young people receive an effective EHC plan within statutory timescales.

Actions planned	Owner	Timescale	Progress Update
1. Priority Action Plans for SEND to be implemented and change embedded.	Director of Children's Services at HBC and Place	30/04/24 15/08/24 19/09/24 17/10/24 21/11/24	Priority Action Plans developed for SEND priorities and approved by OFSTED/CQC. **<u>Oversight and progress monitoring:</u>** Delivery Group SRO regular meetings.

	Director/Priority Action SROs	19/12/24 Ongoing	Joint Management Oversight Group. Improvement Board to be established.

Assurances		
Planned	**Actual**	**Rating**
Delivery and implementation of the SEND Priority Action Plan.	Improvement Plan approved by OFSTED/CQC. Now in implementation phase.	**Reasonable**
Evidence of progress against Priority Action Plans to be monitored by SEND Improvement Board and supporting governance arrangements.	Governance arrangements agreed and approved by OFSTED/CQC. First Board meeting on 17 April 2024.	

Gaps in assurance
Over-arching governance agreed, but Improvement Board now needs to be implemented/embedded. Lack of established data flows and reporting to enable timely monitoring of progress.

Actions planned	**Owner**	**Timescale**	**Progress Update**
2. Development of dashboard and on-going monitoring of PAPs to address action areas covering points 1 & 2.	SROs	On-going	In progress as part of developed PAP.
3. SEND Improvement Board arrangements to commence and become embedded as part of over-arching governance.	SROs	30/04/24 15/08/24 19/09/24 17/10/24 21/11/24 19/12/24 Ongoing	In progress. First meeting 17 April 2024.

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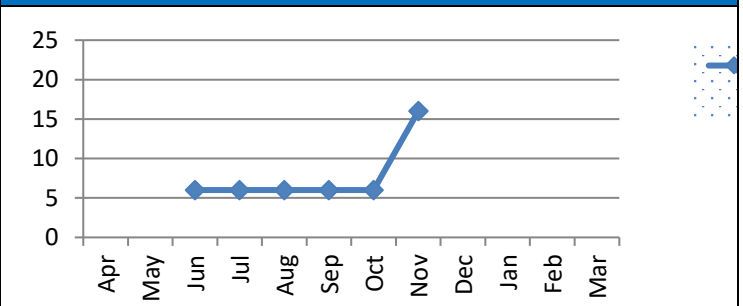
ID No: WiP006	Risk Title: Risk that the high prevalence of C.Difficile infections in Wirral System impacts on the quality of patient care and exacerbates operational pressures

	Likelihood	Impact	Risk Score	Trend
Inherent Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	3	3	**9**	
Current Risk Score	4	4	**16**	
Target Risk Score				
Risk Appetite	NHS Cheshire and Merseyside are still working on guidance on Risk Appetite.			

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Associate Director of Quality & Safety Improvement (Wirral), NHS Cheshire and Merseyside	Associate Director of Quality & Safety Improvement (Wirral), NHS Cheshire and Merseyside	NHS Cheshire and Merseyside, Wirral Place	Place Based Partnership Board

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Strategic Objective 1: Tackling Health Inequalities in Outcomes, Access and Experience	Quality Performance		Place	Manage

Date Raised	Last Updated	Next Update Due
17/06/2024	19/11/2024	January 2025

Linked Wirral Plan 2026 objective(s)	

Risk Description
Risk that the high prevalence of C Difficile infections in the Wirral system impacts on harm to patients due to AMT and extended length of stay and exacerbates operational pressures within the hospital setting

Linked operational risks	Urgent and Planned Care

Current Controls		Rating
Policies	IPC, Prescribing	
Processes	Hand hygiene and IPC measures Cleaning and decontamination	
Plans	Wirral C. Diff improvement plan C&M Cdiff toolkit	
Contracts	NHS Standard Contract- NHSE set thresholds Public Health contract for community IPC services	
Reporting	Health Protection Board Wirral Place based Partnership Board Q&P group/Q&P committee	

Gaps in control
Process for the management of diahorrhea within the community

Actions planned	Owner	Timescale	Progress Update
Development of a policy for Primary Care	Wirral Cdiff Lead	Q1 2025/26	

Assurances		
Identified as a System priority and Quality Improvement methodology implemented. Local Governance process in place		
Planned	**Actual**	**Rating**
Development of a system dashboard		
Gaps in assurance		
System dashboard		

Actions planned	Owner	Timescale	Progress Update
17/06/24 - Priorities identified, and support provided by collaborative unit when required	Lorna Quigley	To be reviewed in September 2024	Approved at Health Protection board 27/09/24 Reviewed in October 2024
01/10/24 - risk assessed and measures include the development of a c-diff strategy and improvement plan.	Lorna Quigley	To be reviewed in November 2024	Reviewed in November 2024
19/11/24 - increased scoring due to increase in Q2 C-Diff rates. System C-Diff plan established. Governance in place and project identified but not yet running. Review again in January 2025	Lorna Quigley	Review again in January 2025	Reviewed in January 2025.- suggested amendment made to risk descriptor. Planned actions from November completed: Driver diagrams with action plans in place and governance process established. Risk scoring reviewed to remain the same.
10/1/25 Development of dashboard Development of policy for diarrhea management within community settings	Lorna Quigley	Review effectiveness March 2025	

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