

PUBLIC – Board of Directors
31st March 2026

Report	Agenda Item 21*.	Cheshire and Merseyside Population Health Improvement Plan (2026-2031)					
Purpose of the Report	Decision		Ratification		Assurance	Information	X
Accountable Executive	Jon Develing			Director of Strategic Partnerships			
Author(s)	Cheshire and Merseyside Integrated Care Board			-			
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			X	Linked to all BAF areas with a clear focus on BAF 9 partnerships and population health.		
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health						X X X X X X
CQC Domains	Safe Effective Caring Responsive Well led						X X X X X
Previous considerations	Not applicable						
Executive summary	<p>The document presents the Population Health Improvement Plan (PHIP) 2026-2031 for Cheshire and Merseyside, outlining a strategic framework aimed at improving health outcomes, reducing inequalities, and enhancing care through system collaboration, data-driven management, and targeted investments across the life course. The plan is structured around key life stages and health priorities, supported by system-wide enablers such as digital innovation, workforce development, and infrastructure improvements.</p> <p>The key goals set out in the plan are:</p> <ul style="list-style-type: none"> • Improve health outcomes using data and population health approaches. • Reduce inequalities in experience, outcomes, and access. • Address social, economic, and environmental determinants of health. • Enhance patient experience with proactive, personalized care. • Increase value through productivity and efficiency improvements. 						

	The priorities in the Trust's Transforming Care Together Strategy (2023-2028), Clinical Strategy and recently developed 5 year integrated plan (2026-2031) demonstrate alignment of the Trust's strategic goals, with objectives refreshed each year.
Recommendations	The Board of Directors is asked to note the Cheshire and Merseyside Population Health Improvement Plan (2026-2031).

Corporate Impact Assessment	
Statutory/regulatory requirements	Provider response to the 10 year health plan and expectations.
Risk	Various risks included on Board Assurance Framework (BAF) and risk registers.
Equality & Diversity	Meets Equality Act 2010 duties & Public Sector Equality Duty 2 aims and does not directly discriminate against protected characteristics.
Communication	Not confidential.

Population Health Improvement Plan (PHIP) 2026-2031



Contents – Population Health Improvement Plan

1. What is a population health improvement plan
2. How we have developed the priorities in this plan
3. Our approach to Population Health Management
4. Outcome and Value Based Contracting
5. Investing in the ‘Left Shift’ to provide neighbourhood health
6. Assuring delivery and monitoring of our Plans
7. What are the key risks to our plan

Our Population Health Improvement Plan

8. Living Healthy Lives

- Cancer
- Cardiovascular disease / renal metabolic
- Diabetes
- Respiratory
- Health protection
- Neighbourhood Health
- Neighbourhood health / Community Services
- Routine Immunisations
- Oral Health
- Serious Violence duty
- Smoking cessation
- Weight Management

9. Starting Well

- Maternity and Neonatal Care

10. Growing Well

- Population Health and Joint Commissioning
- Neighbourhood Health and Accountable Care
- Corporate Parenting
- Mental Health
- Neurodiversity

11. Living Well

- Mental Health
- Learning Disability & Autism
- Neurodiversity
- Diagnostics
- Community Pharmacy
- General Practice
- Optometry
- Planned Care
- Primary Care Dental
- Stroke
- Women’s Health

12. Ageing Well

- Prevention of Frailty Escalation
- Dementia
- Falls Prevention
- Urgent and Emergency Care

13. Dying Well

- End of Life and Palliative Care

14. Enablers

- Digital and Data
- Workforce
- Estates and Infrastructure
- Governance and Executive Accountability

Glossary (Acronym buster)

There are many acronyms throughout the document - these are explained in the glossary this can be accessed through the link on each slide.

1. What is a population health improvement plan

A Population Health Improvement Plan (PHIP) is a strategic, data-driven approach to improving the overall health, wellbeing, and health equity of a defined group of people by addressing root causes of illness and promoting wellness across communities, not just within individual clinical visits, but across wider pathways, involving collaboration between healthcare, local government, and community partners.

Our PHIP is aimed at improving the health of the entire population. It is about improving the physical and mental health outcomes and wellbeing of people while reducing health inequalities.

It includes action to reduce the occurrence of ill health, deliver appropriate health and care services and action on the wider determinants of health. It requires working with communities and partner agencies.



Our vision is to embed a culture of improving population health and reducing inequalities through increasing system collaboration, capacity, capability and intelligence.

Our key goals:

- **Improve outcomes:** for all people by using data, intelligence and insight and embedding a population health approach across Cheshire and Merseyside.
- **Reduce inequalities:** in experience, outcome and access to care by increasing collaboration capacity and capability across the system.
- **Address wider determinants:** act on social, economic, and environmental factors influencing health (e.g., housing, education, employment and poverty) helping support broader social and economic development.
- **Enhance care:** Improve patient experience and make care more proactive and personalised.
- **Increase value:** Enhance productivity, efficiency and value for money while improving quality.

Living Healthy Lives

Starting Well

Growing Well

Living Well

Ageing Well

Dying Well

The PHIP is built around our key priorities and follows a life course approach. For each section of the plan we outline:

The case for change

Key outcomes

The key impacts

Our 26-27 commissioning intentions

Our 27-28 commissioning intentions

Our commissioning intentions years 3-5

Our key metrics and measures

Governance route and Exec Lead

2. How we have developed the priorities in this plan

In developing our PHIP priorities we have built from:

- Our Health and Care Partnership Strategy and Joint Forward Plan
- Priorities identified in our System Recovery Plans including efficiency, service sustainability and reconfiguration
- Our [Integrated Needs Assessment](#) (at C&M and Local Authority level)
- The Cheshire and Merseyside NHS Provider Blueprint

In addition to this our plan reflects additional priorities outlined in the NHS 10-Year Plan and Medium-term Planning Framework with a specific focus on delivery of the national shifts.

We have reflected the current context with a key focus on:

- Preventing and intervening early to prevent ill health; targeting priorities and populations identified through our population health needs assessment
- Commissioning for outcomes and value-based healthcare
- Providing more care in our neighbourhoods
- Reducing waiting times (Electives, Diagnostics and Cancer (EDC) as well as Mental Health, Neurodiversity and Primary, Community & Urgent Care)
- Delivering financial and operational efficiency and service sustainability through the opportunities highlighted in our [Integrated Needs Assessment](#)
- Safe, appropriate and cost-effective use of medicines cuts across our ambitions and is a key enabler of improved outcomes. The medicines management work plan is supporting several key system-wide areas where we are an outlier or have scope to improve, i.e., polypharmacy and frailty, antimicrobial stewardship, pain including opioids, safety and cost effectiveness.

We have recently refreshed our [Integrated Needs Assessment](#):

Current situation:

- The gap in life expectancy between those living in our richest and poorest areas continues to grow
- Cardiovascular Disease, Respiratory Disease and Cancer remain the leading causes of this gap
- Healthy life expectancy continues to reduce in all areas of C&M except Warrington.
- Increasing rates of chronic conditions, multiple chronic conditions and poor mental health are key contributing factors to declining healthy life expectancy.
- Growth in need and insufficient capacity to support neurodevelopmental conditions.

Future projections:

- Over the next three years in C&M we expect to see an increase of 84,783 people with long-term conditions costing an additional £187 million
- By 2040 - a 50% increase in diabetes, 31% increase in cancer and a 51% increase in atrial fibrillation.
- By 2040 - there will also be a 44% increase in people aged 75+.
- As an area with higher than average rates of frailty and falls this poses another significant challenge.

The PHIP is built around our key priorities and follows a life course approach.



3. Our approach to Population health management

Improving outcomes: for all people by using data, intelligence and insight and embedding a population health management approach across Cheshire and Merseyside.

We will take a [Population Health Management](#) approach to turn Data into Action and identify and then deliver the priorities in our Population Health Improvement Plan by:

Using data and benchmarking tools, including the Federated Data Platform Strategic Commissioning Tool, to inform commissioning decisions and target investment for maximum impact.

Applying segmentation and risk-stratification across NHS providers so people with the greatest need – such as those with long-term conditions or long waits – receive proactive, coordinated support.



Clinical Risk

Physical health conditions, mental health, medications, complications, episodes of ill health

Service Interaction

People at risk of being admitted to hospital, missing appointments or not accessing support that could improve their health and wellbeing

Linked Data: Broader Perspective

Inequalities

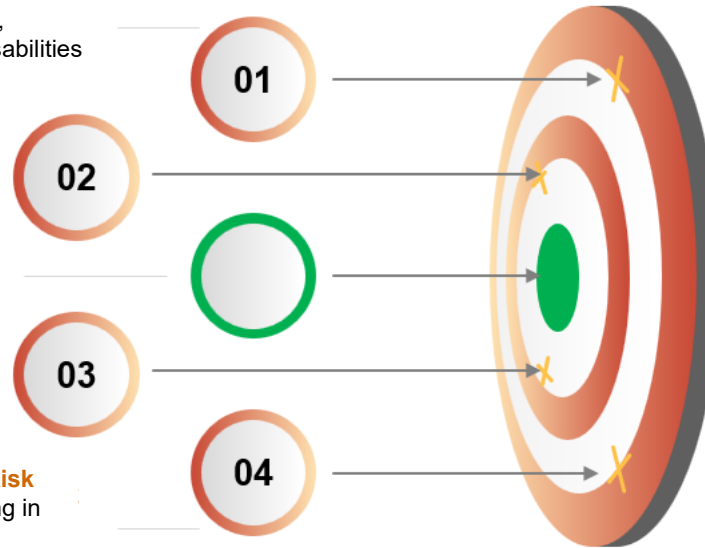
Factors such as age, gender, ethnicity, disabilities and deprivation

Combination of key factors

Key issues all taken into account to find the people most in need

Social/Household Risk

Socially isolated, living in poor conditions, fuel poverty, caring responsibilities



[Enhanced case finding](#) to predict population health needs, considering multiple conditions and severity to enable targeted interventions. Developing capability through our [Population Health Academy](#) so staff can use analytical tools to tackle health inequalities locally and lead commissioning and transformation at scale.

We are using insight from our Integrated Needs Assessment and the Johns Hopkins Model to identify population groups needing support. This shows:

- 25.4% of residents are “low-need adults” but account for only 4.4% of spend.
- The multimorbid, high-complexity group represents 4.7% of the population but 26% of spend.
- The multimorbid, medium-complexity group makes up 14.8% of the population and 22.4% of spend.

This approach helps us work with our partners to target support by:

- Predicting who is at risk of deteriorating health.
- Identifying people not receiving optimal care, such as people who would benefit from a review of the medicines they are taking.
- Highlighting who would benefit from a managed care plan, including people living with frailty or nearing end of life.
- Focusing on residents in the most deprived areas who may be facing a range of challenges.
- Co-ordinating resources to have the most positive impact.

4. Outcome and Value based contracting

In line with the principles outlined in our Five-Year Strategic Commissioning Plan (see page 15), we have identified a set of commissioning and contracting approaches that will enable our transition toward a strategic commissioning approach centred on improving population health outcomes. These approaches are designed to support collaborative, long-term planning; incentivise outcome-focused delivery; and ensure that all commissioning activity remains compliant with national regulations, statutory responsibilities, and recognised best-practice guidance.

Neighbourhood Health is our key delivery vehicle to delivering the 10-year plan. As a commissioner we will develop a consistent framework from which neighbourhoods will be commissioned:

- An outcomes-based commissioning specification that will align with the Neighbourhood Health Framework expected to be published later this year.
- To coordinate proactive and preventative care and urgent and rehabilitative care locally in line with the population priorities identified through our Integrated Needs Assessment.
- Assess how, over time, we might delegate population-based budgets that would be underpinned by clear contractual documentation and expectations and use of financial levers to reflect delivery of key outcomes.

In line with the Provider Selection Regime (PSR), we will **work with partners to support market-development** activity that enables accountable care models and creates a more agile, stable care market.

Our priorities are:

- Maximising Alder Hey's role as an early Advanced Foundation Trust, improving outcomes for children and young people through an Integrated Health Organisation (IHO) and planning how we adopt the IHO contract model.
- Implementing lead-provider arrangements in mental health, with the lead subcontracting to capable partners.
- Strengthening provider collaboratives across NHS and VCFSE sectors and developing a Primary Care Collaborative to support neighbourhood delivery.
- We recognise this is a significant shift for commissioners and providers, requiring collective capability-building and realignment of system capacity.

Our plans for **service change** centre on developing neighbourhood health, with partners working to defined geographies and initially using the new Single/Multi Neighbourhood Provider contracts to support delivery at scale.

- NHS providers will realign services to neighbourhood footprints, ensuring consistent access to community care, diagnostics and specialist support.
- Commissioning will move to a single primary-care specification, based on integrated needs-assessment and neighbourhood population-health priorities.
- Provider collaboration will be strengthened through working to single service specifications, building on Modern Service Frameworks and agreed priorities with the ICB.
- We will only commission services able to meet national standards for access, quality, safety, outcomes and which are financially sustainable.

We will **shift resources from hospital to community** by commissioning neighbourhood health services based on allocative efficiency, in line with population need and to achieve equitable health outcomes.

- For 2026–27, we have identified a £29.6m transformation fund (with further growth in future years) to drive the “left shift” from hospital to community, analogue to digital, and sickness to prevention.
- This investment will support transitional periods where new models transform from existing services. It will be tied to demonstrable reductions in demand for elective and non-elective acute care and will require providers to deliver additional efficiencies so that core activity can be sustained within a reduced funding envelope.

5. Investing in the ‘left shift’ to provide neighbourhood health (1 of 2)

Our strategic commissioning plan sets out priorities that will drive the 10-Year Plan shifts—from hospital to community, sickness to prevention, and analogue to digital—through a neighbourhood health model.

We have committed significant investment to support this, including a £29.6m transformation fund in 2026–27 (rising in future years) and additional to national Service Development Funding (SDF) and national funding allocations which support a number of areas already included in our plans, such as improved access to mental health services, capital developments, and the expansion of our digital capability.

Our approach focuses on integrating existing services and aligning current resources into new innovative models of care, building support around people, and will actively avoid creating parallel services that add complexity and cost to our system.

The investment areas opposite reflect our initial priorities—those identified through our integrated needs assessment as having the greatest potential to improve population health while reducing pressure and cost in the most challenged parts of the system.

In making these investments we will determine clearly the outcomes which will measure success and how we will ensure plans deliver their intended goals.

Creating integrated pathways with Primary, Community and Secondary Care Clinicians working together in a “multidisciplinary teams” model to support people to be cared for in their own home or neighbourhood, through:

- **Diagnose to Refer model:** holistic symptom assessment with rapid access to diagnostics through community diagnostic centres/local testing, reducing unnecessary urgent care and outpatient referrals. Initial pathways will focus on respiratory, CVD risk management and frailty.
- **Single Urgent Care Clinical Assessment Service:** a Cheshire & Merseyside-wide model with community and secondary care clinicians supporting people to receive care at home.
- **Community-based intermediate tier services:** focusing on high-volume elective specialties moving care into community settings/models (initially Gynaecology, Dermatology and ENT).

Our Population Health Improvement Plan includes further areas of “left shift” where we aren’t immediately planning to make additional investment but will work with partners to maximise existing assets within new care models, including:

- *Implementing 24/7 mental health neighbourhood crisis centres and community rehabilitation.*
- *Developing an intermediate urgent-care tier, including virtual wards and community beds (including step-up beds), to use existing capacity more efficiently.*

5. Investing in the “left shift” to provide neighbourhood health (2 of 2)

Investing in a consistent universal community services offer for our residents:

- In 2026–27, as part of developing a whole-system frailty offer, we will introduce a Home Assessment service for people who fall, including home-based diagnostics (e.g., X-ray) to avoid unnecessary hospital conveyance.
- We will implement single service specifications and tackle long waits for community services, with priorities including:
 - **Children and Young People:** speech and language therapy, physiotherapy, occupational therapy, community paediatrics and neurodiversity.
 - **Adults:** neurodiversity
- A consistent care-home MDT model (including wider primary-care input such as oral health).
- We will also invest in achieving a consistent end-of-life care model across Cheshire and Merseyside.

Using Population Health Management intelligence to proactively support those with greatest need in neighbourhoods:

- We will commission Neighbourhood Teams to use population-health-management tools to deliver proactive support and personalised care plans. Until national neighbourhood contracts are available, this will be commissioned through General Practice providers using a Local Enhanced Service (LES) with clear, measurable outcomes. This approach will give partners flexibility to use local assets including VCFSE organisations and NHS provider resources to implement the model.
- Commission a consistent Shared Care neighbourhood based prescribing service to reduce unnecessary outpatient attendances.

Supporting this:

- We will also commission system wide digital solutions to enable this and other community-based MDT models.
- Neighbourhood priorities will be intelligence-led and focus on key population groups - people with multimorbidity, long-term conditions (including CVD risk management and respiratory), frailty, and children and young people - to prevent escalation in care needs and reduce reliance on secondary care.
- This approach will align with, not duplicate, existing commissioning arrangement, including the national GP Contract.

As referenced earlier it is recognised there are wide ranging opportunities for investment. Over the coming year, we will use the intelligence from our integrated needs assessment to work with partners to agree further priorities for future years as part of a longer-term investment strategy.

6. Assuring delivery and monitoring of our Plans

- As part of our new operating model, we will reflect revised and enhanced governance to oversee how we operate, and this will be reflected in our approach to delivery of the priorities in this plan.
 - Each Programme will have an Executive Senior Responsible Officer and Programme Lead who will be responsible for ensuring that plans will deliver against agreed objectives with clear measures of success and timescales.
 - As part of our revised operating model programmes will be assured through a consistent programme management approach, reporting delivery progress through either a new Strategic Commissioning Programme Board or, if appropriate, through another Board sub-committee and then as part of a single improvement plan to the ICB Board.
 - Monitoring of progress against delivery will use strategic trackers of our key priority milestones, metrics and measures (based on outcomes wherever possible) through Board Sub Committees and through a monthly Integrated Performance Report (IPR) to Board.



See Page 64 for a summary of programme governance and executive accountability for each work programme.

The PHIP is built around our key priorities and follows a life course approach.

Living Healthy Lives	
Starting Well	Living Well
Growing Well	
Ageing Well	Dying Well
Living Healthy Lives – Prevention and Proactive Care	
Neighbourhood Health	
Maternity and Neonatal Care	
Children and Young People	
Mental Health	
Neurodiversity and Autism	
Frailty and Falls	
Palliative & End of Life Care	

7. What are the key risks to our plan?

Our Five-Year Strategic Commissioning Plan and Population Health Improvement Plan have been developed to directly support addressing key risks identified by our Board.

NHS Cheshire and Merseyside has formally accepted 'enforcement undertakings' with NHS England. In response we have committed to delivering rapid improvement work to provide additional assurance in a number of key areas – including financial planning, quality (with particular regard to mental health), leadership and governance.

The service and delivery requirements included in the national planning guidance, alongside local commissioning priorities, may be challenging to achieve given the current financial, performance and capacity context and as such need to be prioritised.

Delivery of the requested reduction in the running cost allocation may have a significant impact on the ICB's ability to deliver against our commissioning intentions. This will become clearer as we begin to understand the details of the revised operating models.

In embedding the new NHS operating model we will ensure that the ICB has the resources, skills, and abilities to deliver our role as strategic commissioner. It is recognised that the programme management resources we have to deliver our plan are limited, so we will target resources at the priorities in this plan. Progress will be closely monitored by our Executive Team and Board.

The intentions outlined in both plans will help mitigate these risks.

Board Assurance Framework:

- **Quality and Safety Failures in Commissioned Services:**
Risk that services may not consistently deliver high-quality, safe, and equitable care, especially during the shift from hospital to community-based models.
- **Digital and Cyber Resilience Gaps:**
Inadequate digital infrastructure, data sharing, and cybersecurity could disrupt care and hinder the transition to a digitally enabled NHS.
- **Failure to Reduce Health Inequalities and Improve Population Health:**
Risk of not achieving measurable improvements for deprived and vulnerable groups if resources and actions are not sufficiently targeted.
- **Financial Sustainability and Productivity Challenges:**
Inability to meet mandated savings and productivity targets could limit investment in prevention and digital transformation, and breach statutory financial duties.
- **Failure to Recover Access and Performance Standards:**
Risk of not meeting national standards for access and performance, undermining public confidence and exacerbating inequalities.
- **System Fragmentation and Provider Sustainability:**
Potential service loss or fragmentation if provider landscape is not proactively managed during commissioning of integrated, digital-first services.
- **Failure to Deliver Shift to Neighbourhood and Community-Based Care:**
Risk of insufficient investment, workforce capability, or collaboration to achieve the transition from hospital-centric models.
- **Workforce Capacity, Capability, and Morale:**
Organisational redesign and headcount reductions may destabilise morale and impede delivery of transformation priorities.

8. Living Healthy Lives

- Cancer
- Cardiovascular disease / renal metabolic
- Diabetes
- Respiratory
- Health protection
- Neighbourhood Health
- Neighbourhood health / Community Services
- Routine Immunisations
- Oral Health
- Serious Violence duty
- Smoking cessation
- Weight Management



Cancer – prevention and early intervention (Inc. Lung Health Checks)

Case for Change: Cancer is a leading cause of mortality in Cheshire and Merseyside, with around 7,000 deaths per year. Whilst early diagnosis and cancer survival rates have improved in recent years, cancer incidence and mortality rates remain higher than the national average.

Health Inequalities: Each percentage point improvement in early diagnosis rates delivers 731 years additional life expectancy and 454 healthy life years/Quality-Adjusted Life Years (QuALYs) per year. Individuals from deprived communities are disproportionately impacted by cancer. Consistent achievement of the constitutional waiting times for cancer will ensure all patients have equity of access to timely diagnosis and treatment which improves outcomes, especially in fast-progressing cancers. In addition to this, the HPV vaccination programme aims to reduce the incidence of cervical cancer. The NHS aims to eliminate cervical cancer by 2040, emphasising the vaccine's role in preventing HPV-related cancers in both sexes.

Financial: Improved prevention, early diagnosis and successful treatment of cancer has a direct positive impact on the health economy. Each percentage point improvement in early diagnosis rates delivers over £2.3m saving to the NHS in Cheshire and Merseyside and £5.6m benefit to the local economy.

Other Services: Early-stage cancers require less complex, less intensive diagnostics, treatments and aftercare. However, to detect more cancers early requires an increase in routine diagnostic tests and surveillance programmes. Sufficient diagnostic and treatment capacity will be required to achieve and maintain cancer waiting times.

*Medium Term Planning Framework (metric/measure or narrative)

We will: Reduce lives lost from cancer - Reduce the proportion of cancers diagnosed at an early stage and Improve five-year cancer survival rates - Reduce lives lost to cancer by improving the early detection of cancer and reduce cancer-related mortality pertaining to Breast, Bowel and Cervical

Our ambitions are:

- Increase the proportion of cancers diagnosed at an early stage by 3% points each year in line with CMCA ambitions
- Reduce the gap in rates of early diagnosis between the most and least deprived neighbourhoods
- Eliminate Cervical Cancer by 2040

2026-27 – Priorities

- Improve HPV vaccination rates (26-28)
- Introduce lung cancer screening to Cheshire, completing 100% coverage.
- Raise awareness of the lifestyle risk factors for cancer and the symptoms of cancer and improve uptake of cancer screening programmes through targeted campaigns and engagement in partnership with VCSFE organisations, focussing on those communities in IMD 1 and 2.
- Implement changes to the bowel cancer screening programme (FIT@80).
- Undertake a strategic review of robotic-assisted surgery.
- Optimise treatment outcomes through prehabilitation and rehabilitation.
- Develop and implement guidance for frailty assessment and management for patients with suspected and diagnosed cancer from initial presentation through to end of life.
- Improve urgent cancer care in line with CMCA's five-year urgent care strategy.
- Reduce the gap in rates of early diagnosis between the most and least deprived areas
- Continue to work with NHSE and partner ICBs on development of NW OPIC ahead of Section 7a commissioning transfer in 2027*
- Support changes to Cervical screening Programme, i.e. self-sampling

2027-28 – Priorities

- Work with system partners to reduce environmental risk factors for cancer.
- Transition lung cancer screening programme into two-year rolling programme for eligible population 2027-31
- Introduce a targeted triage tool to identify early-stage cancers in individuals who have never smoked.
- Implement changes to the cervical cancer screening programme.
- Improve identification of individuals at higher risk of cancer and optimise surveillance programmes 2026-28
- Reduce the proportion of cancers diagnosed in emergency settings, focusing on rarer cancers that cannot be staged.
- Implement the outputs of the review of robotic-assisted surgery.
- Using national and local clinical audits, identify and reduce variations in treatment outcomes.
- Improve urgent cancer care in line with CMCA's five-year strategy.
- Introduce patient-reported outcome measures (PROMs).
- Commission more flexible models of screening delivery

2028-31 – Priorities

- Maintain progress in line with the national cancer plan.
- Support patients living with and beyond cancer in the most appropriate setting (at neighbourhood level where possible).
- Strengthen screening workforce and provider resilience and scalability where it makes sense to do so

Key Metrics and Measures

- Reduce the incidence of preventable cancers by 3% by 2031*.
- Increase the proportion of cancers diagnosed at an early stage by 3% points each year*.
- Reduce the number of late-stage diagnoses (age-standardised rate per 100,000 to reduce from approximately 210 to 200, equivalent to 5%, by 2030)*.
- Improve treatment outcomes (improve five-year cancer survival by at least 1% point per year)*.
- Reduce health inequalities*.
- Improved HPV vaccination rates
- Improved screening uptake in all programmes by deprivation quintile

2026-27 – Priorities

- Introduce Single Queue Diagnostics for specialist investigations to create equity of access, choice and to achieve shorter average waiting times.
- Fully optimise MDT to improve timeliness of treatment.
- Deliver system pathway approach for skin, lung and gynae pathways, sharing resource where possible, building resilience and adopting best practice.
- Utilise AI and RPA to reduce administrative burden, improve efficiency and reduce errors.
- Expand care pathways which are straight to test (STT) to expedite access to diagnostics and target the non-cancer component of FDS, leading to increased focus on high-risk and diagnosed cancers*.
- Optimise workforce to ensure roles are continually developed, staff are able to work at the 'top of their licence' to exploit capacity with shared and mobile workforce models to allow scarce workforce resource to operate across organisations.
- Improve visibility and access to data and intelligence to drive improvement through an intelligence strategy.
- Maintain a clear focus on cancer waiting times via a dedicated cancer performance forum and managed collaborative improvement plans and trajectories.
- Develop use of CDCs to increase diagnostic capacity and to support the spread of one-stop service models.
- Develop an SOP for inter-provider transfers to support timely management from diagnostic to tertiary sites, including the development of service contract agreements to facilitate joint care models.

2027-28 – Priorities

- Expand Single Queue Diagnostics for specialist cancer investigations and high-impact non-specialist diagnostics to create greater equity of access, choice and to achieve shorter average waiting times.
- Continue to optimise and embed MDT to improve timeliness of treatment.
- Deliver a whole-system pathway approach for breast, LGI and urology pathways, sharing resource wherever possible, building resilience for seasonal impacts and adopting best practice from across England.
- Further development of AI and RPA for example in referral optimisation, diagnostic reporting and information transfer.
- Continue to expand care pathways for cancer which are STT models to expedite access to diagnostics and target the non-cancer component of FDS, leading to increased focus on high-risk and diagnosed cancers.
- Continue to Optimise the cancer workforce and the development of shared and mobile workforce models to allow scarce workforce resource to operate across organisations.

2028-31 – Priorities

- Maintain progress in line with the national cancer plan (due to be published in 2026).

Key Metrics and Measures

- Maintain performance against the 28-day cancer Faster Diagnosis Standard at the new threshold of 80%*.
- Achieve 80% performance against the 62-day cancer waiting times standard by March 2027, and 85% by March 2029*.
- Maintain performance against the 31-day cancer waiting times standard at 94% or above, rising to 96% by March 2029*.

*Medium Term Planning Framework (metric/measure or narrative).

CVD-RM secondary prevention

The Case for Change: CVD is the leading cause of morbidity, disability, mortality, and health inequalities in England with inequalities across the pathway from prevention to treatment. It causes around a quarter of all deaths in the UK.

Risk factors for CVD are more prevalent in Cheshire and Merseyside with high blood pressure the leading risk factor. Improving both the identification, treatment and management of atrial fibrillation, high blood pressure and cholesterol (ABC) would have a positive impact on economic productivity, prevent premature mortality and improve the quality of life for individuals and families.

Impact on Health Inequalities: CVD is among the largest contributors to health inequalities in life expectancy, accounting for one-fifth of the life expectancy gap between the most and least deprived communities. People living in our most deprived communities are four times more likely to die prematurely.

Financial and impact on services: If Cheshire and Merseyside met the 80% blood pressure treatment target ambition, we could prevent 337 heart attacks, saving £3.7m; prevent 502 strokes, saving £8.9m; and prevent 269 deaths in the next 3 years.

**Medium Term Planning Framework (metric/measure or narrative).*

We Will: Improve the cardiovascular health of the population by optimising the identification and treatment of those with Atrial Fibrillation, high Blood Pressure (hypertension) and high Cholesterol (ABC)

Our ambitions are:

- Target of a 25% reduction in CVD related premature mortality over the next 10 years
- Systematically scale up CVD prevention in primary care focussing initially on those practices furthest away from target

2026-27 – Priorities

- Continue to develop evidence-based support for primary care enabling them to proactively identify, monitor and treat high-risk individuals with ABC risk factors at scale, initially targeting practices that are both lowest performers and experience greatest health inequalities.
- Develop a robust response to the CVD Modern Service framework.
- As a CVD Prevention Accelerator site we will work with our partners to test new community-led delivery models for secondary prevention.
- Develop an implementation plan in response to the lipid management mapping exercise including considerations re: lp(a) testing?
- A whole system approach to prevention, strengthening efforts to reduce smoking prevalence and obesity; working with partners in local government and VCSFE to ensure that referrals into pathways reference the impact on CVD.
- Work with North West Kidney Network to support identification of Chronic Kidney Disease (CKD) and optimisation of treatment.

2027-28 – Priorities

- Rollout of tools to support primary care and systematically work through practice/ PCNs targeting those with greatest need with the ambition of having a named CVD lead in every practice/ PCN.
- Ensure reference to CVD Prevention in any C&M wide Locally Enhanced Service specification for primary care and consider enhanced payments for results with communities at highest risk of CVD.
- Continued expansion of Prevention Accelerator work completed to establish appropriate outcomes/ metrics.

2028-31 – Priorities

- Continued rollout of 2027/28 priorities.
- Supporting the target of a 25% reduction in CVD-related premature mortality over the next 10 years, including testing the NHS Health Check online service*.

Key Metrics and Measures

26-27

- Increase in identification and treatment of ABC

26-28

- Prevention Accelerator outcomes and measures
- Yearly improvement and increase in identification and treatment of ABC

28-31

- Reduction in referrals to secondary care lipid services due to optimisation in primary care

CVD-RM - Diabetes

Case for Change: Diabetes is a major public health problem with diagnoses in the UK having risen from 1.4 million to 3.9 million since 1996. One in ten people over 40 now has type 2 diabetes. Core to Children and Young People (CYP) Core20PLUS5 - Improved access to gold standard care in deprived areas and ethnic minority communities, and more CYP with Type 2 diabetes receiving annual health checks. Delivery of national priority work programmes /Diabetes Prevention Programme (NDPP).

Inequalities: Managing patients' health will likely reduce emergency admissions, reducing morbidity and mortality and delays in CVD events and extends life expectancy and support groups who are more at risk of disproportionately adverse outcomes. People with higher risks should be proactively identified and offered screening in accordance with NICE guidance, including people from high-risk groups.

Financial: The NDPP is a nationally funded programme. Reduction in diabetes will reduce treatment and social care costs. Maintaining control of diabetes will reduce the burden of disease reducing emergency hospital episodes. Medicines optimisation will reduce overall costs with an initial increase in prescribing costs i.e., use of best value SGLT2i treatments and appropriate and best value CGM and other treatments to offset costs.

Other Services: preventing and treating diabetes will reduce demand on primary and secondary care. The demand on social care and treatment costs in the longer term will reduce. People are more likely to remain without diabetes complications for longer, which will prevent the development of cardiovascular, stroke and myocardial infarction disease conditions.

*Medium Term Planning Framework (metric/measure or narrative)

We Will: Slow down the year-on-year incidence of type 2 diabetes as well as increasing the uptake of patients onto prevention programmes and improving the care and outcomes for people with diabetes.

Our ambitions are:

- Targeted case finding to identify people at high risk of developing type 2 diabetes (National Diabetes Prevention Programme NDPP)
- Optimising proactive management, targeting those at risk

2026-27 – Priorities

- Increase the proportion of people with NDH who had a glycaemic test in the previous 12 months.
- Increase the proportion of people with NDH who have been referred to the NDPP. Including gestational diabetes.
- Increasing the proportion of patients whose last HbA1c record is 42 - 47mmol/mol (at high risk of NDH), without a GP record of non-diabetic hyperglycaemia or diabetes mellitus.
- Improving care and outcomes for Children and Young adults with type 2 Diabetes and variation through GIRFT action plans.
- Improving care for those transitioning from Paediatrics to adult care and addressing poorer outcomes through GIRFT action plans.

2027-28 – Priorities

- Increase the proportion of adults with diabetes receiving all 8 care processes in the preceding 12 months, ensuring increased proportion in the most deprived groups.
- Increase the proportion of people with diabetes meeting all NICE 3 treatment targets.
- Utilise available commissioned places for eligible patients for the NHS T2D Path to Remission Programme.
- Increasing the proportion of people with type 2 diabetes prescribed an SGLT2i except those patients with frailty/other more susceptible groups*.
- Increase the proportion of people with diabetes who are eligible for CGM or Hybrid Closed Loop who are prescribed this technology. Targeting susceptible ethnic groups and more deprived groups, including pregnancy.
- Increase the rate of referral and attendance of structured education programmes for T1 and T2 diabetes.

2028-31 – Priorities

- Tackling diabetes related foot disease and retinal health could be brought into plans.

Key Metrics and Measures 27-28 and beyond

- Maintain a year-on-year increase in the number of patients identified for being eligible for NDPP and an increase in the number of eligible patients referred into the NDPP programme.
- Year-on-year increase in the identification, utilisation or referral, with a focus on hard-to-reach groups.
- Year-to-year increase in the identification, utilisation or referral.
- number of people receiving diabetes care processes.
- Major foot amputation rates / surveillance of foot disease.
- Surveillance of retinal screening / retinal screening rate (this is the ninth diabetes Care Process).

Respiratory Disease

Case for Change: Respiratory disease is a leading cause of death and emergency hospital admissions in Cheshire and Merseyside.

Impact:

Inequalities: Prevalence of respiratory diseases, such as COPD and Asthma, is higher among those living in our most deprived communities and inclusion health groups, such as substance misusers.

Financial: Emergency hospital admissions for Asthma, COPD and LRTI cost £33.7 million in Cheshire and Merseyside in 2024/25.

Other Services: Respiratory disease impacts on economic productivity through lost productivity, missed workdays and early retirement. Children with Asthma often miss school frequently, leading to educational setbacks and the need for additional support.

We Will: - Improve outcomes for all patients living with respiratory disease:

- Reduce the rate of emergency hospital admissions for respiratory disease
- Increase the proportion and quality of respiratory disease reviews
- Reduce the prevalence of smoking among those with a respiratory disease diagnosis

2026-27 – Priorities

- Every patient with Asthma or COPD to have a high-quality face-to-face annual review in primary care delivered by an adequately trained practitioner.
- GP practices should review patients based upon agreed risk stratification tools- patients with the greatest need are reviewed at the earliest opportunity.
- All Asthma and COPD patients should have a confirmatory diagnostic test recorded in their primary care record.
- Systems established to maximise people receiving annual flu vaccinations.
- Ongoing smoking should be addressed at every clinical interaction, and Ottawa model tobacco dependency treatments provided at every hospital.
- People with COPD who would benefit from pulmonary rehabilitation should receive this within national timelines.

Key Metrics and Measures

- Inc. the % of face-to-face COPD and Asthma annual reviews in primary care.
- Increase the % of patients with Asthma with a FeNO recorded.
- Increase the % of patients with COPD with spirometry recorded.
- Increase the % of patients with COPD receiving the influenza vaccination.

2027-28 – Priorities

- Primary care practitioners conducting respiratory annual reviews should be trained adequately in line with PCRS 'Fit to Care' document.
- Neighbourhoods should case-find COPD amongst high-risk patients, linking in with the Targeted Lung Health Programme.
- Patients with Asthma and COPD who live in cold and fuel-inefficient homes should be referred to appropriate services.
- Implementation of asthma guidance, reducing SABA monotherapy and use of appropriate inhalers in COPD and asthma.

Key Metrics and Measures

- Increase the percentage of practitioners performing annual respiratory reviews who have appropriate qualifications.
- Increase in the number of patients with COPD in C&M.
- Increase in the number of patients assessed for fuel poverty.

2028-31 – Priorities

- Respiratory services should integrate primary, community and secondary care on a neighbourhood footprint.
- Pulmonary rehabilitation teams should proactively case-find people who would benefit from Pulmonary Rehabilitation.

Key Metrics and Measures

- Respiratory outpatient transformation.
- Increased number of patients completing Pulmonary rehabilitation.

Health Protection incl. BBV, TB, HCAIs and Outbreak Management

The Case for Change: ICBs have a statutory duty under the Health and Social Care Act 2022 to plan and coordinate the NHS response to infectious disease outbreaks, ensuring service resilience, managing resources and collaborating with public health bodies for population health protection.

Healthcare-acquired infections continue to exceed national targets, although there have been improvements in C.Diff. Significant community outbreaks in the past 12 months include: Measles, Respiratory disease in care homes, Avian Influenza, Tuberculosis, Meningococcal and Hepatitis A.

We will work with partners to support strategies which focus on eliminating Blood Borne Viruses and Tuberculosis.

Impact on Health Inequalities: As detailed in: [Health inequalities in health protection report 2025 - GOV.UK](#) Health inequalities in health protection have a high human cost across people and Place. In England, those living in the 20% most deprived areas bear the greatest burden, with emergency hospital admission rates due to infectious disease almost twice as high as those in the least deprived.

Financial and impact on services: Whilst health protection matters have a high human cost across people and places, they have an impact on health services and economic productivity.

We Will: Reduce the number of people harmed by vaccine preventable disease, BBV, TB and HCAI

Our ambitions are:

- Achieve zero new HIV infections, zero AIDS-related deaths and zero new viral hepatitis infections by 2030
- 90% reduction in TB incidence by 2035
- To reduce the harms associated with outbreaks of infectious diseases

2026-27 – Priorities

- Continue to review against: Clinical response to local incidents and outbreaks of infectious disease: Commissioning guidance for ICBs agree a preferred delivery model and commission this in 2026/27.
- Support our LRC partners' ambition to become a HIV Fast Track Cities+ area by including viral hepatitis/TB.
- Consider TB service commissioning arrangements models to ensure future sustainability.
- Continue to work with Providers in relation to reducing rates of HCAIs and the harms associated with them.
- Continued support for BBV testing in Emergency Departments programme.

Key Metrics and Measure

- Commissioning cycle for a clinical outbreak response service is complete.
- Increased vaccination rates across all programmes.
- Increase in identification of people in EDs with BBV who go onto a treatment plan.

2027-28 – Priorities

- Support mobilisation and/or contract management of outbreak management Provider(s).
- Ensure robust and sustainable commissioning arrangements are in place for TB services.
- Continue to work with Providers in relation to reducing rates of HCAIs and the harms associated with them.

Key Metrics and Measure

- Improve vaccination uptake and coverage year on year across all eligible cohorts.
- Increase in identification of people in EDs with BBV who go onto a treatment plan.

2028-31 – Priorities

- Continue to review and strengthen ICB and wider system preparedness and responses to known and emerging health threats with key partners including UKHSA and Local Authorities.
- Contract management of outbreak management and TB service provider(s).

Key Metrics and Measure

- Improve vaccination uptake and coverage year on year across all eligible cohorts.
- Zero new HIV infections, zero AIDS-related deaths and zero new viral hepatitis infections by 2030.

Neighbourhood Health

The Case for Change: Integrated Neighbourhood Teams (INTs) will become the cornerstone of neighbourhood health delivery, replacing fragmented models with integrated, outcome-focused care. Providers will be expected to organise services around INT footprints rather than historic organisational boundaries. This will prioritise proactive support for residents with high and ongoing needs, ensure continuity of care, and embed collaboration.

The approach will help reduce unwarranted variation in access to GPs and unnecessary non-elective hospital care (inc. for people with frailty or at the end of their life).

Inequalities: We have an inconsistent approach to proactively supporting residents across neighbourhoods and Places, use of consistent risk stratification approaches allows us to proactively target support and those with greatest need and reduce inequality of access and care.

Financial: Through our risk stratification intelligence we know that we spend disproportionate levels of activity on segments of our population in relation to those with multiple health conditions (high complexity – 26% cost to <5% of population and medium complexity >22.39% against <5% and for those identified as frail 7% for 1% of the population).

Other Service: Unnecessary attendances/admissions in both planned and unplanned hospital-based services.

*Medium Term Planning Framework (metric/measure or narrative).

2026-27 – Priorities

- Creating joined-up teams (across health and care) in each neighbourhood in line with Neighbourhood Health Framework*.
- Use CIPHA to risk-stratify patients most in need of support and continuity of care with General Practice and Neighbourhood Teams delivering care plans.
- Agree Neighbourhood Footprints: Define footprints that are meaningful to local people.
- Reduce variation in GP Access with recovery plans in place where needed*.
- Improving the Primary - Secondary Interface including improving access to diagnostics and specialist opinion.
- Implementing INTs with agreement on which patient groups (cohorts) to focus on.
- Implementing non-elective plans across multiple neighbourhoods with demonstrable impact on GP appointments, ED attendance and length of stay*.
- Implementing a Neighbourhood Outpatient Model of Care.

2027-28 – Priorities

- An expansion in the cohorts and numbers of patients supported by integrated neighbourhood teams.
- Transfer of service/workforce capacity into “out of hospital settings” to enable more planned and early intervention activity.
- Continue to focus on improving the quality and efficiency of all-age continuing care (AACC) services, addressing unwarranted variation and preparing for full transition to AACC Data Set v2.0 by March 2027*.

Key Metrics and Measures 2026-28

- Reduction in risk profile of our population (CIPHA).
- Reduction in unplanned admissions for chronic ambulatory care sensitive conditions.
- Reduction in emergency admissions due to falls in people aged 65+.

2028-31 – Priorities

- Continued expansion of the cohorts being supported and of the community-based services available with a reduction in hospital capacity in prioritised areas.

Key Metrics and Measures from 2026-28+

- Prioritised population health indicators show an improvement in health and wellbeing outcomes.

Neighbourhood Health – Community Services

The Case for Change: There are different models for community healthcare provision, and the providers delivering care don't always align to Place footprints, resulting in variation of care, access and outcomes and increased costs. In line with the NHS 10-Year Plan priority to move from Hospital to Community, ensuring sufficient capability is a core component of developing neighbourhood-based services and supporting a movement of clinical services from hospitals into community settings.

Our ambitions are improved outcomes and reductions in:

- Improve population health outcomes
- Emergency admissions (in line with cohorts identified in NHS Neighbourhood Health Framework)
- Hospital length of stay and Delayed Transfers of Care will reduce

Impact on Health Inequalities: A consistent offer and access to services will enable earlier treatment, reduce inequalities and improve outcomes.

Financial: Through our risk stratification intelligence, we know that we spend disproportionate levels of activity on segments of our population in relation to those with multiple health conditions (high complexity – 26% cost to <5% of population and medium complexity >22.39% against <5% and for those identified as frail 7% for 1% of the population).

Other Services: Neighbourhood health models include a range of NHS, Local Authority and Community Partners, and effective models need a shared approach to support communities and prevent escalation of need, including use of hospital and specialist services.

*Medium Term Planning Framework (metric/measure or narrative).

We Will: Provide local community-based care that is personalised to meet individual need take a preventative and proactive approach to reduce the need for hospital-based care

2026-27 – Priorities

- Commission neighbourhood partnerships to reduce emergency admissions and other national priority metrics through use of population health management tools with investment targeted through a proportionate universalism approach.
- Implement standard specifications across community services (falls, community nursing, care homes and end of life care) develop specifications for the second phase priorities in 27-28*.
- Waiting list reduction to increase proportion seen within 18 weeks.
- Holistic model for CYP mental health and community services developed & implementation commences as part of C&M Provider Blueprint.

Key Metrics and Measures

- No patients waiting more than 52 weeks for an appointment & At least 78% of people seen in less than 18 weeks*.
- Reduction in emergency admissions against baseline.

2027-28 – Priorities

- Transfer of resources from hospital to community into neighbourhood health models reflective of neighbourhood progress in reducing hospital admissions and outpatient activity.
- Implementation of standard specifications for second phase service specifications and develop timeline and third phase for implementation from 2028.
- Delegation of population budgets to “early adopters” and where all neighbourhood partners agree to contractual model.
- Implementation of holistic C&M model for CYP mental health and community services and development of outcomes-based ACO contract.

Key Metrics and Measure

- 79% of people seen in less than 18 weeks.
- Reduction in Emergency Admissions.

2028-31 – Priorities

- Year on year transfer of resources from hospital to community into neighbourhood health models reflective of neighbourhood progress in reducing hospital activity.
- Neighbourhood Partners to agree on their agreed contractual model and commencement of delegation of population budgets to agreed “lead” provider*.
- CYP IHO model (or similar) for programme budget against agreed outcome measures.

Key Metrics and Measure

- 80% of people will be seen in less than 18 weeks.
- Reduction in Emergency Admissions.

Routine immunisations

The Case for Change: Vaccination is one of the most effective ways of protecting ourselves and our children against ill health and death. However, if uptake decreases it's possible for diseases to quickly spread e.g. measles is starting to appear again even though the MMR vaccine is the best protection against this. Without improvements:

- Uptake will continue to fall
- Inequalities will widen
- Outbreaks of Vaccine preventable disease will become more frequent
- Pressure on the NHS will increase

We will commission vaccinations as consistent national programmes delivered locally, embedding equity, quality and safety, addressing unwarranted variation across our places.

Impact on Health Inequalities: Lower uptake persists for::

- Those from the most deprived quintiles
- Some ethnic minority, migrant & transient populations
- Children missing school & those not registered with a GP

Financial and impact on services: Vaccination remains one of the most cost-effective public health interventions. Besides the cost to individuals and their communities, preventing outbreaks reduces pressure on:

- NHS activity including UEC
- Costs associated with outbreak management

*Medium Term Planning Framework (metric/measure or narrative).

We Will: Reduce the incidence and associated morbidity and mortality of vaccine preventable disease.

Our ambitions are:

- Reduction in respiratory-related emergency hospital admissions
- Reduction in paediatric ICU admissions associated with vaccine preventable illness
- Commit to achieving and sustaining $\geq 95\%$ coverage for MMR vaccination to eliminate measles

2026-27 – Priorities

- Continue to work with NHSE and partner ICBs regarding development of NW OPIC ahead of Section 7a commissioning transfer in 2027.
- Develop robust systemwide plans to increase uptake in all routine vaccination programmes with a focus on:
 - those in Quintile 1 & 2
 - clinical at-risk groups
 - Pregnant cohort
 - Health Care Workers
- Continue to deliver a C&M response to the national vaccination strategy in collaboration with our key partners including LAs*.

2027-28 – Priorities

- Commission more flexible delivery models, e.g. mobile services, extended access.
- Increase the number of vaccines that can be administered in Community pharmacy*.
- Continue to deliver a C&M response to the national vaccination strategy in collaboration with our key partners including LAs.
- Strengthen vaccinator workforce
- Strengthen provider resilience and scalability.

2028-31 – Priorities

- Continue to deliver a C&M response to the national vaccination strategy in collaboration with our key partners including LAs.
- Continued focus on strengthening vaccinator workforce and provider resilience and scalability.

Key Metrics and Measures

- Improve uptake and coverage year on year across all eligible cohort.
- Improve equality of uptake and coverage in underserved and Core20PLUS populations.

Oral Health – All Together Smiling supervised toothbrushing programme

Case for Change:

Tooth extraction due to oral decay is the leading cause of hospital admissions for children aged five to nine in England despite it being largely preventable.

Impact:

Inequalities: Tooth decay disproportionately affects those living in our most deprived communities. Children in these areas are three times more likely to have decay than their more affluent peers. Poor oral health also affects children's ability to sleep, speak, socialise and participate in education.

Financial: The cost to the NHS for hospital admissions for decay-related extractions for children aged 0-19 was £50.9 million in 2021/22.

Governance route and Exec Lead:

The All Together Smiling Programme reports into the Beyond C&YP transformation programme board and the ICB Population Health Partnership.

Exec Lead – Executive Director of Health and Integrated Care Commissioning.

We Will: To ensure children and young people have the skills and equipment to brush their teeth

Our ambitions are:

- Increase the number of settings participating in supervised toothbrushing
- Increase the number of children participating in supervised toothbrushing
- Increase the number of oral health packs distributed

2026-27 – Priorities

- Reach and maintain >50% setting participation in the programme as recommended within national evidence (46% achieved at Q3 25/26 end).
- Targeted distribution of oral health packs to: CORE20 General Dental Practices and Community Dental Services, [CORE20 PLUS](#) communities, and CYP within specialist SEND settings/ alternate provisions.
- Enhance programme reach by piloting a universal offer for CYP within SEND settings (supervised toothbrushing [STB] and oral health packs) with a view to roll out in 26/27.

2027-28 – Priorities

- Continued programme alignment to Local Authority commissioned STB programmes, ensuring CORE20 groups remain the focus.

2028-31 – Priorities

- Longer-term commissioning intentions to support transition to business as usual in partnership with Health and Local Authority.

Key Metrics and Measures

- Number of eligible settings taking part in STB.
- Number of children participating.
- Number of oral health packs distributed.

Serious Violence Duty

Case for Change:

The ICB is a statutory partner in the Serious Violence Duty. The ICB plays a key role in the multiagency public health approach to tackling the drivers and impact of serious violence with a focus on prevention and early intervention.

Impact:

Inequalities: Violence disproportionately affects those living in our most deprived communities. We also know that violence against women and girls is a significant driver of gender-based health inequalities. Impacts include direct health burdens as well as impacts on education, employment and quality of life.

Financial: The cost of violence to the NHS in England is approximately £921 million, with a further £1 billion in costs associated with violence towards NHS staff.

Other Services: The impact on other services will include a reduction in the number of serious violence victims presenting to A&E, the number of serious violence victims being admitted to hospital and ultimately an overall reduction in the number of repeat victims of serious violence presenting to services.

We Will: Prevent and reduce serious violence across Cheshire & Merseyside

Our ambitions are:

- Increase NHS staff awareness of serious violence and their role in preventing it
- Reduce the number of serious violence victims presenting to A&E
- Reduce the number of serious violence victims being admitted to hospital
- Reduce the number of repeat victims of serious violence

2026-27 – Priorities

- Develop a plan for delivering training to all frontline staff on identifying risk of violence.
- Begin delivering training to the staff groups identified as the first priority cohort for training.
- Begin to establish referral pathways for frontline staff who identify at risk patients.

Key Metrics and Measures

- Number of staff trained in each NHS Trust.

2027-28 – Priorities

- Develop a population health academy training programme on how to use the C&M violence dashboard.
- Consider how the C&M violence dashboard can be developed to encompass additional NHS data.
- Identify a minimum dataset that clinicians within the NHS should be recording to support the development of violence-related data.

Key Metrics and Measures

- Number of staff trained in the population health academy from each NHS Trust.

2028-31 – Priorities

- Consider how preventing serious violence can be integrated into service specifications and NHS contracts.

Key Metrics and Measures

- Number of service specifications and contracts that include duties to reduce serious violence.

Smoking cessation (Opt out)

Case for Change: Smoking is the leading cause of preventable illness, premature death and health inequalities in Cheshire and Merseyside, creating significant pressure on health service demand and costs. The NHS can prevent smoking-related illness by identifying patients who access healthcare services and supporting them to access evidence-based treatment services.

Impact:

Inequalities: Smoking is the leading cause of health inequalities in C&M. Rates of smoking are significantly higher among those living in the most deprived communities and among men.

Financial: Smoking costs C&M £1.75 billion each year. The NHS in C&M incurs £75.9 million of these costs each year.

Other Services: Smoking has a negative impact on a range of services including social care (cost £598m per year, productivity £1.06bn per year)

Governance route and Exec Lead: Each provider requires a Senior Responsible Officer for this work. Progress should be reported to the All Together Smokefree Board and Population Health Partnership.

Exec lead - Executive Director of Health and Integrated Care Commissioning

*Medium Term Planning Framework (metric/measure or narrative)

We Will: Ensure all hospital patients who smoke are supported to access tobacco dependency treatment

Our ambitions are:

- 95% of patients have their smoking status assessed when in contact with hospital services
- 75% of patients who are identified as smokers are referred to community smoking cessation services as part of the opt-out pathway
- 60% of referred patients become a treated smoker
- 40% of patients who are a treated smoker quit at 28 days

2026-27 – Priorities

- Implement opt-out across all surgical pathways.
- Consider how opt-out can be integrated into the all-new service specifications and existing NHS Trust contracts*.

Key Metrics and Measures

- By the end of 2027 75% of surgical patients who are smokers are referred to community stop smoking services.

2027-28 – Priorities

- Implement opt-out across all outpatient clinics*.

Key Metrics and Measures

- 75% of outpatient patients who are identified as smokers are referred to community stop smoking services.

2028-31 – Priorities

- Implement opt-out across all other hospital-based planned care.
- Implement opt-out in ED.
- Implement in any remaining hospital departments*.

Key Metrics and Measures

- 75% of planned care patients (excluding inpatients) who are identified as smokers are referred to community stop smoking services.
- 75% of ED patients who are identified as smokers are referred to community stop smoking services.
- 75% of patients (excluding inpatients) who are identified as smokers are referred to community stop smoking services.

Weight Management Services

Case for Change:

Unhealthy weight places a significant burden on the NHS in C&M. Currently there are a range of specialist weight management services funded by the ICB, but there are inconsistencies across geographical Places in terms of eligibility criteria, staffing models, capacity and access arrangements. To ensure we reduce inequalities and maximise.

Impact:

Inequalities: Overweight and obesity disproportionately affect those living in the most deprived communities. This then leads to poorer health outcomes in these groups due to obesity related health conditions. People from certain ethnic groups are also disproportionately affected by overweight and obesity and the associated health conditions. Obesity can then impact on mental health, the ability to work and participation in education for children and young people.

Financial: Overweight and obesity cost the NHS around £6.5 billion annually and this is projected to increase to £9 billion by 2050.

Other Services: Overweight and obesity can impact on a person's ability to be economically active.

*Medium Term Planning Framework (metric/measure or narrative).

We Will: Ensure patients living with obesity can access specialist weight management services.

Our ambitions are:

- 60% of patients lose 5-10% of their body weight
- 75% of patients report an improved quality of life score
- 30% reduction in the prevalence of obesity related comorbidities in this patient cohort

2026-27 – Priorities

Establish a service improvement programme for weight management services across Cheshire and Merseyside that:

- Establishes a single service specification for tier 3 services across C&M (including a minimum dataset and management service dashboard to monitor activity and outcomes for these services).
- Continue work around GLP-1 weight management drugs and managing the pipeline of new drugs*.

Key Metrics and Measures

- Increase in the capacity of tier 3 weight management services.

2027-28 – Priorities

- Explore alternative operating models to maximise the capacity within tier 3 services in C&M.

Key Metrics and Measures

- Increase in referrals for weight management services.
- Increase in patients successfully completing tier 3 weight management interventions.

2028-31 – Priorities

- Implementation of identified alternative operating models.
- Contribute to the national target of 250,000 referrals to the NHS Digital Weight Management programme by Mar 2029*.

Key Metrics and Measures

- Increase in the number and proportion of patients losing weight.
- Reduce in the prevalence of obesity related comorbidities.

9. Starting Well

- Maternity and Neonatal Care



Maternity and Neonatal Services:

Case for Change: Maternity and neonatal services are facing increasing complexity with more women with co-morbidities, long-term conditions and wider socio-economic factors requiring enhanced care. In addition, there are ongoing workforce pressures, with recent Birthrate Plus reports identifying the need for additional resources to meet care requirements across 8 maternity units with a falling birth rate and national mandates for safety and improvement, which require significant financial resources. Limitations in digital and data capabilities continue to impact service efficiency and hinder effective monitoring. In line with the 10 Year Plan and national reports such as [MBRRACE](#), address disparities in access and outcomes, particularly for women from deprived areas and majority communities, who face higher risks.

Improving services will deliver the following measurable benefits:

- Better health outcomes and patient experience
- Reduced inequalities across ethnicity and deprivation
- Enhanced workforce resilience and retention
- Lower long-term healthcare costs and improved productivity

Inequalities: By standardising best practice, protecting high-risk groups, enhancing access through culturally sensitive and personalised care, and preventing complications, this approach delivers measurable improvements in outcomes, patient experience, and long-term system sustainability.

Financial: Improving services can deliver significant cost savings and system efficiencies. Preventing complications reduces emergency and acute care costs, while avoiding birth injuries and preterm complications lowers long-term health and social care expenses.

Other Services: reduced demand on emergency and acute care by preventing complications, reducing unplanned interventions and neonatal intensive care admissions. Decreasing pressure on paediatric, mental health, and social care services by improving maternal and infant health outcomes.

****Medium Term Planning Framework (metric/measure or narrative).**

We Will: Strengthen the quality and safety of local maternity and neonatal services

2026-27 – Priorities

- **Implementation of ALL national best practice, safety initiatives and reviews*.**
- Develop/implement a transformation plan, incorporating reviews, to ensure providers can sustain and deliver safe, high-quality care.
- Ensure the provision of high-quality patient information and support the implementation of initiatives to improve health literacy.
- Increase awareness of and support for ethnicity-related pregnancy risks with women of the global majority.
- Expand Enhanced Continuity of Carer for women with increased vulnerability and embed personalised care and support.
- **Deliver population health improvements and access to neighbourhood health in line with the Maternity/Neonatal Equity Plan*.**
- Commission Engagement & Maternity and Neonatal Voice Partnerships (MNVP).
- Commission clinical networks, i.e. Preterm Birth, Foetal Medicine and Maternal Medicine to deliver enhanced care for complex LTC & maternal health conditions in line with national guidance.

2027-28 – Priorities

- Support providers to deliver digital transformation that enables improvements in key areas of maternity care, including triage.
- Implement developments in community hub provision, including low-risk pregnancy triage pathways and postnatal care visits.
- Improve integration between maternity services, primary care, health visiting, mental health and voluntary/community sectors.
- **Participate in the Perinatal Equity and Anti-Discrimination Programme to improve culture and practice and implement the Maternity Outcomes Signal System*.**

2028-31 – Priorities

- Transform maternity services, through expanding access to community based antenatal and postnatal care, ensuring high quality maternity care for all women and babies, regardless of setting.
- Commission a sustainable maternity workforce, strengthening resilience and retention and the capacity to deliver safe, high quality maternity care.

Key Metrics and Measures 26-27

- Reduced stillbirths, preterm births, maternal and neonatal deaths, maternal morbidity, and brain injuries.
- Improved experiences of care across antenatal, intrapartum and postnatal care.

27-28 See 26-27 metrics plus –

- Reduced harm in maternity and neonatal services by 50% by 31st March 2028.

10. Growing Well

Children and Young People

- Population Health and Joint Commissioning
- Neighbourhood Health and Accountable Care
- Corporate Parenting
- Mental Health
- Neurodiversity



Children and Young People - Population Health and Joint Commissioning

Case for Change: Around 25% of the population is under 19. Some Children and Young People in Cheshire and Merseyside do not “Start Well”, and this translates into poorer outcomes. As examples:

- In C&M we see higher than England averages in the percentage of 5-year-olds with visually obvious dental decay.
- 24.0% of year 6 children in C&M were obese compared with the England average of 22.7%, with one area in the sub-region as high as 30.7%.
- In C&M there are higher than England averages for teenage conceptions, hospital admissions for asthma and mental health conditions among under-18s.

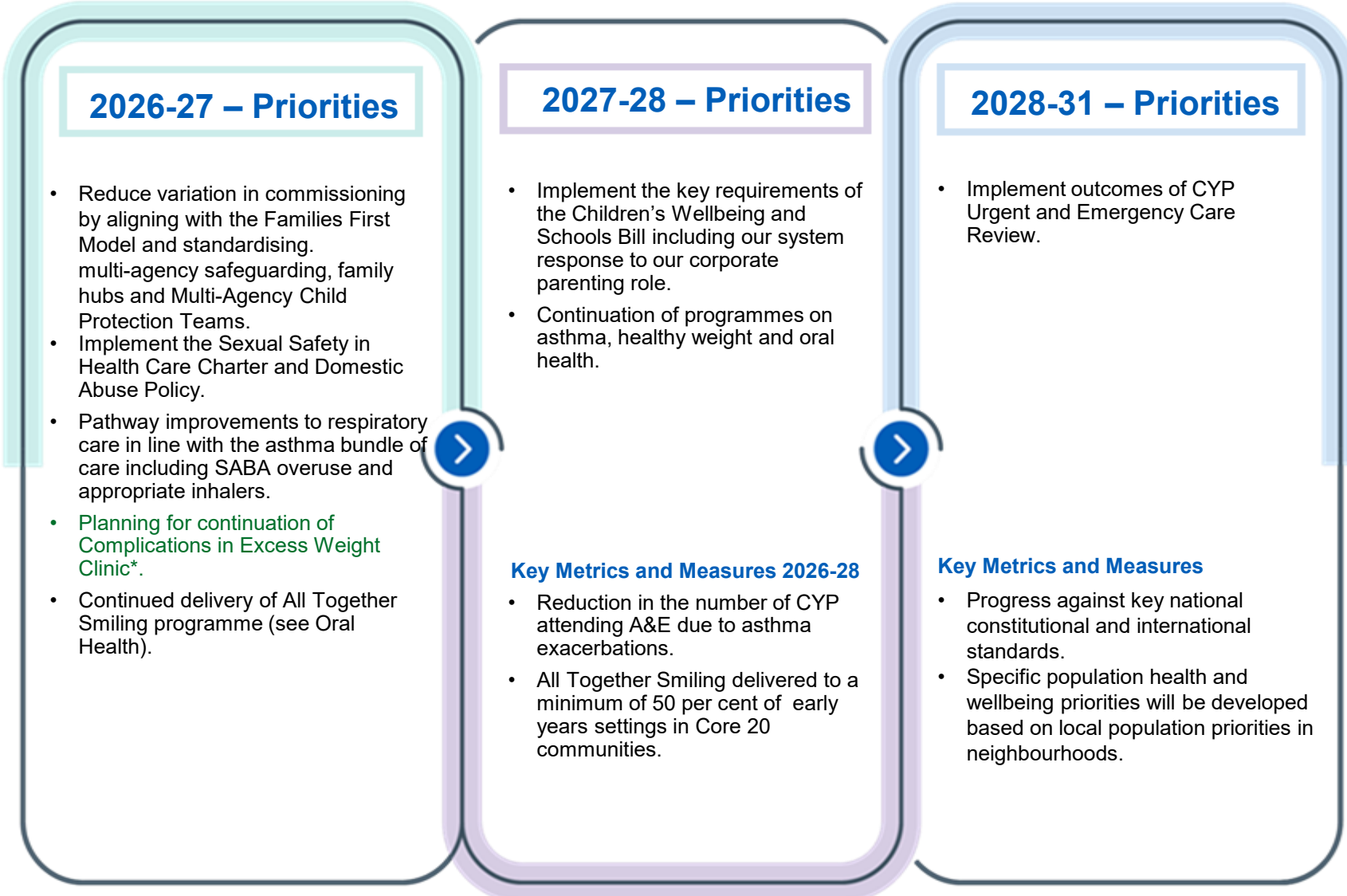
Inequalities: In our subregion we have 100,300 children living in poverty. This amounts to 22.3% of all children and young people, which is higher than the national average of 19.8% and is reflected in the poorer outcomes.

Financial: The cost of the poorer outcomes is not just personal to the children and their families but also costs the health and care system and economy.

Other Services: There is a significant opportunity to improve the consistency of services and outcomes across Cheshire and Merseyside through a more holistic model of community and mental health services, as well as developing a service chain model for hospital-based services with an aspiration to create an integrated health organisation (IHO) approach to oversee the health budget for the CYP population. See next slide:

*Medium Term Planning Framework (metric/measure or narrative).

We will: Improve access and outcomes through a holistic, joined-up system for our children and young people that brings together our partnerships and community, mental health, hospital, and tertiary services



Children and Young People – Neighbourhood Health and reducing waiting times

Services for children and young people can feel disconnected, with multiple providers and pathways that are hard to navigate. NHS Cheshire and Merseyside is planning to strategically commission an Integrated Health Organisation (IHO) model to transform services for children and young people. This approach aims to deliver a holistic, joined-up system that brings together our partnerships and community, mental health, hospital, and tertiary services which will complement the expected publication of a national Modern Service Framework for Children and Young People.

Benefits:

The accountable care approach will enable our neighbourhood health model and provide a range of benefits to our children and young people and their families:

- **Coordinated and Seamless Care:** Health and social care professionals will work together, sharing information across GPs, specialists, social care, and voluntary organisations to provide an integrated experience.
- **Proactive and Preventative Focus:** Early identification and intervention will help address health concerns before they become serious, reducing the need for specialist care.
- **Improved Health Outcomes and Reduced Inequalities:** By adopting a population health approach, the IHO will work with partners to tackle wider determinants of health – such as housing, education, and employment – ensuring targeted support for those with the greatest need.
- **Personalised Care:** Each child or young person will have a care plan tailored to their specific needs, preferences, and goals, ensuring a truly person-centred approach.
- **Enhanced Access to Services:** Integrated neighbourhood teams will make it easier to access community and mental health support closer to home, reducing reliance on specialist or emergency services.

*Medium Term Planning Framework (metric/measure or narrative).

We will: Commission a holistic, joined-up system for our children and young people that brings together our partnerships and community, mental health, hospital, and tertiary services

2026-27 – Priorities

- Commission a hosted secondary and tertiary care provider model.
- A single elective waiting list (PTL) with priority on reducing ENT and dental waits.
- A single point of access, including a digital front door.
- Co-design and implement a holistic model for universal community, mental health and neurodevelopmental services, improving access to community paediatrics including ADHD, speech and language, physio and occupational Therapies, and paediatric audiology in line with national standards.
- Establish an MDT in at least one neighbourhood in each Place.
- Develop a Strategy to improve outcomes, reduce inequalities and optimise resources, strengthening collaboration across partners and aligning with national opportunities*.

Key Metrics and Measures

- Reduction in waiting times in community services and for elective care.

2027-28 – Priorities

- Commission secondary/tertiary care services from a Children's Lead provider.
- Commission community and mental health services in line with holistic model.
- Review of C&M wide CYP Urgent and Emergency Care Services and development of a case for change.
- Review of different MDT frameworks and develop outcomes monitoring framework.
- Implement the Paediatric Early Warning System (PEWS) by April 2027 for hospitals with a paediatric inpatient setting, and by April 2028 for all other hospitals*.

Key Metrics and Measures

- Reduction in waiting times in community services and for elective care.
- Reduction in A&E attendances and admissions for urgent care.

2028-31 – Priorities

- Commission community, mental health, secondary and tertiary care services from an Accountable Care Organisation.
- Implement outcomes of CYP Urgent and Emergency Care Review.
- Development of a consistent MDT framework with funding transitioning into neighbourhoods to reflect need. Each neighbourhood will have embedded delivery of CYP MDTs across a range of needs.
- Develop ringfenced CYP capacity using existing NHS estate by running regular dedicated paediatric surgery days in either a day surgery or hub setting, with an aim to increase CYP activity delivered through surgical hubs*.

Key Metrics and Measures

- Further reduction in A&E attendances and admissions for urgent care.
- Specific population health and wellbeing priorities will be developed based on local population priorities in neighbourhoods.

Children and Young People – Corporate parenting

Case for Change: The number of children in care in the UK has doubled over the past 10 years. In C&M there are circa 7,200 children currently in care. The Education and Wellbeing in Schools Bill legislates the role of corporate parent for the ICB/NHS. We will work with partners regarding our corporate parenting duties, including initial health assessments for Children in Care. We need to ensure we can evidence compliance with the United Nations Convention on the Rights of the Child. In addition, we need to focus on meaningful employment and pathways through the care leavers covenant.

Impact:

- Expanded Corporate Parenting duty to the NHS
- Introduction of a Single Unique Identifier (SUI) for children intended to be their existing NHS number
- Young people leaving care to have access to free prescriptions, dental and eyecare services up to age 25
- NHS guaranteed interview scheme and paid internships to break down barriers to opportunity

Inequalities: Most children become “looked after” due to various forms of traumatic events, abuse and/or neglect, they may have the same health issues as their peers, the extent of these is often greater because of their past experiences, an estimated half of CECYP have a diagnosable mental health disorder and two-thirds with special educational needs More than one quarter of those leaving care are not told how to get help with their physical health, including registering with a GP or dentist.

Financial: The cost of the poorer outcomes is not just personal to the children and their families but also costs the health and care system and economy.

Other Services: There is a significant opportunity to improve the consistency of services and outcomes through an integrated lens with both ICS and integrated health and care systems.

Outcome: "Would this be good enough for my child?"

Our ambitions are:

- To develop an integrated system approach to improving the experience and health outcomes of
- Care Experienced Children and Young People (CECYP) within Cheshire and Merseyside

2026-27 – Priorities

- Clarify the ICB offer regarding corporate parenting duties in line with the proposed.
- Develop ICS response to the corporate parenting role
- Develop an ICS approach to Initial Health Assessments for Children in Care (CiC) (including workforce review of current approach, commissioning intentions and development of integrated dashboards).
- C&M baseline audit of IHA processes, timelines, and outcomes.
- Updated training model and resources for social workers and health professionals.

Key Metrics and Measures

- Baseline understanding of Place level offers.
- Promote care experienced as protected characteristic in local policy and practice.
- C&M Corporate parenting workplan (ICB and LA).

2027-28 – Priorities

- Collaborate with Regional Improvement Partnership to develop an integrated C&M IHA performance dashboard CECYP led revision of current IHA process ensuring Voice of the child is clear and informs future commissioning practice.
- Scale work under the Care Leavers Covenant building capacity seek additional funding opportunities.
- Work with Edge Hill University and CWP to develop a set of NHS corporate parenting principles based on lived experience.
- Workforce model redesign to address surge capacity and CECYP access needs.
- Scope where possible integrated/pooled funds to managing all applications for IHA.

Key Metrics and Measures

- Dashboard design and development.
- I-Support auditing / pilot / implementation.
- Full implementation of C&M model and service.
- Care leavers covenant in place with positive outcomes.

2028-31 – Priorities

- Develop a standardised regional IHA pathway (referral, assessment, follow-up, info sharing).
- Implement digital solutions for referral/tracking and data sharing.
- Remove disparities and standardise entitlements and processes.
- Ensure access to CAMHS, dental, and expedited NHS pathways.
- Ensure all CiC and CECYP have access to support for their Emotional wellbeing and mental health.
- Scale work under the Care Leavers Covenant and build capacity across the system, seek additional funding for growth.
- Support work for transitions into employment for care leavers, CECYP implementing employability offer.
- Targeted work with virtual schools & NEET for into training and apprenticeships.

Key Metrics and Measures

- Launch and implementation of integrated performance dashboard.
- Review and modernisation of workforce model.
- Publish collaboration with Edge Hill.

Children and Young People – Mental Health

Case for Change: At any one time, 1 in 5 children and young people have a diagnosable mental health problem. Most adult mental health illness can be traced back to childhood. The Ten-Year Plan recognises the importance of early intervention and community-based support for children and young people with mental health needs. It also recognises that, when specialist help is need, it should be available in a timely manner to avoid escalation to more expensive interventions.

Inequalities: There is evidence that appropriate mental health support in childhood and adolescence improves life expectancy, outcomes and experience.

Financial: reduced spend on expensive clinical interventions, such as inpatient care, will allow for investment in community services. Maintaining children and young people in their own homes, with access to good education and social support opportunities will improve their ability to move into employment in adult life.

Other Services: Opportunity to reduce unnecessary attendances at EDs due to breakdowns in care. Enhance Special Educational Needs and Disabilities (SEND) support. Reduce admissions to CAMHS inpatient beds.

*Medium Term Planning Framework (metric/measure or narrative).

We Will: Widen access to services closer to home, reduced unnecessary delays and the delivery of mental health care based on a clear understanding of the needs of children and young people. Our ambitions are :

- All children and young people have timely access to mental health support appropriate for their needs.
- All schools and colleges in Cheshire and Merseyside to have access to a Mental Health Support Team (MHST)
- Admissions to Child and Adolescent Mental Health Services (CAMHS) inpatient beds and crisis attendances at Emergency Departments (EDs) are reduced.

2026-27 – Priorities

- Implement refreshed 1-year CYP MH Strategy for 2026/27 and develop future strategy.
- Mobilise waves 15 and 16 of MHST’s in schools and colleges.
- Strengthen inclusive mental health pathways so that children and young people with neurodiversity, learning disabilities and autism can access the right support at the right time, aligned with SEND reform.
- Develop alternatives to CAMHS inpatient admission and ED attendance (Appropriate Places of Care).
- Ensure that the mental health needs of children and young people are considered in the Neighbourhood Health model and in the roll out of Young Futures hubs.

Key Metrics and Measures

- 77% coverage of MHST’s and teams in training by March 2027*.
- Reduce long waiting times for access community mental health.
- Increase number of direct/indirect contacts per whole time equivalent practitioner.

2027-28 – Priorities

- Implement refreshed MH Strategy
- Mobilise waves 17&18 of MHST’s in schools and colleges.
- Continue to improve access, reduce waits, expand early help and strengthen prevention.
- Increase consistent use of clinical outcomes and patient/carer-reported measures to inform improvements.
- Develop integrated 16–25 pathways that support transition, continuity and preparation for adulthood.
- Embed best practice Eating Disorder model, including ARFID pathway.
- Reduce avoidable attendances and inpatient admissions with safe, timely, community alternatives to crisis care.
- Strengthen early identification and intervention for 0-5’s focusing on attachment and early development.

Key Metrics and Measures

- 94% coverage of MHST’s and teams in training*.
- Increase the % of CYP receiving first contact within 6/12/18 weeks.
- % CYP mental health episodes with a paired outcome measure recorded.

2028-31 – Priorities

- Mobilise waves 19 to 21 to ensure full coverage of MH support teams.
- Create an integrated MH pathway that is easy to navigate, reduces fragmentation, and supports CYP at the right level, at the right time.
- Use digital tools and data to enable proactive, needs-led identification, navigation and delivery of MH support through blended models of care.
- Reduce self-harm and suicide risk through a whole-system approach to prevention and crisis response.
- Build strong lifelong foundations through joined-up perinatal, infant and family mental health support (0–5).
- Address inequalities by ensuring mental health support is equitable, culturally responsive and proportionate*.

Key Metrics and Measures

- 100% coverage of MHST’s in training by March 2029*.
- Reduction in CYP emergency department attendances for self-harm.
- Improved uptake of support among families in deprived communities and those under-served by services.

Children and Young People – Neurodiversity

We Will: Ensure ALL neurodivergent children and young people have improved access to early and ongoing support and when needed wait no longer than 28 weeks for assessment and diagnosis by 2029.

Case for Change: The current service model is diagnosis rather than needs-led, meaning individuals are not getting the early support they need. The number of referrals to assessment services significantly exceeds commissioned capacity, leading to long and growing waiting times. Right to choose referrals to Independent Sector Providers is increasing, however this offers a variable experience for patients, with some experiencing incomplete pathways and difficulty receiving subsequent support through NHS services.

There has been a lack of investment into NHS provision in terms of capacity for assessment, as well as digital technology to streamline processes and improve communication with parents/carers and families.

Our aim is to improve the identification and access to early and ongoing support for neurodivergent Children and Young People. This includes the roll out of the Knowing Me profiling tool to identify needs early, multi-disciplinary triage of referrals, standardised stratification, streamlined assessment processes and more comprehensive ongoing support.

Inequalities: there is significant variation in access and waiting times across Cheshire and Merseyside, in particular when accessing independent sector provision, where waiting times are significantly shorter. This means some of our most complex patients are waiting the longest.

Financial: increased noncontract activity on Right to Choose activity, creating financial pressure.

Other Services: unmet and delays in meeting need impacts on the NHS (e.g. urgent care/MH demand) and wider society (e.g. school attendance, youth offending behaviour).

2026-27 – Priorities

- Continue implementation of needs-led pathway across all Places.
- Complete rollout of Knowing Me profiling tool including digital version.
- Address gaps in early / ongoing support.
- Agree and pilot shared care framework.
- Consistent implementation of stratification tool for waiting lists and streamlined assessment.
- Develop digital tools to support patients while waiting.
- Expand capacity for assessment inc. within CAMHS.
- Develop lead Provider model.

Key Metrics and Measures*

- Increase number of staff trained and number of profiling tools completed.
- Increase number of patients accessing early support.
- Reduce number of patients referred on for assessment following triage.
- Reduce numbers on waiting list by 30%.
- Reduce average waiting time for assessment.
- Reduced independent sector spend.
- Eliminate over 52-week waits.



2027-28 – Priorities

- Embed new model across all Places including profiling tool.
- Roll out shared care framework and annual reviews in primary care.
- Further enhancements to needs-led community-based support including alternatives to medication.
- Implement digital tools that improve patient access and experience and provider and system efficiency.
- Ensure an integrated offer for patients under MH services with ADHD/Autism.

Key Metrics and Measures 2026-27 metrics and measures plus

- Reduce number of patients on waiting list by 20%.
- Shared care uptake.



2028-31 – Priorities

- Eliminate over 52-week waits.
- Continue to balance needs-led support, primary and secondary care provision.
- Consider further expansion of care model to support wider neurodevelopmental need.

Key Metrics and Measures Ongoing metrics as outlined 2026-28 plus

- Number of patients triaged for diagnostic assessment.
- Eliminate waits for assessment of over 28 weeks.

*Note: baselines and targets to be confirmed.

11. Living Well

- Mental Health
- Learning Disability & Autism
- Neurodiversity
- Diagnostics
- Community Pharmacy
- General Practice
- Optometry
- Planned Care
- Primary Care Dental
- Stroke
- Women's Health



Mental Health (Adults Page 1 of 2):

Case for Change: In line with the 10 Year Plan we are continuing a programme of reform to transform services with the aim of putting mental health on an equal footing to physical health. The plan continues the expansion of a mental health urgent and emergency care offer and the development of community-based services, aligning this to neighbourhood health. We will apply the proposed modern service frameworks for severe and enduring mental illness and dementia alongside enhanced support to reduce ill-health related inactivity, as well as a focus on digitalisation, prevention and tackling health inequalities.

Inequalities: 1 in 4 adults experiences at least one diagnosable mental health problem in any given year. People in all walks of life can be affected at any point in their lives. Mental health problems represent the largest single cause of disability in the UK.

Financial: reduced spend on clinical interventions, such as inpatient care, will allow for investment in community services. Talking Therapies and Individual Placement and Support, along with community and preventative services, will support people to remain as economically active as possible.

Other Services: Reductions in unnecessary attendances at A&E and improved access to primary care support and preventative care helping support more people in community settings with access to social care and housing support when needed.

*Medium Term Planning Framework (metric/measure or narrative).

We Will: Ensure support is provided for people with mental health needs, improving their health outcomes and ensuring access to services meeting their needs.

Our ambitions are:

- Fewer people with a mental health need will require inpatient care and present to services in crisis.
- More people with a mental health need will be supported to in the community and close to home.
- The health outcomes and life expectancy of people with mental health needs will be improved.

2026-27 – Priorities

- Build on existing mental health Urgent and Emergency Care (UEC) plan to scope single offer for C&M.*
- Improve the care and treatment of individuals who require an intensive and assertive approach from health services.
- Ensure parity on discharges to reduce numbers who are Clinically Ready for Discharge (CRFD) in MH inpatient beds.
- Use ring-fenced funding to support the delivery of effective courses of treatment within Talking Therapies and expand Individual Placement and Support (IPS).

Key Metrics and Measures

- Reduce the number of Mental Health A&E attends by 50% from 24/25 base.
- 50% reduction in >12 hour and > 24 hour MH waits in A&E.
- No inappropriate out-of-area placements.*
- Reduce length of stay and delayed discharges (50% reduction).
- Increase Reliable Improvement Rate for Talking Therapies to 69% and Reliable Recovery to 51%.*
- Increase access to IPS based on agreed recovery plan.*

2027-28 – Priorities

- Continue to develop single health UEC offer.*
- Assertive outreach care and treatment expansion.
- Maintain focus on reducing CRFD and lengths of stay.
- Expand NHS Talking Therapies and Individual Placement and Support in line with planned growth.

Key Metrics and Measures

- As a minimum, subject to further guidance, maintain delivery in reduced A&E attendances and achieve MH waiting time standards, out of area placements, length of stay and CRFD.*
- Increase Reliable Improvement Rate for Talking Therapies to 70% and Reliable Recovery to 52%.*
- Increase access to IPS in line with trajectories (as determined by future guidance).*

2028-31 – Priorities

- Implement single Cheshire and Merseyside mental health UEC offer.*
- Assertive outreach care and treatment expansion.
- Expand NHS Talking Therapies and Individual Placement and Support in line with planned growth.
- Implement capacity management software and digitised Mental Health ACT (MHA) pathways by 2030.

Key Metrics and Measures

- Comprehensive mental health UEC offer to support system, including for Type 1 Emergency Departments.
- Expand NHS Talking Therapies and Individual Placement and Support in line with planned growth.*
- 100% coverage of Assertive Outreach Care and Treatment.
- Increase Reliable Improvement Rate for Talking Therapies to 71% and Reliable Recovery to 53%.
- Increase access to IPS in line with trajectories.*

2026-27 – Priorities

- Develop a model for an integrated inpatient and community mental health rehabilitation offer.
- Implement the personalised care framework.
- Develop 24/7 Neighbourhood Mental Health Centre in Cheshire West.
- Review HACT housing recommendations and co-produce plans to implement where possible without additional resource.
- *Develop a common approach to management of complex mental health and s117 cases.*
- *Develop a C&M plan to respond to the Modern Service Framework for mental health when published.*
- Ensure mental health practitioners across all providers undertake training and deliver care in line with the *Staying safe from suicide* guidance.
- Improve control of “slow stream” Acquired Brain Injury (ABI) and neurorehabilitation pathways to reduce clinical and financial risk.
- Develop options to reduce reactive spend on mental health secure transport.

Key Metrics and Measures

- Reduction in out of area, spot purchased and locked rehabilitation placements for mental health rehabilitation.
- Establish first 24/7 neighbourhood mental health centre.

2027-28 – Priorities

- Commence delivery of integrated inpatient and community mental health rehabilitation model.
- Develop a further four 24/7 Neighbourhood Mental Health Centres.
- Deliver a common approach to management of complex mental health and s117 cases across Cheshire and Merseyside.
- Commence implementation of Cheshire and Merseyside plan to deliver the Modern Service Framework for mental health.
- *Staying safe from suicide* embedded in provider’s training offer.
- Enhance collaborative approaches for improved control of “slow stream” Acquired Brain Injury (ABI) and neurorehabilitation pathways.
- Implement options to reduce reactive spend on mental health secure transport.

Key Metrics and Measures

- Sustained reduction in out of area and spot purchased rehabilitation placements for mental health rehabilitation. Move to zero locked rehabilitation placements.
- Establish next four 24/7 neighbourhood mental health centres.

2028-31 – Priorities

- Full implementation of integrated inpatient and community mental health rehabilitation model.
- Develop a further four 24/7 Neighbourhood Mental Health Centres to ensure one in every place by March 2029.
- Common approach to management of complex mental health and s117 cases across Cheshire and Merseyside fully implemented.
- Continue implementation of Cheshire and Merseyside plan to deliver the Modern Service Framework for mental health.
- Responding to impact of MHA Reform.

Key Metrics and Measures

- No out of area, spot purchased and locked rehabilitation placement for mental health rehabilitation.
- Establish final four 24/7 neighbourhood mental health centres.



Learning Disability and Autism:

Case for Change: Improving care and support for people with a learning disability and autistic (LDA) people is part of a national programme known as Transforming Care. It covers people with a learning disability and autistic people of all ages. Reducing inpatient numbers through increased discharges and admission avoidance, through improved community support. Improved access to health checks, primary care services, and appropriate prescribing will improve outcomes. There is also learning from the lives and deaths of people with a learning disability and autistic people (LeDeR).

Impact:

Inequalities: People with a learning disability and autistic people too often experience avoidable health inequalities and can also be inappropriately admitted to mental health hospitals for long periods. People with a learning disability are dying on average nearly 20 years younger than people without a learning disability. Almost 2 in 5 deaths are avoidable.

Financial: reduced spend on expensive clinical interventions, such as inpatient care, will allow for investment in community services.

Other Services: Improved access to primary care and prevention. More people maintained in community settings with social care and housing support as appropriate.

*Medium Term Planning Framework (metric/measure or narrative).

We Will: Ensure comprehensive support is provided for individuals with autism and learning disabilities, improving their health outcomes and ensuring access to necessary services.

Our ambitions are:

- Fewer people with a learning disability and autistic people will need mental health inpatient care.
- More people with a learning disability and autistic people will be supported to in the community and close to home.
- The health outcomes and life expectancy of people with a learning disability and autistic people will be improved.

2026-27 – Priorities

- Reduce longest lengths of stay in mental health hospitals.*
- Reduce admissions to mental health hospitals for LDA & Autism.*
- Improved management of packages of care in community settings.
- Develop an integrated inpatient and community rehabilitation offer within transition.
- Adult Dynamic Support Databases to be fully established to meet revised Mental Health Act (MHA).
- C(E)TRs fully coordinated to meet MHA.
- Agree new delivery model for LeDeR.
- Establish agreed CYP LD Pathway
- Establish new units of LDA Crisis Accommodation.
- Implement and embed Green Light Toolkit.

2027-28 – Priorities

- Reduce longest lengths of stay in mental health hospitals.
- Reduce admission rates to mental health hospitals.
- Continue to develop a Community LDA Crisis /Respite provision.
- Develop integrated community Rehabilitation model for LDA.
- A DSD to be fully commissioned for people with Autism.
- Implement new delivery model for LeDeR.

2028-31 – Priorities

- Reduce longest lengths of stay in mental health hospitals.
- Reduce admission rates to mental health hospitals.
- Established integrated inpatient and community rehabilitation offer.
- To have a fully commissioned/implemented community offer for LDA crisis provision.

Key Metrics and Measures 26-27

- Min 10% year on year reduction in number of people with LDA in mental health inpatient care.*
- Deliver on 75% of Annual Health Checks and complete 100% of Health Action Plans.
- Meet Length of Stay targets for CYP, restricted and unrestricted patients.

2028-31

- Delivery on the Annual Health checks and Health Action Plans.
- Deliver on LOS target for CYP, restricted and unrestricted patients.

Neurodiversity – Adults

Case for Change: Our aim is to improve the identification and support for neurodivergent individuals with an initial focus on a needs-led Attention-Deficit/Hyperactivity Disorder (ADHD) model. The current model is diagnosis rather than needs-led, meaning patients are not getting the early support needed. This drives growth in demand for assessments when not all patients referred for assessment meet a formal diagnosis threshold. The number of referrals for assessment exceeds commissioned capacity, leading to long and growing waiting times.

There are many NHS and Independent Sector organisations providing assessments, which is leading to inconsistencies in the way care is accessed and provided, including provision of partial pathways of care.

Inequalities: there are significant variations in access and waiting times specifically when accessing independent sector provision, where waiting times are significantly shorter, meaning some of our most complex patients are waiting the longest.

Financial: The rising right to choose referrals are driving significant increases in spend on adult ADHD services – from £11 million in 2023/24 to £35 million in 2025/26.

Other Services: unmet and delays in meeting need impacts on the NHS (e.g. urgent care / Mental Health demand) and wider society (e.g. economic inactivity and offending behaviour)

We Will: improve the identification and support for neurodivergent individuals our initial focus will be around a needs led model for those with Attention-Deficit/Hyperactivity Disorder (ADHD).

2026-27 – Priorities

- Continue implementation of needs-led model across all Places, including new primary care service.
- Agree and launch revised shared care framework.
- Consistent implementation of local specification and diagnostic assessment referral criteria.
- Commence repatriation of ongoing treatment to primary care service.
- Revise secondary care provision and stratify secondary care waiting lists.
- First phase of enhancements to needs led community-based support.
- Set Indicative activity plans with providers of assessment services.

Key Metrics and Measures

- 92% of patients referred for diagnostic assessment have their first appointment within 52 weeks of referral.
- 75% of patients report they understand their needs and that they are better met.
- 75% of patients report a positive experience of adult ADHD services.
- 95% of ADHD activity is provided by locally commissioned providers.

2027-28 – Priorities

- Conclude implementation of new model across all Places.
- Shift patients on secondary care waiting lists to primary care service.
- Further repatriation of ongoing treatment to primary care service.
- Further enhancements to needs-led community-based support including alternatives to medication.
- Set Indicative activity plans with providers of assessment services.
- Implement digital tools that improve patient access and experience and provider and system efficiency.
- An integrated offer for patients under MH services with potential ADHD.

Key Metrics and Measures

- % of PCNs operating primary care model.
- Number of patients referred for diagnostic assessment.
- Number of patients on waiting lists.
- Average waiting time for assessment.
- Independent sector activity / spend.
- Shared care uptake.
- Reduction in ADHD treatment costs.

2028-31 – Priorities

- Reducing over 52-week waits.
- Continue to balance needs-led support, primary and secondary care provision.
- Consider further expansion of primary care model to support wider neurodevelopmental need.

Key Metrics and Measures

- As per 26-28 metrics

Diagnostics

Case for Change: We know it is important to our residents to reduce the length of time people wait to be diagnosed and treated and that addressing long waits will support improved outcomes and deliver greater system resilience and performance on behalf of our population.

Rapid access to locally delivered diagnostic services will support earlier intervention and decision making for patients requiring planned care, cancer and treatment for long-term conditions.

Impact: Access to diagnostics is a major source of health inequality, with deprived groups, minorities, and rural populations facing barriers like distance, cost, digital exclusion, and discrimination, leading to later-stage diagnoses, worse outcomes, and underdiagnosis

Financial: Early diagnosis offers significant financial benefits by enabling less intensive, cheaper treatments, reducing the need for costly emergency care, delaying expensive long-term care and unlocking crucial government benefits and support for patients and caregivers, ultimately saving money for individuals, families, and healthcare systems

Other Services: Work to implement straight-to-test pathways will help to reduce avoidable Outpatient appointments. Rapid access to locally delivered diagnostic services will support earlier intervention and decision making for patients requiring planned care, cancer and treatment for long-term conditions

Improving access as part of a multidisciplinary team approach with clinicians from primary, community and secondary care will provide more effective, timely treatment.

*Medium Term Planning Framework (metric/measure or narrative).

We Will: Improve performance against diagnostic waiting times working towards diagnostic services being delivered as a single provision, ensuring service consolidation for critical diagnostics tests whilst ensuring local provision.

2026-27 – Priorities

- Straight to test pathways to reduce avoidable outpatient appts.*
- New service models to minimise risk, maximise efficiency and ensure services are delivered in line with activity and performance and best practice guidance i.e. interventional radiology, phlebotomy, pathology hubs and integration of paediatric and neuro pathology.*
- Deliver the recommendation outlined in the high-level Phlebotomy review including maximum waiting time KPIs.
- Improve the early and accurate diagnosis of respiratory conditions, promote the use of technology and enable more care to move from hospitals to community settings.
- Prioritise diagnostic (including CDC) and treatment capacity for urgent suspected cancer (USC) pathways, stratifying referrals in primary care, identifying alternative pathways and diverting lower-risk people to more appropriate access routes for their condition.*

2027-28 – Priorities

- Service consolidation for critical diagnostic tests to be provided in several sites to ensure local provision but hosted by a single provider.
- Implement networked C&M service model for Interventional Radiology to minimise patient risk, maximise efficiency and ensure that service development in line with guidance.
- Implement recommendations of the review for phlebotomy (inc. standardised commissioning across primary and acute care and standardised Key Performance Indicators (KPI) of max waiting times of 2 weeks for routine patients & 2 days for urgent patients.
- Implement 3 hub pathology service and phased approach of integration for Paediatric and Neuro pathology to ensure maximum efficiency and resilience.
- Implement hub model for Imaging services to fit with Provider Collaborative Blueprint and LAASP plans. Will network services to allow great efficiency.

2028-31 – Priorities

- Move to Diagnostic Services being delivered as a single provision across C&M to include single-hosted services; Hubs could be run by wholly owned subsidiaries.
- Implement a single PTL and diagnostics waiting list across which will be embedded in contracts and coordinated through our collaborative embedding risk stratification to prioritise based on clinical risk and broader population health priorities.
- Mitigate demand growth in excess of agreed growth assumptions, increasing the role of neighbourhood health teams over time.*

Key Metrics and Measures

- Continue to deliver performance of 95% of patients seen within 6 weeks Targeting tests below 95%.*
- 80% of cancer biopsies processed within 10 days.
- 70% of cancer biopsies are processed within 10 days and imaging is reported in line with national guidelines.

Community Pharmacy

Case for Change: Position community pharmacy as the front-line prevention and early intervention service. Described in the 10-year plan, 'from hospital to community' positions the Neighbourhood Health Service, to which community pharmacy will be integral. Contribute to the traditional model of outpatient care and take on new roles in relation to secondary care prescribing – consistent with a shift left approach.

Impact: Pharmacies are flexible health anchors, tackling inequalities, supporting ageing populations, and adapting to growth pressures.

Inequalities: Inequalities concentrated in Core20PLUS5. Rising CVD, cancer, respiratory and mental health burden. Local PNAs highlight different priorities depending on population needs.

Financial: Annual budget £96 million – potential for reduced demand on pressured services.

Other Services:

- CVD: Hypertension case-finding and management, statin adherence, lifestyle support.
- Contributor to weight management and alcohol brief interventions
- Cancer: Early symptom recognition, smoking cessation, mould/mask checks
- Respiratory: Inhaler technique checks, rescue pack optimisation
- Mental Health: Medication adherence, physical health checks
- Neurodiversity: Sensory-aware consultations and tailored medication support
- Pharmacy Needs Assessments (PNA) determine the commissioning of community pharmacy, and the PNA is a statutory local authority function.

*Medium Term Planning Framework (metric/measure or narrative).

We Will: Position community pharmacy as the front-line prevention and early intervention service for Cheshire & Merseyside.

2026-27 – Priorities

- Increase Pharmacy First Consultations.*
- Continue developing the relationships between general practice and community pharmacy to support access to pharmacy services.*
- Introduce prescribing-based services into community pharmacies during 2026/27.*
- Develop and shape role of Community Pharmacy in Neighbourhood health Services.*
- Preventing ill health and supporting wellbeing
- Providing clinical care for patients and system resilience.

Key Metrics and Measures

- Plan total 456,151 consultations (2.9%).
- Clinical Pathway – 155,881 (5.0%).
- Oral Contraception – 57,779 (10.0%).
- Blood pressure – 242,490 (0.0%).

2027-28 – Priorities

- Become the primary access point for prevention.
- Deliver high-volume contact points for underserved groups.
- Act as clinical risk-detector for CVD, cancer, respiratory, mental health.
- Become trusted community anchors in deprived areas
- Act as data-rich contributor to population health management.
- To contribute to the traditional model of outpatient care, and to take on new roles in relation to secondary care prescribing.
- Expand access to emergency contraception through community pharmacies.*

Key Metrics and Measures

- Plan total 464,495 consultations (1.8%).
- Clinical Pathway - 161,337 (3.5%).
- Oral Contraception - 60,668 (5.0%).
- Blood pressure 242,490 (0.0%).

2028-31 – Priorities

- Lead for hypertension case-finding.
- Lead for smoking cessation.
- Contributor to weight management and alcohol brief interventions.
- Provider of rapid access advice for minor conditions.
- Key partner in medicines optimisation and polypharmacy reduction.*
- Single neighbourhood provider and multi-neighbourhood provider contracts referenced in 10-year plan align with refreshed contract for community pharmacy services.

Key Metrics and Measures

- Plan total - Increase
- Clinical Pathway - Increase
- Oral Contraception - Increase
- Blood pressure – Maintain/Increase

General Practice (Primary Medical Services)

Case for Change: Increasing demand for general practice services and gaps between demand and capacity, acknowledging workforce challenges.

Variation of patient experience and key indicators for measuring access to general practice results in an unequal offer for our residents, including in our most deprived wards.

Increasing patient complexity and needs are compounded by remaining barriers between system provider and patient pathways.

Clinical areas: Focus driven by population health data: CVD, Respiratory, Diabetes, Frailty/Falls, Cancer, Immunisations.

Inequalities: Current variation linked to deprivation with both access and clinical outcomes including mortality.

Financial: SDF allocation, local noncore spend, digital and estates spend.

Other Services: Reduction in unnecessary attendances at A&E; referrals to Pharmacy First maximised.

*Medium Term Planning Framework (metric/measure or narrative).

We will: Ensure Primary Care first model of delivery as part of a neighbourhood health offer / Timely access to services for the whole population via a consistent commissioned approach / Harnessing/maximising digital technology to support and improve all outcomes, patient experience and productivity / High quality care driven by measurement of and improvements in continuity particularly for our most vulnerable patients

2026-27 – Priorities

- Complete review of investment streams (SDF/Noncore) and Enhanced Services.
- Establish a consistent, outcomes-based contractual framework of local enhanced services aligning contracts with population health needs.*
- Prioritising use of Advice and Guidance prior to/instead of a planned care referral where clinically appropriate (excluding referrals for urgent suspected cancer).*
- Implement national contract / policy asks, including red tape challenge recommendations.*
- Identify GP practices where demand is above capacity and create a plan to reduce variation in access.*
- Support/underpin neighbourhood working
- Review work to align prescribing incentives in key areas of financial efficiency, medicines safety and antimicrobial stewardship.

Key Metrics and Measures

- 2.2% growth in appointments (Planning guidance) (16,691,997).*
- 90% of appointments within 2 weeks min.
- Measurement of continuity indicators with improvement in-year.
- Number of clinically urgent appts. and % seen same day (Indicative 90%).
- QOF/local quality clinical indicators.
- Patient Experience measures via GPSS and ONS data.*

2027-28 – Priorities

- First full commissioning year of new enhanced offer for PC.
- General practice/neighbourhood health ambitions formalised into an ongoing arrangement, full realisation of impact of new contractual forms implemented during 26/27.
- Delivery/contract methods fully in place to deliver at scale solutions.

Key Metrics and Measures

- 2% growth in appointments.*
- Agreed care plans for patients with complex needs.
- Developing measurement for proactive personalised care.
- Key metrics from new enhanced service offers including clinical targets/areas.
- Developing digital targets.
- Revised June 2025 plan access. variation targets including stretch access targets in deprived areas (TBC).
- Equalisation of access entry modes.
- Shift of £ resources from secondary to primary care.
- Improvements in continuity measures.
- Progress against patient experience measures.*

2028-31 – Priorities

- Digitally-enhanced, team-based model with increased workforce.
- More patient choice in consultation methods (digital/in-person) – including management of medicines online.*
- Focus on complex care and continuity.
- supported by digital methods for triage, and models which better manage growing demands with new technology and tools.
- Realisation of primary care at scale ambitions.

Key Metrics and Measures

- Mix of appointments.
- QOF and local quality clinical indicators.
- Demand and referrals between services as part of NH models.
- Shift of £/f resources from secondary to community/primary services.
- Routine measurement of proactive, personalised care leading to improved outcomes and reduction in avoidable admissions.
- Progress against patient experience measures.*

Optometry

Case for Change: Pressure on hospital eye services and GPs – Reducing unnecessary hospital / GP visits

Prevalence of age-related eye conditions such as glaucoma increasing overall demand for eye care services.

Inconsistency of enhanced services throughout Cheshire and Merseyside leading to disparities based on geographic location.

Underutilisation of key optometry skill set and supporting more preventative work.

Impact:

Inequalities: disparities in eye health outcomes / access to care equalised.

Financial: Local enhanced services, Special Education Settings Services (SES) allocation, General Ophthalmic Services (GOS) budget flexibilities.

Other Services: Unnecessary attendances at A&E, referral pathways into Secondary Care, and reduced presentations at GP surgeries.

Governance route and Exec Lead: System Primary Care Committee Executive Lead Clare Watson.

We Will: Further enable optometrists as first-contact practitioners and expand access supported by high quality eye health pathways delivering better care – with a focus on prevention and early detection.

2026-27 – Priorities

- Improving access to GOS services and delivery quality of care maximising national and local contract opportunities.
- Embed optometry as key part of neighbourhood health plan and priorities.
- Review and expand services for homeless and other vulnerable groups including SES for children.
- Review and embed outcomes and learning from CVD pilot.

Key Metrics and Measures

- SES services outcomes and measures within spec year 1.
- Reduction in GP eye-related consultations.
- Reduced acute presentation for eye-related symptoms in emergency care.
- Specific patient pathway rollout – Glaucoma Enhanced Referral Services (GERS) measurements.

2027-28 – Priorities

- First full commissioning year of enhanced eye care services offer.
- Optometry/neighbourhood health ambitions formalised and in place.
- Implement national contract/policy asks (TBC).
- Year 2 of commissioned schemes for SES and other vulnerable groups.

Key Metrics and Measures

- Eye tests for vulnerable groups.
- SES numbers year 2.
- Reduction in GP eye related consultations.
- Reduction in acute presentation for eye related symptoms.
- Specific patient pathway target (e.g. glaucoma monitoring pathways across all hospitals in Cheshire and Merseyside).

2028-31 – Priorities

- Digitally integrated, community-focused service, shifting more care from hospitals to high streets.
- Expanded roles for optometrists, advanced diagnostics (e.g. remote monitoring), integrated electronic systems (EERS).
- Focus on prevention, supported by better workforce planning and training for a wider scope, including enhanced prescribing and specialist pathways to tackle increasing demand and reduce hospital pressure.

Key Metrics and Measures

- Equitable Access: Reduction in geographic variation for core and enhanced services.
- Reduced Hospital Referrals: Decrease in unnecessary referrals for minor eye conditions to hospital.
- Chronic Disease Management: Improved outcomes in glaucoma/medical retina managed in primary care.

Planned Care

Case for Change: Our NHS Providers are leading work with partners to address clinical, workforce and financial challenges across C&M ICB, reducing the fragility of clinical services and unwarranted variation of quality in care, improving health inequalities across populations and making services more sustainable for the future. This will see us develop and implement a system capacity management process (for adults and CYP) that will significantly increase the level of inter-organisational support provided for elective care, improve utilisation of system assets (mainly elective hubs) and enable the development of a 'business as usual' model for the longer term.

Appropriately manage waiting lists, including thorough validation and the application of referral to treatment guidance and local access policies.*

To implement clinical pathway changes at the point of referral to safely reduce the level of demand on acute services by increasing self-care and utilisation of primary and community-based services to deliver care closer to home.

Inequalities: The consistency of offer and use of analytics to target interventions to those with the greatest clinical benefit will help address current inequalities.

Financial & Other Services: Through streamlining pathways, the total costs of treatment will start to reduce as well as a transfer of resources to prevention and early intervention. This will include the integration of clinical teams across hospital, community and primary care teams to support prevention and early intervention.

*Medium Term Planning Framework (metric/measure or narrative).

2026-27 – Priorities

- Undertake pathway optimisation of Gynaecology, Ophthalmology, MSK, Dermatology and ENT, including community-based options and implementing Single Point of Access and Referral Triage.
- Implement a single PTL and diagnostics waiting list for agreed pathways.*
- Delivery of national efficiency measures including outpatients digital first, patient led model; expanding the use of Advice and Guidance and digital triage tool and follow-up care including access to patient-initiated follow-up (PIFU), remote consultations and digital monitoring.*
- Commissioning a North West Complex Termination of Pregnancy Service.
- Specialised Services specification review.

Key Metrics and Measures

- Every trust delivering a minimum 7% improvement in 18-week performance or a minimum of 65%, whichever is greater (to deliver national target of 70%).
- Reduce the number of people waiting over 52 weeks.
- An increase Advice and Guidance rates baseline to be confirmed.*
- Outpatient follow-up rates improve in line with national standards.*

2027-28 – Priorities

- Expand whole pathway optimisation to further specialties.
- Implement a single PTL and diagnostics waiting list for agreed priority pathways.
- Implement recommendations from Specialised Services specification review.
- Significantly reduce the number of routine, clinically low- value follow-up appointments.*
- Conduct comprehensive reviews of clinic templates and standardising these in line with GIRFTs. specialty-level good practice and job planning guides.*

Key Metrics and Measures

- Achieving the standard that at least 92% of patients are waiting 18 weeks or less for treatment.
- Reduce the number of people waiting over 52 weeks.

2028-31 – Priorities

- Expand whole pathway optimisation to remaining specialties and pathways to have single standard model across C&M.

Key Metrics and Measures

- Improvement in defined population health outcomes in line with our population health needs assessment.
- Maintain delivery of national waiting time standards.
- Upper quartile delivery of NHS efficiency standards across C&M Providers.

Primary Care Dental

Case for Change: NHS dental access remains a major challenge. Contract reform needed to unlock dentistry's role in prevention and Neighbourhood care. Oral health integration supports wider system dividends.

Impact: Improvement of oral health and related benefits to the Cheshire and Merseyside population.

Inequalities: 31.2% of 5-year-olds have tooth decay. Oral health inequalities concentrated in Core20PLUS5. Links to rising CVD, cancer, respiratory and mental health burden.

Financial: £15m ring-fenced dental budget; potential for local "shift left" funding.

Other Services:

- Early oral cancer detection and digital referrals.
- GP cancer referrals routed to urgent dental care.
- Dental homes for vulnerable groups.
- Trauma-informed pathways for SMI; sensory-adapted care for neurodiverse patients.
- Improved outcomes in diabetes and COPD.

*Medium Term Planning Framework (metric/measure or narrative).

We Will: Transform NHS dentistry into a population health prevention platform, expanding access, embedding oral health into neighbourhood models, and shifting resources to where need is highest.

2026-27 – Priorities

- Deliver 46k additional urgent dental appointments against baseline
- Ensure routine access and vulnerable groups.
- Implement dental reforms. Review Units of Dental Activity (UDA) rates to create a fairer system, but with caveats attached for providers* where their UDA rate is increased.
- Implement locally driven quality improvement approaches for dentistry.*
- Prevention and integration of oral health within Neighbourhood services.
- Data Dashboard to encompass end-to-end pathway.

Key Metrics and Measures

- 85% units of Dental activity delivered.*
- 42% of resident population seen by an NHS Dentist (Adults).
- 64.41% of resident population seen by an NHS Dentist (Children).
- 46,617 Urgent Care appointments.*

2027-28 – Priorities

- Deliver 46k urgent dental appointments.
- Ensure routine access and vulnerable groups.
- Develop Dental as a Neighbourhood frontline provider.
- Integrate Dentistry into the Neighbourhood MDT model.
- Develop local PDS contract with core outcome framework.

Key Metrics and Measures

See 26-27

2028-31 – Priorities

- Build shared data flows and shift from "services" to "platforms" driven by population health management.
- Commission through a single provider model, not separately from GP Pharmacy and Optometry.
- Dental as the Neighbourhood's proactive outreach engine.
- Dental to contribute to Neighbourhood level inequalities reduction*

Key Metrics and Measures

- An increase in units of Dental activity
- An increase % of resident population seen by an NHS Dentist (Adults).
- An increase % of resident population seen by an NHS Dentist (Children).
- Outcome measures from local PDS contract.

Stroke

Case for Change: Stroke is a major health challenge in the UK with 152,000 strokes annually, with 1.2 million survivors. It is among the top four causes of death and a leading cause of adult disability. Current care is fragmented, creating health inequalities and inefficiencies. Key Solution: Integrated Community Stroke Service (ICSS) Early Supported Discharge (ESD): Enables specialist rehabilitation at home, reducing disability and improving outcomes. ICSS provides rapid access to hyper-acute units, consistent inpatient therapy, and robust community rehabilitation.

Our ambitions are:

- Improvement of patient-reported experience measures
- Reduction in length of stay in acute inpatient setting.
- Reduction in secondary stroke
- Improved survival and functional independence for patients.
- Faster access to thrombectomy and thrombolysis
- Embed digital imaging and AI (e.g. Brainomix) to support rapid diagnosis and equitable access.

Inequalities: ICSS addresses disparities by proactive screening for high-risk groups (e.g. ethnic minorities, cardiometabolic disease, severe mental illness, learning disabilities).

Financial: ESD can halve inpatient stays, saving ~£325 per patient. ICSS is highly cost-effective (£10,000–£18,000 per Quality-Adjusted Life Year QALY), reducing long-term dependency and admissions.

Other Services: Reduces pressure on acute stroke units and emergency departments. Improves continuity of care, lowers complications, and prevents unnecessary residential placements. Provides psychological and vocational support, reducing mental health referrals. Streamlines therapy provision, minimising duplication and gaps.

*Medium Term Planning Framework (metric/measure or narrative).

We will: Enhance quality of life, reduce long-term disability, and deliver substantial cost savings through integrated, standardised stroke care and delivery of a consistent, high-quality 24/7 thrombectomy and hyperacute stroke pathway across Cheshire and Merseyside in line with the 2023 guidelines.

2026-27 – Priorities

- Establish consistent thrombectomy and hyperacute stroke pathways across all sites.
- Secure commissioning of AI-enabled imaging and review standardised SOPs.
- Gap analysis of current post-discharge rehabilitation services to understand the services better and where inequalities etc. are. Work up of existing “Case for Change” paper.
- Commission a sustainable NROL model to bolster current post-discharge rehab offer.
- Pre-hospital video triage and remote follow-up in selected sites.
- **Increase use of best value and correctly dosed DOACs across the system.***

Key Metrics and Measures

- NROL available at all post-discharge rehabilitation teams across Cheshire and Merseyside.
- Increase in mechanical thrombectomy %.
- SSNAP (Stroke Sentinel National Audit Programme).

2027-28 – Priorities

- Expand community rehabilitation services with equitable access.
- Strengthen secondary prevention programmes (AF detection, hypertension).
- Develop regional workforce plan for stroke specialists.
- Pan ICB-Workforce planning and hub integration.

Key Metrics and Measures

- 10% increase in access to community rehab.
- Prevention KPIs (AF/hypertension) tracked across all sites.

2028-31 – Priorities

- Integrate stroke rehabilitation into ICS community hubs.
- Pilot virtual MDTs for complex cases.
- Implement virtual monitoring with wearables across ICB.
- Scale up digital-first pathways (tele-rehab / NROL, remote monitoring).
- Embed patient-reported outcome measures (PROMs) into routine care.
- Achieve region-wide equity in thrombectomy access and outcomes.
- Deliver measurable reduction in stroke-related disability. Publish regional outcomes report.

Key Metrics and Measures

- 50% of community teams delivering stroke rehab / ICSS.
- Workforce gaps identified and recruitment underway.
- PROMs embedded in 80% of stroke pathways.
- 20% reduction in readmissions.
- Equity in thrombectomy access.
- Reduction in avoidable hospital admissions by 10% by 2031.

Women's Health Services

Case for Change: Women make up over half the UK population and live longer than men yet spend **25% more of their lives in poor health**. Systemic gaps persist – only **7% of healthcare research** focuses on women-specific conditions. Women also face longer waits for care, with those in deprived areas waiting the longest. Gynaecology waits remain among the **second highest in England** (RCOG Elective Recovery Tracker), leading to worsening physical and mental health.

- **Health Equity:** Women experience conditions such as endometriosis, heavy menstrual bleeding, and menopause that are frequently underdiagnosed or undertreated, affecting overall wellbeing.
- **Economic Impact:** Poor health limits participation in work and education, reduces productivity, and increases financial pressures.
- **Quality of Life:** Women spend more years in poor health, affecting their ability to work, care for families, and maintain independence.
- **Systemic Efficiency:** Early diagnosis and preventive care reduce long-term healthcare demand and costs.
- **Social Justice:** Meeting women's health needs is fundamental to fairness and societal progress.

Financial: Reduced resource demand: Long waits (18+ weeks) increase GP visits, prescriptions, and hospital use. System-wide savings: Neighbourhood women's health hubs offer more cost-effective care than reliance on acute secondary services.

Other Services: Less outpatient demand through care in neighbourhood hubs. Fewer A&E attendances through faster diagnosis and treatment. Reduced non-elective admissions via improved clinical pathways.

*Medium Term Planning Framework (metric/measure or narrative).

We will: Ensure timely and equitable access to diagnosis and treatment for key women's health conditions across the life course, addressing health inequalities and informed by women's experiences and needs.

2026-27 – Priorities

- A sustainable neighbourhood hub model to increase the proportion of diagnosis, treatment, and care of conditions managed in the community.
- Expand training for primary care and community professionals supporting early diagnosis, reducing delays, improving care co-ordination and quality of care.
- Implement system-wide Endometriosis pathways across primary and secondary care, enabling early identification and referral, diagnostics, co-ordinated care, and faster access to treatment.
- Support delivery of the National Equity Framework for Menopause and Heavy Menstrual Bleeding.
- Implement women's health group consultations, use of digital platforms to support the delivery of virtual patient clinics, virtual clinician Advice & Guidance and peer support networks.
- Ensure women and girls have input into and access to information on key conditions to support and improve health outcomes.

2027-28 – Priorities

- Increase access to specialist menstrual health and gynae service provision within the community, starting with national 'pioneer' areas for the development of neighbourhood health.
- Strengthen 'train the trainer' model for primary care and community health professionals.
- Develop and implement a collaborative model of care to improve the mental and emotional health of women with key women's health conditions, to help address psychological and emotional impacts alongside physical symptoms.
- **Improve health literacy among women to promote prevention and access to women's health services to help close gaps in health inequalities.***
- Support the roll-out of national and local integrated clinical care pathways developed for key women's health conditions to enable prompt diagnosis and management.

2028-31 – Priorities

- Increase access to specialist menstrual health and gynae service provision within the community.
- Deliver a model of care where health maintenance in the community becomes 'business as usual' with women with specific conditions referred to the right service and seen by the right clinician optimising care.

Key Metrics and Measures 26-27

- Increased HPV and cervical screening rates to achieve national targets.
- Increased utilisation of Advice and Guidance for gynae conditions.
- Reduced number of patients on elective waiting lists for gynaecology.
- Reduced average wait to first appointment for gynae conditions.
- Reduced the proportion of patients waiting over 52 weeks for treatment.
- Meet the 18-week referral to treatment standard by March 2029 for gynae conditions.
- Increased proportion of patients diverted to neighbourhood hubs to receive care.

12. Aging Well

- Prevention of frailty escalation
- Dementia
- Prevention of falls
- Urgent and emergency care



Prevention of frailty escalation

Case for Change: Older people living with frailty are the highest users of health and social care services and have the highest levels of emergency admissions. Our over-75 population is forecast to grow by 45% by 2040.

Our Ambitions:

- Shifts the focus from reactive to proactive care.
- Prevents avoidable deterioration through early identification and intervention.
- Enables timely crisis response when required.
- Supports recovery and rehabilitation close to home, promoting independence and quality of life.

Inequalities: The highest percentage of people living with moderate or severe frailty lives in deprivation quintile one.

Financial: Our frailty population consume 10.7% of the healthcare costs in Cheshire and Merseyside. Older people with frailty are more likely to have a delayed transfer of care. Federated data platform projections identify 45,000 patients at risk of transitioning to high frailty by 2027 at a cost of £266.1m and 106,000 patients at risk of transitions into intermediate frailty by 2027 at a cost of £260.9m.

Other Services: People with frailty are likely to require significant health, social and informal support over a considerably longer period than those dying of a single condition.

*Medium Term Planning Framework (metric/measure or narrative).

2026-27 – Priorities

- Develop the target operating model for system frailty services.
- Map out frailty services across Community and Acute providers, including falls pick-up services, *frailty-at-the-front-door* and care home services.*
- Collect quantitative and qualitative evidence about the impact of existing services.
- Implementation of the polypharmacy strategy – rapid polypharmacy reviews for the top 200 high-risk patients as per development and deployment of ICB polypharmacy dashboard.*
- Strengthen discharge-to-assess by prioritising frailty cases with reablement needs and embedding discharge planning across the patient journey.

Key Metrics and Measures

- An increase in the percentage of polypharmacy reviews completed for high-risk cohort.
- A reduction in the rates of readmission within 30 days.
- A reduction in people aged 65+ being discharged into long-term care after an acute hospital stay.

2027-28 – Priorities

- Implement standardised frailty screening in primary care, community, ambulance, and acute settings.
- Introduce a frailty 'flag' in the shared care record, accessible to all providers.
- Provide frailty training for all front-line staff in ED, ambulance, primary care, and community teams.
- Develop, agree, and commence implementation of frailty assessment and management guidance for patients with suspected or diagnosed cancer.
- Improve identification of people who may be in their last year of life, increasing the number of end-of-life patients with care plans in place.

Key Metrics and Measures

- An increase in the number of patients screened for frailty within 30 mins of arrival.
- An increase of 15% in the number of people who die who had an end-of-life care plan in place (EPACCS or ACP).
- A reduction in non-elective admissions for patients on gold standards framework (GSF).

2028-31 – Priorities

- Establish co-located multidisciplinary teams delivering prevention, assessment, and ongoing support.
- Ensure universal access to strength and balance programmes, nutrition support, and loneliness interventions.
- Implement real-time frailty data dashboards to track performance, outcomes, and health inequalities.*
- Redirect a proportion of acute expenditure to early intervention and prevention programmes.
- Complete phased roll-out of frailty assessment and management guidance for patients with suspected or diagnosed cancer.

Key Metrics and Measures

- Achieve a 10% reduction in non-elective admissions for patients 65+ with frailty.
- Achieve a 15% reduction in length of stay for patients 65+ with frailty.
- A reduction in patients 65+ being discharged onto pathway 3 after an acute hospital stay.

Dementia

Case for Change: In line with the NHS Long Term Plan and the C&M Dementia Strategy (2025–2030), we are continuing a programme of reform to transform mental health and dementia services, ensuring parity between mental and physical health. Dementia is a growing public health challenge, with over 35,000 people currently living with dementia in C&M and prevalence projected to rise significantly over the next decade.

Our ambitions are:

- Fewer people with dementia will require inpatient care or present in crisis, through proactive support, virtual wards, and urgent community response.
- More people with dementia will be supported in the community and close to home, via integrated neighbourhood teams, social prescribing, and assistive technology.
- Health outcomes and quality of life for people with dementia will be improved, reducing inequalities and enabling people to live well with dignity and purpose.

Inequalities: Significant disparities exist in diagnosis and support, particularly for deprived communities, global majority populations, LGBTQ+ individuals, and those with Young Onset Dementia. Rural isolation and digital exclusion further widen gaps.

Financial: Investing in prevention, early diagnosis, and community-based support will reduce reliance on costly inpatient care and avoidable hospital admissions.

Other Services: Plans will reduce unnecessary A&E attendances and improve urgent care through virtual wards and UCR services. Integrated neighbourhood teams will strengthen links with social care, housing, and voluntary sector support, enabling people to live well in their communities.

2026-27 – Priorities

- Improve Diagnosis and close diagnostic gaps through Dementia 100 toolkit analysis, expand timely care home diagnosis using DiADeM, standardise physical checks and neuroimaging.
- Enhance Access and Involvement – providing clear guidance on dementia services and establishing Place-level involvement groups for people with dementia and carers.
- Strengthen Post-Diagnostic Support – Implement shared care protocols and minimum standards and promote NHS Talking Therapies for ongoing support.
- Improve Hospital Care and Transitions – Deliver delirium protocol training and embed improved hospital discharge and transition planning.

Key Metrics and Measures

- Achieve ≥67% Dementia Diagnosis Rate.
- Increase timely diagnosis in care homes.
- Ensure person-centred care plans for all diagnosed individuals.
- Reduce avoidable hospital admissions.
- Embed dementia risk messaging in NHS Health Checks.
- Operational Place-level involvement groups and complete Equality Impact Assessments.

2027-28 – Priorities

- Training – Roll out tiered training across health, social care, and the third sector, with targeted programmes for unpaid carers, palliative care staff, and Young Onset Dementia support.
- Prevention – Embed messaging into NHS Health Checks and campaigns, supported by an ICB dashboard to identify at-risk populations and targeted monitoring through frailty pathways.
- Personalised Care – Improve development and annual review of personalised care plans, ensuring consistent standards.

Key Metrics and Measures

- Achieve 80% workforce completion of tiered dementia training across health and social care.
- 100% of NHS Health Checks include dementia risk messaging.
- 90% of people with dementia have an annually reviewed care plan.
- Reduce social isolation among people with dementia (Place-level surveys).

2028-30 – Priorities

- Promote engagement in dementia research and embed NICE guidelines.
- Commission services for underserved populations and implement health inequality plans.
- Awareness campaigns in schools, universities, and public events, alongside peer-led storytelling and counselling initiatives.
- Grow Dementia Action Alliance, deliver inclusive toolkits, and host cross-sector summits to strengthen partnerships.
- Prepare for disease-modifying treatments, embed integrated palliative care models with seamless end-of-life coordination and bereavement support.

Key Metrics and Measures

- Growth in Dementia Action Alliance and dementia-inclusive organisations.
- Equality Impact Assessments and tailored services for underserved groups.
- Increased participation in research and readiness for disease-modifying treatments.
- Reduction in emergency admissions for dementia-related crises and improved end-of-life care.
- Annual audit of performance and equality metrics – strategy refresh for post-2030.

Prevention of falls

Case for Change: Falls in over-65s creates a significant burden on both the individual, their family and the health and care system through loss of independence, injury and death, hospital admissions and a precipitating factor for a person going into long-term care. Need to develop a single pathway for frailty and falls across Cheshire and Merseyside with a clear plan for commissioning these services consistently across C&M in partnership with local authorities and the VCFSE sector

Impact:

Inequalities: People aged 65 and over have the highest risk of falling, with around half of those aged 80 plus falling once a year. A third of falls emergency admissions live in the 20% most deprived communities.

Financial: Falls-related emergency admissions in over-65s cost £116 million in 24/25. Opportunity to improve case finding to ensure at risk patients are identified and receive interventions to prevent progression. FDP projections identify 45,000 patients at risk of transitioning to high frailty by 2027 at a cost of £266.1m and 106,000 patients at risk of transitions into intermediate frailty by 2027 at a cost of £260.9m.

Other Services: Falls increase a person's risk of losing their independence and can therefore create a significant burden on both informal care demand and formal adult social care services. Taking this approach is key to improving patient outcomes, reducing demand on secondary care and releasing funding to invest in community.

We will: Reduce falls-related hospital admissions –

Our ambitions are:

- To ensure all patients 65+ opportunistically have their history of falls assessed
- 100% of patients with a history of falls receive a comprehensive falls risk assessment
- Increase the number of patients referred to falls prevention interventions

2026-27 – Priorities

Identify programme management capacity and through this capacity:

- Establish a task and finish group to agree the contents of a comprehensive falls risk assessment.
- Map the commissioning of falls prevention services across C&M.
- Develop a standard service specification for falls prevention exercise interventions in C&M.
- Implement a consistent approach to responding to falls and diagnosis in the community.

2027-28 – Priorities

- Develop a standard service specification for falls prevention services in C&M.

2028-31 – Priorities

- Commission integrated community-based falls prevention services across C&M.

Key Metrics and Measures

- Increase in comprehensive falls risk assessments.
- A reduction in falls related emergency hospital admissions.

Urgent and Emergency Care

The Case for Change: Urgent and Emergency Care demand continues to rise earlier in the year, with increasing acuity, complexity and health inequalities. Hospital-centric models are no longer sustainable. Performance challenges in ED waits, ambulance handover delays and delayed discharges reflect system flow constraints rather than isolated provider issues. A step-change is required to shift care upstream, strengthen neighbourhood and community capacity, and deliver safe, timely urgent care.

Impact:

- Improved patient experience and safety.
- Reduced avoidable ED attendances and admissions.
- Improved ambulance response and handover performance.
- Better flow through acute, community and social care.
- Reduced health inequalities and unwarranted variation.

Inequalities:

- Targeted approaches for frailty, Children and young people and high intensity users. Improved access to urgent care alternatives in deprived and rural communities.

Financial and other services:

- Reduced non-elective length of stay. Improved productivity through reduced escalation and stranded patients. Better use of community and intermediate care / virtual capacity.
- Reduced reliance on premium escalation measures.
- The Shaping Care Together Programme remains a key priority, reviewing urgent and emergency care (UEC) services across Southport, Formby and West Lancashire.

*Medium Term Planning Framework (metric/measure or narrative).

2026-27 – Priorities

- Stabilise 4-hour and 12-hour ED performance through early senior decision-making, SDEC-first pathways, redirection and streaming.*
- Strengthen urgent care alternatives (UTC, NHS 111 CAS, mental health crisis response) to reduce avoidable ED demand.*
- Enhance early decision-making and same-day options for CYP, including improved front-door streaming, paediatric advice/assessment outside ED, and clearer CYP mental health crisis routes.*
- Improve Category 2 ambulance response times and reduce handover delays
- Deliver proactive joint health-and-care risk assessment for frail populations.*
- Optimise intermediate care capacity, prioritising home-first and reducing acute/community length of stay.*
- Embed system-wide UEC leadership and shared data discipline.
- Implement a single North West Adult Critical Care Transport Service.
- Agree and plan implementation from Shaping Care Together Review.

Key Metrics and Measures

- $\geq 82\%$ 4-hour A&E by March 2027 (no month below 80%).*
- Reduce patients >12 hours in ED by 20%.*
- Reduce paediatric Type 1 attendances by 5% and achieve $\geq 80\%$ of CYP streamed to an age-appropriate pathway/same-day assessment.
- Category 2 mean response time ≤ 25 minutes.*
- Reduction in corridor care by 50%.
- Reduced adult G&A occupancy trajectory aligned to <92%.
- Reduce NCTR to 12%.

2027-28 – Priorities

- Shift from stabilisation to sustained improvement.
- Deliver whole-pathway frailty models at scale, including prevention, same-day assessment and community follow-up.*
- Scale neighbourhood urgent care to support left shift. Fully integrate urgent care, intermediate care and community services within neighbourhood teams.*
- Redesign UEC for CYP, expanding same-day assessment and age-appropriate alternatives to ED.*
- Embed home first and discharge to assess as standard practice.
- Strengthen integrated working with local authorities and VCSFE partners.
- Reduce reliance on escalation beds and reactive surge responses.
- Embrace new standards and guidance including Model Emergency Department and clinical operational standards for the first 72 hours in hospital.*

Key Metrics and Measures

- 85% 4-hour standard as the annual average.*
- Reduce patients spending >12 hours in ED by further 20%.*
- Reduced delayed discharges and stranded patients.
- Category 2 mean response time <20 mins*
- Reduce NCTR to 10%.
- Intermediate care bed base LOS in line with best practice (<21 days).

2028-31 – Priorities

- Deliver a fully left-shifted, neighbourhood-led urgent and emergency care model with hospital care reserved for those who need it most.*
- Prevent avoidable crisis through proactive, neighbourhood-based care.
- Embed personalised urgent care for frailty, CYP and high-intensity users
- Deliver resilient, equitable urgent care aligned to population need.
- Operate UEC as one system, using shared data, improvement discipline and system accountability to sustain performance.
- Move from recovery to high-performing, sustainable UEC services.
- Accelerate the transition to a more structured, digital-first model, with appointments and scheduling according to clinical prioritisation.*

Key Metrics and Measures

- Sustained $\geq 85\%$ 4-hour A&E performance.*
- Category 2 mean response time ≤ 18 minutes, with 90% within 40 minutes.*
- Reduced emergency admissions per 1,000 population.
- Reduced inequalities in urgent care access and outcomes through a reduction in attendances from patients in IMD 1-4 (To confirm %).*
- Consistent system resilience with minimal escalation periods.

13. Dying Well

- Palliative and End of Life Care (PEOLC)



Palliative and End of Life Care (PEOLC)

Case for Change: The number of people who die each year is expected to rise from around 27,000 to 34,000 by 2035. Most people die from long-term health conditions such as cancer, dementia, heart failure, or liver disease, and rates are expected to rise.

Rates for identifying people likely to be end of life and agreeing Advance Care Plans are below ambition. Rates vary greatly from locality to locality and practice to practice.

The proportion of people dying in hospital is higher than the national average – and the gap is getting wider. Cheshire and Merseyside is the 7th highest area (out of 42) for this key metric.

Unplanned hospital activity in the last 3, 6 and 12 months of life is higher than the national average. Put simply, too many people attend A&E and are admitted unnecessarily.

Inequalities: There are significant differences in life expectancy, outcomes and experience dependent on deprivation, ethnicity, disability and learning disability.

Financial: Each year Cheshire and Merseyside ICB spends at least £300m on unplanned hospital care for people in their last 12 months of life.

Other Services: Unnecessary attendances at A&E: We know that the 27,000 people who died in C&M in 2023 attended A&E around 60,000 times in their final 12 months of life. Non-Elective Admissions (NEL): The number of people admitted, and admitted multiple times, is higher than the national average.

*Medium Term Planning Framework (metric/measure or narrative).

We will: Enable access to good quality end of life care equitably across Cheshire & Merseyside

Our ambitions are:

- 60% of people who die to have been on a palliative care register (referred to as Gold Standards Framework or GSF).
- Our ambition is for 60% of people who die to have had an Advance Care Plan or discussion.
- Our ambition is to reach the England average of proportion of deaths in hospital (currently 42.7%).
- 10% reduction in A&E attendances and Non-Elective Admissions by people in the last 12 months of life by year 5 of the plan.

2026-27 – Priorities

- Development of a C&M PEOLC Strategy.
- Improve early identification and advance care planning.*
- Work in partnership with providers to support and strengthen the learning and development for all staff involved in palliative and end-of-life care.
- Refresh and align commissioning for specialist palliative and end-of-life care, including a review of hospice provision.
- Implementation of aligned ICB contracts and palliative drug stock holding in community pharmacy.

Key Metrics and Measures

- By 2031 60% of people who die to have been on a palliative care register. Year 1 target 37% (Current performance 33%).
- By 2031 60% of people who die to have had an have an Advance Care Plan or discussion. Year 1 target 44% (Current performance is 40%).

2027-28 – Priorities

- Address inequalities in end-of-life care outcomes as outlined in the Population-based Needs Assessment.*
- Transform All Age Continuing Health Care Fast Track pathways into a fully integrated, proactive model offering coordinated 24/7 support.
- Work with General Practice to embed early identification and advance care planning.
- Incorporate babies', children and young people's care in service design: early identification, 24/7 access, and family choice of care setting.

Key Metrics and Measures

- By 2031 60% of people who die to have been on a palliative care register. Year 2 target 41% .
- By 2031 60% of people who die to have had an have an Advance Care Plan or discussion. Year 2 target 48%.
- Place of Death – England average 42.7% year 2 target 45.5% (currently 47.5% of people die in hospital in C&M).

2028-31 – Priorities

- Shared Care Record for PEOLC to be fully interoperable to co-ordinate the wishes of people who are at end of life.
- Ensure palliative care is fully integrated into developing neighbourhood models providing single points of access, treatment escalation plans, and co-ordinated touch points.

Key Metrics and Measures

- 10% reduction in unnecessary A&E attendances by year 5 of the plan.
- Non-elective, and admitted NEL multiple times, is higher than the national average. Our ambition is to meet the national average by year 5 of the plan. (target 60.3% and 6.2%).

14. System Enablers

We have identified the following system wide enablers that support the delivery of our population health plan

- Digital and Data
- Workforce
- Estates and infrastructure
- Governance and Executive accountability



Enablers: Digital and Data

We have identified a number of system wide enablers that support the delivery of our population health plan. Innovation and technology and specifically, Digital and Data is a significant contributor.

The Cheshire and Merseyside Provider Collaborative (CMPC) reset and the creation of a shared multi-year Digital workplan will be a key enabler for the collaborative's priorities. It will enable significant economies of scale; Support a phased consolidation of digital infrastructure and Digital support teams and allow us to organise and deploy our transformation resources more effectively by innovating and scaling faster and more consistently to deliver measurable benefits.

The five-year digital and data roadmap is anchored in the three goals of the Cheshire and Merseyside Digital and Data Strategy which has been in place since 2022.

We Will: Improve health and well-being by weaving our digital and data infrastructure, systems and services throughout our pathways of care.

The five-year digital and data roadmap is anchored in the three goals of the C&M ICS Digital and Data Strategy which has been in place since 2022.

Goal 1

Strong digital and data foundations

We will build the strong foundations on which to deliver our digital and data ambitions for Cheshire and Merseyside

Goal 2

'At Scale' Digital and Data Platforms

'At scale' digital and data platforms, tools and services across C&M, to ensure that a sustainable, standardised technical and data architecture is in place to improve consistency of offer, efficiency and interoperability of solutions

Goal 3

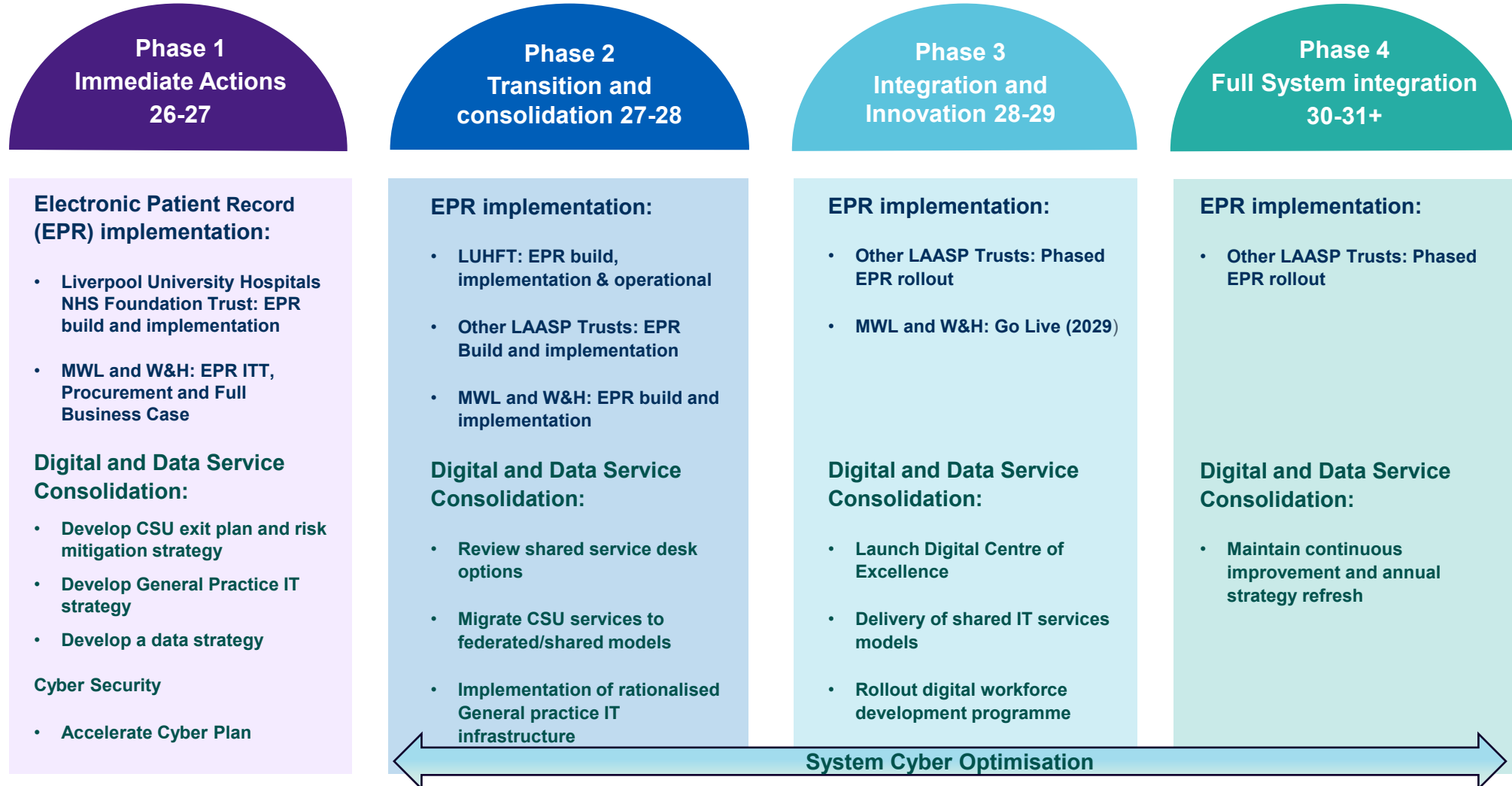
'At scale' Digital and Data Platforms, Tools and Services

Continue to develop and expand its strategic digital and data platforms for use within all health and care providers and at all Places to leverage the benefits of at-scale investment and deliver improved outcomes for the population.

Ensure all parts of our health and care system deliver the digital and data requirements outlined in the NHS Medium Term Planning Framework.

Enablers: Digital and Data

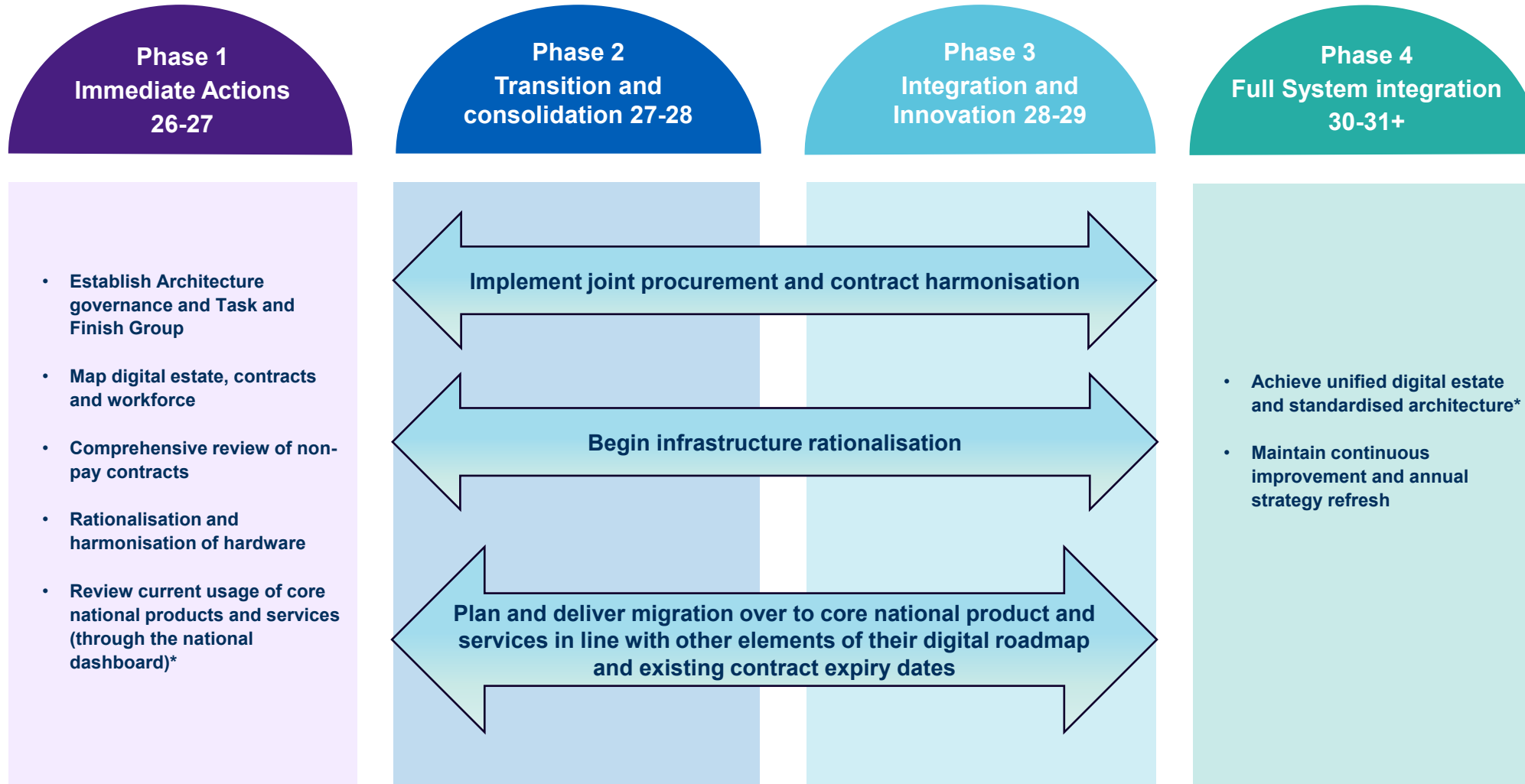
Goal 1. Build Strong Digital and Data Foundations



Enablers: Digital and Data

*Medium Term Planning Framework (metric/measure or narrative)

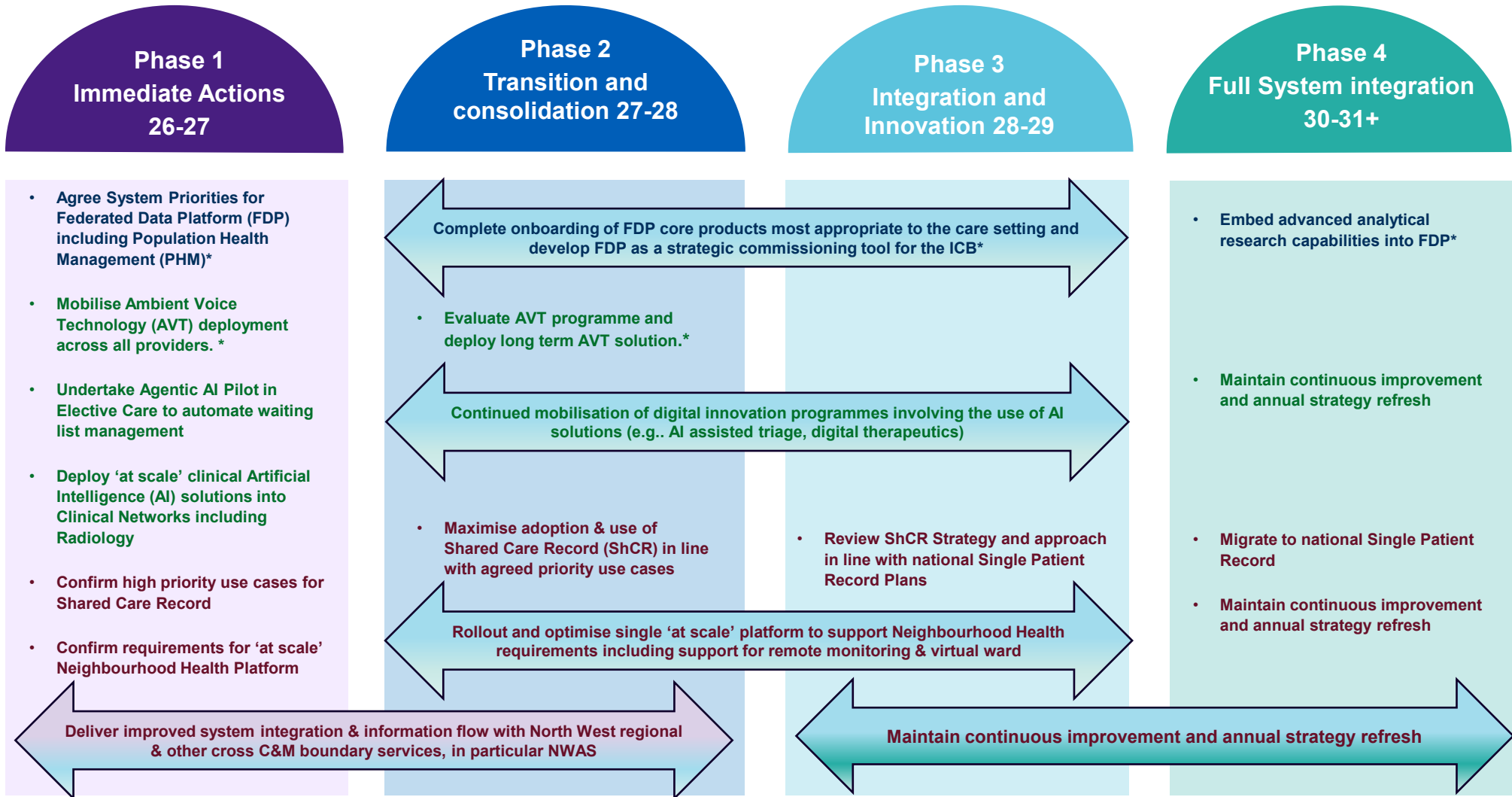
Goal 2. Design and deliver 'at scale' digital and data architecture and infrastructure



Enablers: Digital and Data

*Medium Term Planning Framework (metric/measure or narrative)

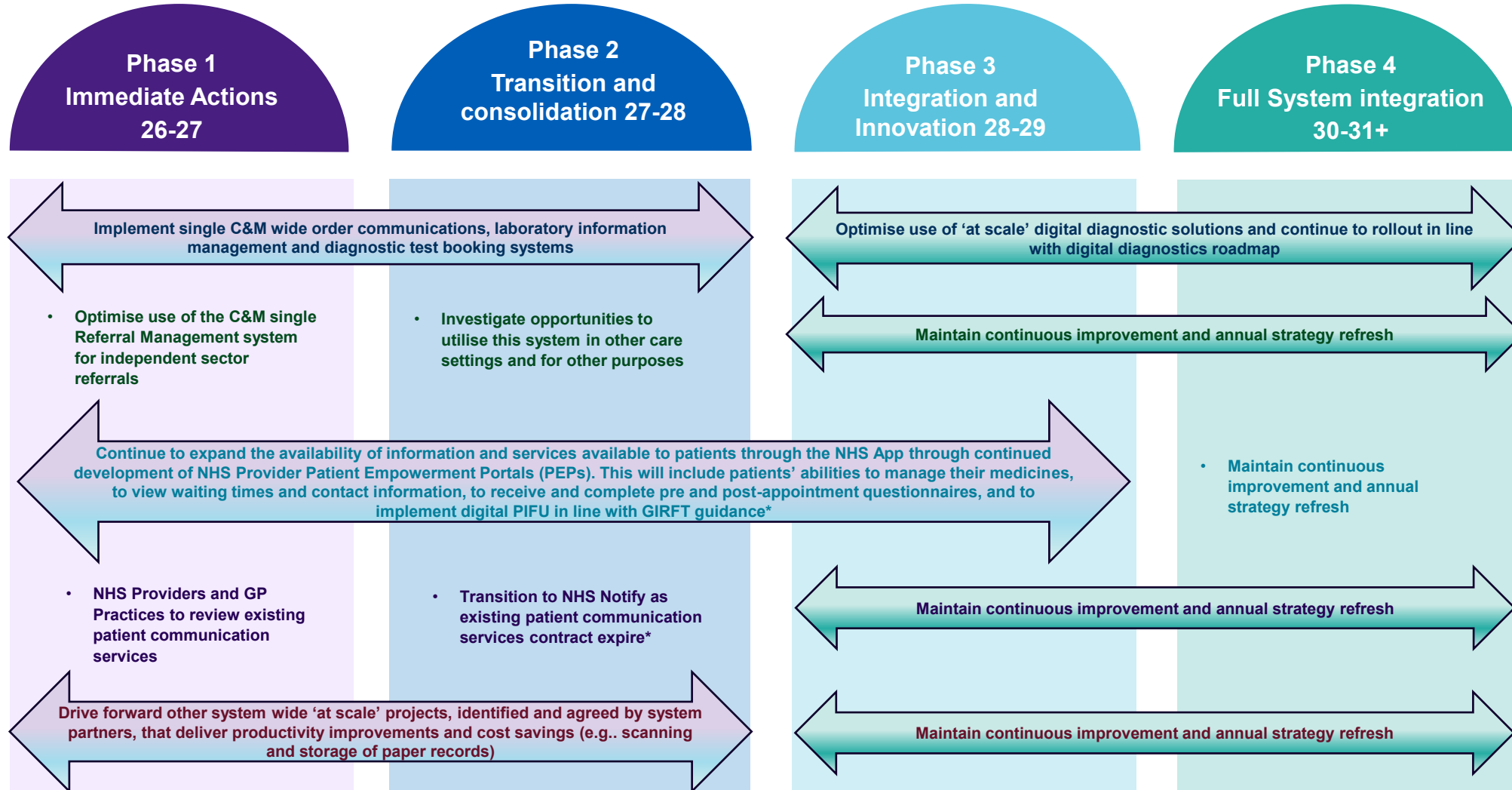
Goal 3. Deploy 'at scale' digital and data platforms, tools and services



Enablers: Digital and Data

*Medium Term Planning Framework (metric/measure or narrative)

Goal 3. Deploy 'at scale' digital and data platforms, tools and services





Enablers: C&M Strategic Workforce Plan

The ambition of our workforce plan:
We Want: Cheshire and Merseyside to be a great place to work and an outstanding place for care; whether in the community, in one of our hospitals or online

The NHS Cheshire and Merseyside ICB system workforce plan frames the workforce as a critical strategic enabler for care closer to home.

It articulates a system-wide ambition to diversify, strengthen and modernise the health and care workforce, enabling a deliberate shift from hospital-centric treatment towards sustained disease management, prevention and personalised, community-based care.

This positions the workforce plan as a catalyst for improving long-term population health outcomes through the:

*Pursuance of affordable workforce models based on supply and demand congruence

*Rationalisation of workforce resources and

* Workforce transformation to support new integrated neighbourhood working models of care.

The NHS C&M ICB System Workforce Plan is supported by the NHSE C&M Workforce Plan: the latter maintaining a specific focus on oversight of acute and secondary care workforce planning.

Affordability

Demand analysis based on population health data, the JSNA and wider health intelligence including the CORE20PLUS5.

Supply and demand planning to achieve optimal affordability and reduced waste across integrated neighbourhood teams.

Workforce gap analysis and remedial action planning to build a futureproof workforce with the capacity and capability to facilitate integrated neighbourhood models of care.

Rationalisation

Rationalisation of non-clinical corporate support services to achieve economies of scale so far as possible.

Workforce redesign to integrate and optimise the benefits of AI, digital capability and technology solutions.

Efficient and effective management of change to maintain clinical quality and safety and optimal wider workforce productivity.

Transformation

Workforce modelling in collaboration with system partners to cultivate integrated neighbourhood multidisciplinary teams.

Workforce innovation informed by epidemiology, public health and the CORE20PLUS5.

Workforce capability planning to enable effective risk management of transitioning from existing to new ways of working.

As an ICB, we will partner with our staff and system partners to deliberately create ways of working that enable human ingenuity to flourish by:

- Setting clear accountability for anti racism and social inclusion.
- Ensuring safe and supportive ways to raise concerns about practices that may harm our staff, patients, or the public.
- Taking a population health approach to staff health and wellbeing.
- Putting people at the centre of how we lead and manage.
- Reducing unnecessary bureaucracy so staff at all levels can take part in decision making through networks or engagement forums.
- Embedding Board level oversight of organisational culture and employee experience, aligned with the NHS Constitution and the Nolan Principles for public service.

To deliver our system workforce plan, we will:

- Look after the health and wellbeing of our workforce
- Cultivate anti-racist and anti-discriminatory ways of working
- Nurture a values-based culture
- Demand personal and communal accountability for health justice
- Create opportunities to learn and continually develop
- Engender civility in the workplace
- Deliver on the NHS People Promise
- Develop psychologically safe places of work where staff can speak up, be heard and challenge without fear of retribution and
- Provide meaningful platforms for staff engagement with organisational decision making.

We want: Cheshire & Merseyside to be a great place to train, work & be an outstanding place for compassionate care; whether in the community, in one of our hospitals or online.

Enabler: NHSE C&M Workforce Priorities

**Immediate Priorities:
Operational Planning
26-27**

- Affordable workforce planning based on supply & demand forecasting, focusing on temporary staffing spend efficiencies & agility.
- Harmonising corporate services & HR&OD through re-design of corporate support functions & incorporating digital solutions for greater efficiency & effective management of resources
- Exploring and understanding root causes of absence – aiming to reduce sickness absence by 1% in 26/27.
- Conducting workforce capacity reviews to understand current ways of working and potential areas of waste, distraction, duplication or efficiency to inform and contribute to delivering 2% average annual productivity growth in 2025/26 and over the Spending Review Period.
- Streamlining People Services across the health economy to achieve economies of scale wherever possible.

**Foundational
Priorities: 27-28**

- Embedding the new National Management and Leadership framework and programmes which actively contribute to delivering the strategic ambitions laid out in the 10-year Health plan.
- Creating close alignment and collaborative working with quality improvement teams and Professional Leads to ensure clinical and professional standards and safe staffing thresholds are met, with a particular focus on Maternity workforce and Mental Health investment standards.
- Overseeing accountability for the performance of the NHS People Promise to ensure we care for those who care.
- Ensuring understanding and quantification of reasonable workloads and that longer term effects on individuals and teams are recognised and addressed within financial recovery plans.

**Foundational
Priorities: 27-28
Continued...**

- Generating good employment opportunities for our local populations through apprenticeship pathways in hard to fill roles.
- Understanding future skills requirements and building responsible talent and progression pathways.
- Protecting student and learner placement opportunities, and appropriate trainer/supervision and education & training capacity required for longer term staffing needs.
- Adapting skill mix and accelerating functional redesign activities, maximising the utility of new and non-medical consultant roles.
- Conducting robust workforce establishment reviews and demonstrating robust establishment control measures.
- Accelerating robust Job Planning and rostering practices to enhance sustainable and agile deployment. Building in flexibility and ownership for staff as well as enhanced pay cost forecasting.

**Longer Term
28-31+**

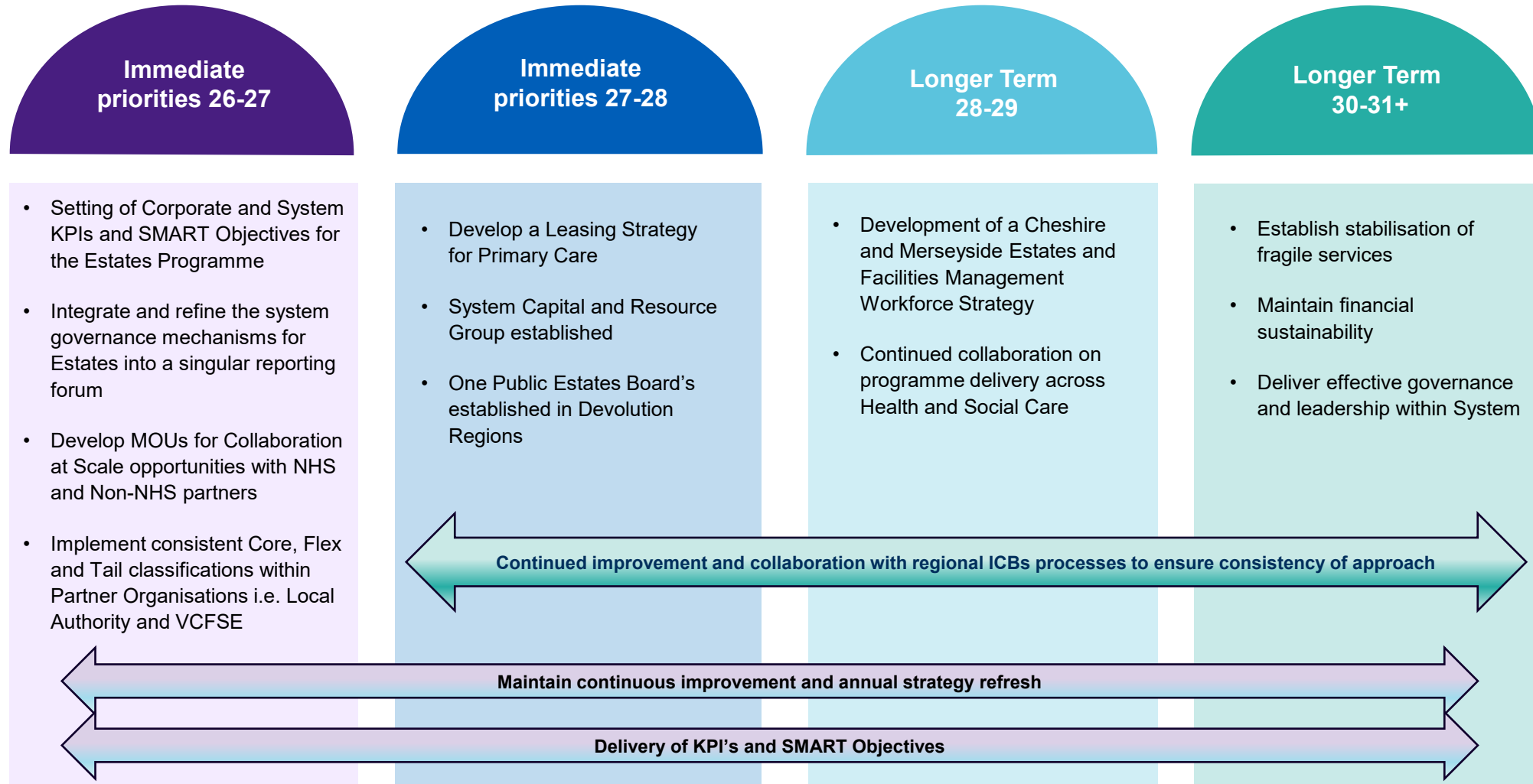
- Delivering national ambitions to enhance employment from local communities and reduce international recruitment to <10% by 2035.
- Embedding skills aligned to digital and technological capabilities & innovation to support efficiency ambitions.
- Translating digital transformation and AI (Artificial Intelligence) integration programmes into readiness and capability programmes for staff.
- Embedding new ways of working, including integrated workforce models, cross-sector, and collaboration across system networks.
- Developing system level solutions to address workforce challenges - prioritising workforce diversity as a key asset in achieving health justice
- Strengthening the interface between hospital and community care pathways, sustaining the transition from hospital to community, treatment to prevention and analogue to digital.

NHS Medium Term Plan - Operational headline targets:

- Trusts to reduce agency and bank use in-line with individual trust limits as set out in planning templates, working towards zero spend on agency by 29/30.
- Annual limits will be set for trusts individually based on a national target of 30% reduction agency in 26/27 and 10% year on year reduction in spend on bank staffing.

Enablers: Estates and Infrastructure

Goal 1 – We will continue to develop and expand the programme; including leadership and governance to enable the delivery of the ICS Infrastructure Strategy



Enablers: Estates and Infrastructure

Goal 2 – Creating fit for purpose, sustainable physical estate

Immediate priorities 26-27

- Outline Business Case Submission of new Neighbourhood Health Centre proposals including, Knutsford, Aintree, Maghull and Handbridge
- Refine the System Estates and Infrastructure Investment Strategy to include Neighbourhood Hub opportunities including identified Pioneer and future Neighbourhood development sites
- Creation of an Estates Asset Management Plan to support better utilisation and cost improvement proposals via disposals
- Develop an Improvement Plan for Modern General Practice where access to the physical Estate is a prevailing factor
- Develop a Utilisation and Optimisation Plan for NHS Property Services and Community Health Partnerships

Immediate priorities 27-28

- Evaluate Full Business Cases for new Neighbourhood Health Centre proposals including, Knutsford, Aintree, Maghull and Handbridge
- Comprehensive review and implementation of a LIFTco End of Concession strategy for our CHP Portfolio
- Support the development of Decarbonisation Plans within Existing Estate
- Develop an ICS Design and Development Standards for New Builds
- Review opportunities for rationalisation and optimisation because of vertical integration (Community to Acute)

Longer Term 28-29

- Deliver New Neighbourhood Health Centres in Key Service Areas including but not limited to: Knutsford, Aintree, Maghull and Handbridge.
- Reduce the level of Tail Estate by 10-15% via rationalisation, optimisation or new investment.
- Support the Full Business Case Submission of a New Hospital for Mid Cheshire Hospitals Foundation Trust (MCHFT)
- Review opportunities for increasing the capacity and provision of existing Community Diagnostic Centres to support more outreach services

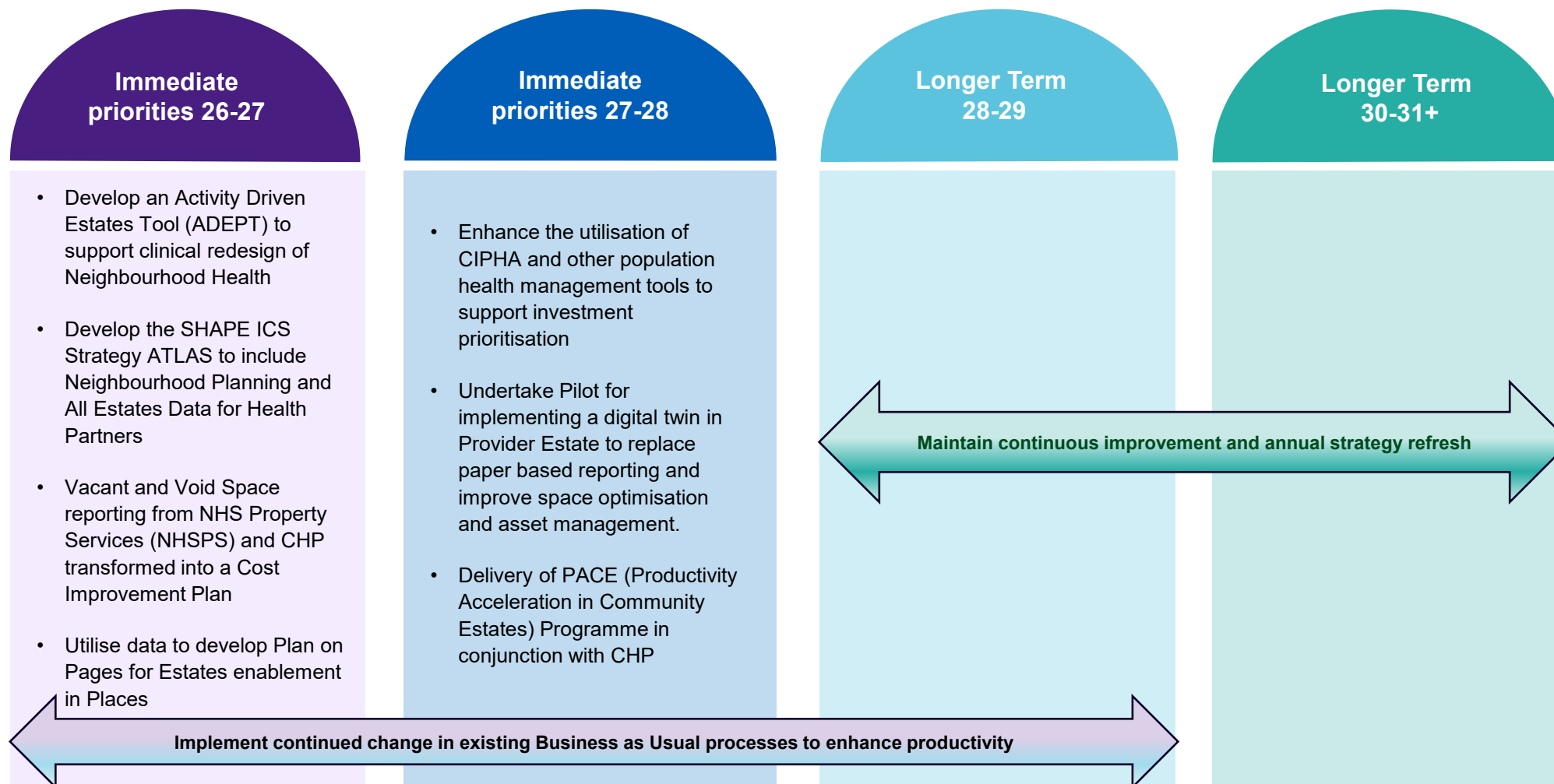
Longer Term 30-31+

- Refresh System Estates and Infrastructure Investment Strategy
- Continue improving access to service and health outcomes
- Completion on construction on the New Hospital for Mid Cheshire Hospitals Foundation Trust (MCHFT)

Deliver Neighbourhood Health Centre's (existing or new)

Enablers: Estates and Infrastructure

Goal 3 – Data Driven Approach



Governance and Executive Accountability Summary

Life Course Stage	Programme	Committee (Programme Board reporting through to ICB Board Sub Committee)	Accountable Executive Director
Living Healthy Lives	<ul style="list-style-type: none"> Cancer Long Term Conditions (Cardiovascular-Renal Metabolic, Respiratory Disease) Healthy Behaviours Screening and Immunisation Outbreak Responses 	Cancer Alliance Board into Strategic Commissioning Committee.	Clinical Director
	<ul style="list-style-type: none"> Serious Violence Duty 	Programmes reporting to Population Health Board into Strategic Commissioning Committee.	Director of Health and Integrated Care Commissioning
Starting Well	<ul style="list-style-type: none"> Maternity and Neonatal Care 	Programme Board into Strategic Commissioning Committee.	Clinical Director
Growing Well (Children and Young People)	<ul style="list-style-type: none"> Neighbourhood Health and accountable care approaches Mental Health Neurodiversity Joint Commissioning and Partnerships 	Programme Board into Strategic Commissioning Committee. <i>(Review to be undertaken for system CYP Governance including development of ACO)</i>	Director of Health and Integrated Care Commissioning
Living Well	<ul style="list-style-type: none"> Mental Health (including community) Learning Disability & Autism Neurodiversity (Adults) Integrated Neighbourhood Teams Community Services Elective (Planned) Care Diagnostics 	Programme Board into Strategic Commissioning Committee.	Director of Health and Integrated Care Commissioning
	<ul style="list-style-type: none"> Primary Care (General Practice, Dental, Optometry and Pharmacy) 	Primary Care Committee.	
	<ul style="list-style-type: none"> Stroke Women's Health 	Programme Board into Strategic Commissioning Committee.	Clinical Director
Ageing Well	<ul style="list-style-type: none"> Prevention of Frailty Escalation Dementia Falls Prevention Urgent and Emergency Care 	Programme Board into Strategic Commissioning Committee.	Director of Strategy and Transformation
Dying Well	<ul style="list-style-type: none"> End of Life and Palliative Care 	Programme Board into Strategic Commissioning Committee.	Clinical Director
Enablers	<ul style="list-style-type: none"> Digital and Data 	Programme Boards to Strategic Commissioning Committee.	Clinical Director
	<ul style="list-style-type: none"> Workforce 	<i>Notes: ICB role in Workforce has changed and arrangements need confirming from 21 April.</i>	TBC
	<ul style="list-style-type: none"> Estates and Infrastructure 	<i>Capital decisions via Finance Investment and Resources Committee</i>	Director of Finance and Contracting

Glossary

- ABC = Atrial fibrillation, high Blood pressure and Cholesterol
- ACO = Accountable Care Organisation
- ADHD = Attention Deficit Hyperactivity Disorder
- AI = Artificial Intelligence
- AIDS = Acquired immunodeficiency syndrome
- ATLAS = Part of the Strategic Health Asset Planning and Evaluation Tool
- BBV = Blood Born Virus
- CAMHS = Child Adolescent Mental Health Services
- CDC = Community Diagnostic Centre
- CETR = Care Education Treatment Review
- CDif = Clostridioides difficile
- CGM = Continuous Glucose Monitoring
- CHC = Continuing Health Care
- CHP = Community Health Partnerships
- CIPHA = Combined Intelligence for Population Health Action
- CMCA = Cheshire and Merseyside Cancer Alliance
- COPD = Chronic Obstructive Pulmonary Disease
- CVD = Cardiovascular Disease
- CSU = Midlands and Lancashire Commissioning Support Unit
- CYP = Children and Young People
- DIA = Data Into Action
- DiaDEM = Diagnosing Advanced Dementia Mandate
- DOAC's = Direct Oral Anticoagulants
- EDC = Elective Diagnostics Cancer
- EDI = Equality Diversity Inclusion
- ENT = Ear Nose and Throat
- EPR = Electronic Personal Record
- FDP = Federated Data Platform
- FDS = Faster Diagnosis Standard
- FeNO = fractional exhaled nitric oxide
- GIRFT = Getting it Right First Time
- HACT = Housing Associations' Charitable Trust
- HCAI's = Healthcare-associated infections
- HIV = Human immunodeficiency virus
- HPV = Human papillomavirus
- ICU = Intensive Care Unit
- IHA = Initial Health Assessment
- IHO = Integrated Health Organisation
- IMD = Index of Multiple Deprivation
- INT = Integrated Neighbourhood Team
- ITT = Invitation to Tender
- KPI = Key Performance Indicator
- LA = Local Authority
- LAASP = Liverpool Adult Acute and Specialist Providers

Glossary

- LD&A = Learning Disability and Autism
- LeDeR = Learning from lives and deaths programme
- LGI = Lower Gastrointestinal
- LIFTco = Local Improvement Finance Trust Company
- LUHFT = Liverpool University Hospitals NHS Foundation Trust
- LOS = Length of Stay
- LRTI = Lower respiratory tract infection
- LTC = Long Term Conditions
- MDT = Multi-disciplinary Team
- MMR = Measles Mumps Rubella
- MOU = Memorandum of Understanding
- MSK = Musculoskeletal
- MWL = Mersey and West Lancashire Teaching Hospitals NHS Trust
- NDH = Non-Diabetic Hyperglycaemia
- NEET = Not in Employment Education or Training
- NEL = Non-Elective
- NROL = Neuro-Rehabilitation On-line
- NWAS = North West Ambulance Service
- OPIC = Office of the Public Independent Conciliator
- PCN = Primary Care Network
- PCRS = Primary Care Respiratory Society
- PHIP = Population Health Improvement Plan
- PTL = Patient Tracking List
- PREM's = Patient-Reported Experience Measures
- PROM's = Patient Reported Outcome Measures
- PTL = Patient Tracking List
- QaLYS = Quality-Adjusted Life Years
- RPA = Robotic Process Automation
- SABA = Short-Acting Beta-Agonists
- SEND = Special Educational Needs
- SHAPE = Strategic Health Asset Planning and Evaluation
- ShCR = Shared Care Record
- SMART = Specific, Measurable, Achievable (or Attainable), Relevant, and Time-bound
- SOP = Standard Operating Procedure
- SRO = Senior Responsible Officer
- STB = Supervised Teeth Brushing
- STT = Straight to Treatment
- TB = Tuberculosis
- UNICEF BFI = United Nations Children's Fund UK Baby Friendly Initiative
- VCFSE = Voluntary Community Faith Social Enterprise
- VPD = Vaccine Preventable Disease
- W&H = Warrington and Halton Teaching Hospitals NHS Foundation Trust

PUBLIC – Board of Directors
31st March 2026

Report	Agenda Item 22.	Equality, Diversity and Inclusion Annual Report						
Purpose of the Report	Decision	X	Ratification		Assurance	X	Information	X
Accountable Executive	Vicki Wilson			Chief People Officer				
Author(s)	Liz Pritchard			Deputy Chief People Officer				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			X	Link to BAF 4 - People and BAF 8 – Governance. This recognises the potential impact of workforce EDI on staff experience (particularly those with protected characteristics) and the Trust requirement to comply with statutory reporting requirements.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health						X	X
CQC Domains	Safe Effective Caring Responsive Well led						X	X
Previous considerations	<p>Following discussion and support at the People and Culture Sub-Committee in September 25, the People Committee received and approved the following reports for publication in October 25</p> <ul style="list-style-type: none"> - Workforce Race Equality Standard - Workforce Disability Equality Standard - Gender Pay Gap Report <p>Following discussion and support at the People and Culture Sub-Committee in January 26, the People Committee received and approved the following report for publication in February 26</p> <ul style="list-style-type: none"> - Equality Delivery System – Domains 2 and 3 							
Executive summary	<p>This report presents the Trust’s statutory workforce Equality, Diversity and Inclusion (EDI) reporting for 2025/26 and supports the Board of Directors in discharging its responsibilities under the Equality Act 2010 and the Public Sector Equality Duty (PSED).</p> <p>The Trust is required, as a public sector employer, to complete and publish a range of statutory workforce equality reports on an annual cycle. These</p>							

include the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender Pay Gap reporting and the Equality Delivery System (EDS). Compliance with these requirements is a legal obligation and a key component of effective workforce governance.

This report brings together all statutory workforce EDI reporting completed during 2025/26. It includes the Workforce EDI Annual Report (**Appendix 1**), which sets out the Trust's workforce equality profile, key findings and equality objectives, alongside the WRES and WDES metrics (**Appendix 2**), meeting statutory reporting requirements. All reports have been completed and progressed through appropriate governance routes in line with national guidance.

The report also acknowledges the Trust's responsibilities under the Public Sector Equality Duty in relation to both workforce and patient equality, diversity and inclusion. Workforce EDI is overseen through People governance structures, while patient and service-related EDI is overseen through Quality governance arrangements, ensuring clear accountability and appropriate Board assurance across the Trust's roles as both an employer and a service provider.

The Workforce EDI Annual Report highlights that the Trust's overall workforce profile has remained broadly stable during the year. The Trust continues to have higher representation from ethnic minority groups compared to the local population, reflecting progress in workforce diversity. However, analysis indicates potential under-representation of staff with a disability. The age profile broadly reflects the local community, with some under-representation of those aged 20 and under. In relation to religion and sexual orientation, the workforce demonstrates higher levels of diversity than the local population. These findings provide important context for the priority actions set out within the report.

Analysis of the statutory reports shows progress across a number of areas, with positive movement reflected in several WRES and WDES indicators, indicating that actions taken by the Trust are beginning to have an impact. However, benchmarking against national averages, together with limited improvement in Gender Pay Gap and EDS outcomes, demonstrates that inequalities in workforce experience and outcomes persist. The report also highlights the key priority actions required to address areas where inequalities persist, focusing on reducing experiences of harassment, bullying and abuse; addressing structural barriers to progression; strengthening inclusive leadership and management practices; and improving representation at senior and Board levels.

Taken together, the reports provide transparency on statutory compliance, highlight areas of improvement and ongoing challenge, and reinforce the need for continued, targeted and long-term action to address structural inequalities and support sustained improvement in workforce equality, diversity and inclusion.

Recommendations	<p>The Board of Directors is asked to</p> <ul style="list-style-type: none"> - receive assurance that the Trust continues to meet its statutory duties as an employer in relation to the Equality Act 2010, and the Public Sector Equality Duty. - receive and note the high level summaries of the statutory reporting completed in year - receive and approve the Trusts Workforce EDI Annual Report 2025/26 for publication (Appendix 1) - receive and note the Trusts WRES and WDES metrics for 2025 (Appendix 2)
------------------------	---

Corporate Impact Assessment	
Statutory/regulatory requirements	NHS England Education Contract
Risk	Failure to comply with the Education Contract could result in loss
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not confidential

Board of Directors

1. Introduction

Equality, Diversity and Inclusion (EDI) is integral to the Trust's ability to deliver safe, high-quality care and to sustain a respectful, inclusive and effective workforce. A diverse and inclusive organisation supports better decision-making, improves staff experience and contributes to better outcomes for our population.

This report provides the Board of Directors with assurance that the Trust continues to meet its statutory workforce EDI obligations, while maintaining transparency on progress, areas of risk and priority actions. It brings together statutory reporting completed during 2025/26 with the Trust's wider People and Culture priorities, supporting effective Board oversight.

2. Background

The Equality Act 2010 and the Public Sector Equality Duty (PSED) set out the Trust's legal responsibilities as an employer to eliminate discrimination, advance equality of opportunity and foster good relations across protected characteristics.

NHS organisations are required to demonstrate compliance through a number of statutory workforce equality reports, including the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender Pay Gap reporting and the Equality Delivery System (EDS). The Trust integrates these requirements through a coordinated approach to workforce EDI, supported by clear governance and oversight arrangements.

3. Purpose

The purpose of this report is to provide the Board of Directors with assurance that the Trust continues to meet its statutory duties as an employer under the Equality Act 2010 and the Public Sector Equality Duty.

The report summarises statutory workforce EDI reporting completed during 2025/26 and provides oversight of progress, performance and priority actions. It includes the Workforce EDI Annual Report (Appendix 1), setting out the workforce equality profile and equality objectives, alongside the WRES and WDES metrics (Appendix 2), enabling the Board to oversee compliance, understand workforce experience and monitor delivery of the Trust's People and Culture priorities.

4. Workforce EDI Statutory Responsibilities

The Trusts current compliance with its statutory responsibilities in relation to Workforce EDI is summarised below.

Requirement	Due	RAG Status
WRES Annual Report	October 25	Completed and published
WDES Annual Report	October 25	Completed and published
Gender Pay Gap Data and Report	March 25	Completed and published
EDS 2022	Feb 26	Completed and published
EDI Annual Report (incl Workforce Equality Profile & Equality Objectives)	April 26	In progress

5. High level summary of completed statutory reporting for Workforce EDI

5.1. EDI Annual Report (including the Trusts Workforce Equality Profile and Trust current Equality Objectives)

The EDI Annual Report provides an overview of the Trust's workforce diversity and summarises progress made in advancing equality, diversity and inclusion during the previous year. It is an annual compliance requirement under the Public Sector Equality Duty and is submitted to the Board of Directors for review and approval prior to publication. A full copy of the report is provided at **Appendix 1**.

The report includes analysis of the Trust's workforce diversity profile compared to the local population, with the following key findings:

- Overall staff numbers by headcount and pay grade have remained broadly stable during the year.
- The Trust has increased the ethnic diversity of its workforce and continues to have higher representation from ethnic minority groups compared to the local community; however, data indicates potential under-representation of staff with a disability.
- The age profile of the workforce broadly reflects the local population, with some under-representation of those aged 20 and under.
- In relation to religion and sexual orientation, the Trust's workforce demonstrates higher levels of diversity than the local community, including higher representation of staff identifying as Muslim or Hindu and slightly higher proportions identifying as Gay, Lesbian or Bisexual.

5.2. Workforce Race Equality Standard (WRES) Annual Report

The Workforce Race Equality Standard (WRES) assesses workforce experience and outcomes for staff from ethnic minority backgrounds compared to White staff across nine indicators. The Trust's 2025 WRES submission meets statutory reporting requirements, with full metrics provided in Appendix 2.

In 2025, the Trust demonstrated improvement in five of the nine indicators, indicating that sustained focus on race equality is beginning to positively influence workforce experience. Contributing actions include the establishment of the Race, Ethnicity and Cultural Heritage (REACH) Network, delivery of EDI awareness and development programmes, targeted leadership development, and continued investment in education and professional development, particularly for international colleagues. Despite this progress, benchmarking against national averages shows that the Trust remains below average in seven of the nine indicators, highlighting that significant inequalities persist. Areas of particular concern include experiences of harassment, bullying and abuse, perceptions of equal access to career progression, and representation at Board level.

The Trust will therefore continue to prioritise targeted actions during 2025/26, including:

- Reducing experiences of harassment and abuse.
- Strengthening inclusive recruitment practices, undertaking targeted recruitment for professions/bandings that currently have significant underrepresentation of ethnic minority groups.
- Further develop plans to improve representation at senior and Board levels.

5.3. Workforce Disability Equality Standard (WDES) Annual Report

The Workforce Disability Equality Standard (WDES) measures the experience of disabled staff compared to non-disabled staff across fourteen indicators. The Trust's 2025 WDES submission meets statutory reporting requirements, with full metrics provided in **Appendix 2**.

The Trust demonstrated improvement in eight of the thirteen reported indicators/sub-indicators during 2025, reflecting continued progress in supporting disabled staff. A key contributing factor has been the development and growth of the ENABLED Staff Network, alongside increased promotion of reasonable adjustments, the Enabled Staff Passport and flexible working arrangements.

However, when benchmarked against national averages, the Trust remains below average in eleven of the thirteen indicators, indicating that disabled staff continue to report poorer experiences across several measures, including harassment, career progression and perceptions of being valued. Disabled representation at Board level also remains an area for improvement.

The Trust will therefore continue to prioritise targeted actions during 2025/26, including:

- reducing experiences of harassment and abuse.
- supporting inclusive management practices, including a focus on raising awareness of reasonable adjustments.

5.4. Gender Pay Gap Data and Report

The Gender Pay Gap report provides transparency on differences in average earnings between male and female employees and forms part of the Trust's statutory reporting requirements. The Trust's 2025 Gender Pay Gap submission meets these requirements, with data published in line with national guidance.

Following a reducing trend since 2021, the 2025 results show little change compared to 2024, with the Trust-level average hourly pay gap remaining at 26% in favour of male staff. This reflects the continued concentration of male staff in higher-paid roles and senior clinical posts, alongside a predominantly female workforce overall.

While women are over-represented across all pay quartiles, significant gender pay gaps persist within specific staff groups, notably locally employed doctors, medical and dental consultants, and senior AfC bands (8d and 9). Bonus pay data also shows a gender pay gap in favour of men, largely driven by medical bonus payments and long-service awards.

The Trust recognises that progress in reducing the gender pay gap has plateaued and that further targeted action is required. Priority areas for 2026 include:

- Improving understanding of pay equity within medical and senior roles.
- Addressing structural barriers to progression that contribute to gender pay inequality.
- Using workforce planning, recruitment and development levers to support sustained improvement in gender pay equity over time.

5.5. EDS 2022

The Equality Delivery System (EDS 2022 as it is now known due to a refresh in 2022) is a national framework that supports NHS organisations to demonstrate progress in delivering inclusive services, improving workforce experience and strengthening inclusive leadership. It requires organisations to assess evidence against defined outcomes, engage stakeholders in grading, and publish results in line with national guidance. There are 3 domains as follows.

- Domain 1- Commissioned or Provided Services,

- Domain 2 – Workforce health and wellbeing,
- Domain 3 – Inclusive Leadership.

Trust oversight of Domain 1 travels through Quality governance structures, whilst oversight of Domains 2 and 3 travel through People governance structures.

Domain 1 Questions	Rating	Decision Matrix
1A: Patients (service users) have required levels of access to the service	2	Achieving activity
1B: Individual patients (service users) health needs are met	1.5	Developing activity
1C: When patients (service users) use the service, they are free from harm	3	Exceeding activity
1D: Patients (service users) report positive experiences of the service	1.5	Developing activity

Domain 2 Questions	Rating	Decision Matrix
2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	2	Achieving activity
2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source	2	Achieving activity
2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	2	Achieving activity
2D: Staff recommend the organisation as a place to work and receive treatment	1	Developing activity

Domain 3 Questions	Rating	Decision Matrix
3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	2	Achieving activity
3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	2	Achieving activity
3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	2	Achieving activity

In relation to Domain 1, the Trust is required to review a minimum of 3 services (different to those reviewed in the previous year). For 2025, the services reviewed were as follows.

- Nutrition and Hydration
- Birthing Debriefs/Maternity and Neonatal Voices
- Emergency Department

The grading against metrics involves Healthwatch and neighbouring Trusts as external stakeholders. The process highlighted that the Trust has significant positive workstreams already in place, and these now need to be supported by data collection and analysis specific to protected characteristics. An action plan has been developed and will be monitored through Quality Governance Group.

In relation to Domains 2 and 3, the 2025 grading shows that the Trust has maintained its overall position, achieving outcomes in seven of the eight measures across these domains. The one outcome assessed as *developing* relates to staff advocacy. While improvements in the 2024 NHS Staff Survey were recognised, further sustained progress is required before a higher grading can be applied in line with EDS technical guidance.

Priority areas for continued focus during 2026 include:

- Implementation of the Trust's Zero Acceptance campaign, with improved reporting, analysis and action on harassment, bullying, abuse and violence by protected characteristic.
- Analysis of long-term sickness absence by protected characteristic to identify themes and inform targeted action.
- Evaluation of workforce support interventions to identify impact, share good practice and strengthen feedback loops to staff.

The EDS overall organisation rating for 2025 is 21, equating to an overall rating of 'Developing'. This is a maintained position from 2024.

6. Monitoring and Reporting

Workforce and patient Equality, Diversity and Inclusion governance are overseen through distinct but aligned Board assurance routes, reflecting the Trust's responsibilities both as an employer and as a provider of services.

Workforce (People) EDI Governance

As an employer, workforce Equality, Diversity and Inclusion is overseen through the Trust's Board-level People Committee, where EDI is embedded within the Committee's cycle of business. Delivery of workforce EDI priorities, including actions arising from WRES, WDES, Gender Pay Gap reporting and EDS Domains 2 and 3, is coordinated through the Workforce EDI Integrated Action Plan. Progress against this plan is monitored through People governance structures, with formal reporting to People Committee on a twice-yearly basis, providing assurance on statutory compliance, workforce experience and progress against agreed priorities.

Patient and Service EDI Governance

As a provider of services, Equality, Diversity and Inclusion in relation to patient experience and access to services is overseen through Quality governance structures, with formal reporting to the Quality Committee. This includes oversight of EDS Domain 1 (Commissioned or Provided Services), service-level equality assessments and actions arising from engagement with patients and communities. Actions relating to patient EDI are monitored through Quality Governance Group to ensure alignment with quality, safety and patient experience priorities.

This dual-route approach ensures clear accountability, appropriate assurance and alignment across the Trust's workforce and service responsibilities under the Equality Act 2010 and the Public Sector Equality Duty.

7. Conclusion

Analysis of the statutory workforce EDI reports shows progress across a number of areas, with positive movement reflected in several WRES and WDES indicators, indicating that current actions are beginning to have effect. However, benchmarking against national averages, together with limited improvement in Gender Pay Gap and EDS outcomes, demonstrates that inequalities in workforce experience and outcomes persist. This underlines the need for continued, targeted long-term action to address structural issues and support sustained improvement in workforce equality, diversity and inclusion.

8. Recommendations

The Board of Directors is asked to:

- **receive assurance** that the Trust continues to meet its statutory duties as an employer in relation to the Equality Act 2010, and the Public Sector Equality Duty.
- **receive and note** the high level summaries of statutory reporting completed in year
- **receive and approve** the Trusts Workforce EDI Annual Report 2025/26 for publication (Appendix 1)
- **receive and note** the Trusts WRES and WDES metrics for 2025 (Appendix 2)

Equality, Diversity & Inclusion Annual Monitoring Report 2025-26





Equality, Diversity and Inclusion Annual Monitoring Report 2025/2026

Foreword

We are pleased to present the Trust's Equality, Diversity and Inclusion (EDI) Annual Monitoring Report for 2025/26, which sets out the progress made over the past year and provides an overview of our workforce equality profile.

At the Countess of Chester Hospital NHS Foundation Trust, equality, diversity and inclusion are central to our purpose and values. Our ambition is to be an organisation where everyone feels respected, valued and able to thrive, and where patients and communities experience care that is fair, inclusive and responsive to their needs.



This report highlights the actions taken during 2025/26 to embed EDI across the organisation, alongside areas where progress has been made and where further improvement is required. It also reflects our ongoing commitment to transparency and accountability through statutory workforce reporting and the Public Sector Equality Duty.

While we continue to see positive movement in a number of areas, we recognise that there is more to do to ensure equity of experience and opportunity for all. Our priorities for 2026/27 will build on this work, aligned to the Trust's People Strategy, and will focus on strengthening inclusive leadership, addressing identified inequalities, and ensuring that the voices of our people continue to shape our approach.

I would like to thank our staff networks, trade union colleagues and teams across the Trust who have contributed to this work and supported progress during the year. Their commitment and challenge are essential as we continue to embed equality, diversity and inclusion in everything we do.

Vicki Wilson (She/Her)
Chief People Officer



Contents

1. Introduction	4
2. About the Trust	5
3. Equality, Diversity and Inclusion - Legislative and national requirements	6
4. Trust commitment to Anti-Racism	7
5. EDI Strategic Objectives	7
6. External Accreditations and/or Charter Marks.....	8
7. Key Achievements – 2025/26	8
8. Workforce Equality and Diversity Profile	10
9. EDI Priorities for 26/27	15
10. Governance and Accountability (how the Trust assures itself it is meeting national and statutory requirements)	15



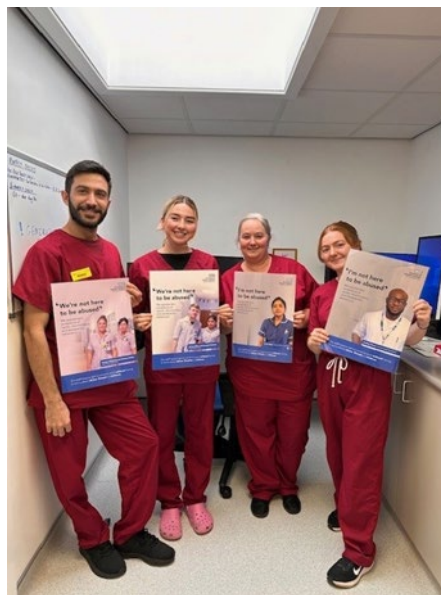
1. Introduction

The purpose of this Annual Equality, Diversity and Inclusion (EDI) Report is to provide an overview of the Trust's progress during 2025/26 in creating an inclusive place to work and receive care, where people are treated fairly, with dignity and respect. It outlines the Trust's approach to EDI and summarises the key strategies, initiatives and actions taken to advance equality across the workforce. The report also presents analysis of workforce diversity across protected characteristics, including comparison with local population data, in line with the Trust's Public Sector Equality Duty.

The key areas covered in this report include:

- **The Trust's approach to Equality, Diversity and Inclusion**, including how EDI is embedded within organisational strategy, governance arrangements and the Trust's People Strategy.
- **Progress and key activity during 2025/26**, highlighting initiatives, actions and areas of good practice that support an inclusive culture and fair experience for staff.
- **Analysis of the workforce diversity profile**, including representation across protected characteristics, pay bands and roles, with comparison to local population data in line with the Public Sector Equality Duty.
- **Future priorities for 2026/27**, setting out the Trust's planned actions to address identified inequalities and support continued improvement in workforce equality and inclusion.

This report supports transparency and accountability in the Trust's approach to equality, diversity and inclusion. While progress continues to be made in a number of areas, the Trust recognises that further work is required to address inequalities and to ensure a consistently inclusive experience for staff and patients. The actions and priorities set out within this report will continue to guide improvement and support the Trust's ambition to be a truly inclusive organisation.





2. About the Trust

The Trust's services are provided from three locations:

- Countess of Chester Hospital providing 473 general and acute beds.
- Ellesmere Port Hospital, providing 60 beds as a rehabilitation, intermediate and outpatient facility.
- Tarporley War Memorial Hospital, a base for community services which serve the local rural population.

The Countess of Chester Hospital NHS Foundation Trust employs approximately 5000 staff to provide care and treatment to a population of over 400,000 people living in Chester and West Cheshire which includes Ellesmere Port and Neston as well as the Deeside area of Flintshire.

The Trust works collaboratively within the wider Cheshire and Merseyside Integrated Care System. Due to its location on the border with North Wales, the Trust also works closely with the Betsi Cadwaladr University Health Board.

The Trust treats patients from England and some parts of Wales. During 2024/2025, there were approximately 643,000 patient attendances (inpatient, A&E, outpatient and diagnostic) ranging from a simple outpatient appointment to major cancer surgery.

Our vision: to achieve outstanding care for our patients and families

Our purpose: to improve the lives of our population by providing safe, kind and effective care.

Our Values:

- **Safe:** avoiding harm and reducing risk to all
- **Kind:** considerate and non-judgemental
- **Effective:** consistently maximising resources to deliver excellent and reliable care.



3. Equality, Diversity and Inclusion - Legislative and national requirements

As an NHS organisation, we have both a moral and legal duty to demonstrate fairness and equality to our patients, service users, workforce and local communities. As a public sector body our legal duties include the following.

- **Equality Act 2010**

Legally protects people from discrimination in the workplace and in wider society. It sets out the different ways in which it is unlawful to treat someone and identifies that it is against the law to discriminate against anyone under the grounds of 9 protected characteristics

- Age
- Disability
- Race
- Sex
- Religion and/or Belief
- Sexual Orientation
- Gender Reassignment
- Pregnancy and Maternity
- Marriage and Civil Partnership

- **Public Sector Equality Duty**

As public sector organisations, all NHS providers are required to demonstrate how they meet the Public Sector Equality Duty as outlined in section 149 of the Equality Act 2010. The general duties of the Public Sector Equality Duty require organisation's to:

1. Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010.
2. Advance equality of opportunity between people who share a protected characteristic and those who do not.
3. Foster good relations between people who share a protected characteristic and those who do not.

- **The Health and Care Act 2022**

This act added an additional legal duty on NHS organisations to consider health inequalities by addressing health inequity and social determinants of health directly. The legislative framework aims to support collaboration and partnership-working to integrate services for patients accessing care. Part of the measures included in the act are around changes to public health, social care, and the oversight of quality and safety.

In delivery of the above legal duties, the Trust is required to participate in and publish results annually in relation to the NHS Equality Delivery System, the Workforce Race Equality Standard, the Workforce Disability Equality Standard, and the Gender Pay Gap Report. All reports have been completed in line with statutory requirements and are available on the Trust website [here](#).



4. Trust commitment to Anti-Racism

The Trust has made a clear anti-racism statement, acknowledging that racism exists within our communities, workplaces and, in particular, within the NHS. We recognise the impact that racism can have on staff experience, wellbeing and patient care, and we are committed to taking sustained action to address it.

Building on the Zero Tolerance campaign launched in 2024, further work was undertaken during 2025/26 to strengthen our approach. This has included the development and implementation of a Violence and Aggression Policy, enhanced staff support resources, and continued awareness-raising activity. Key initiatives during the year also included the celebration of Black History Month, supporting learning, dialogue and engagement across the organisation.

The Trust remains committed to eliminating racism in all its forms and to creating a safe, respectful and inclusive environment where all staff feel valued, supported and able to thrive.

5. EDI Strategic Objectives

Launched in 2023, our current Trust Strategy for Equality, Diversity and Inclusion vision is for the Countess of Chester NHS Foundation Trust to be and feel like a place where we all truly count.

Our strategic objectives commit to achieving the following outcomes:

1. To grow a compassionate and inclusive culture, which is evidenced by our employee and patient voices.
2. To evidence that we can meet the communication needs of patients and others, so that they are able to access all the services we offer.
3. To widen participation in the delivery of Trust services for our local community by increasing employment opportunities across all protected characteristics.
4. To evidence our people are better equipped and feel confident to spot and deal with EDI issues in their day-to-day work.
5. To evidence social disadvantage and health inequalities are addressed by putting EDI at the heart of our institutional processes and decision making.
6. To evidence our commitment for promotion of EDI best practice by being recognised as exemplar in the Northwest Region and beyond.

In November 2025, the Trust ratified a People Strategy 2025 – 2028 that reconfirmed their commitment to continue to develop workforce Equality, Diversity and Inclusion.

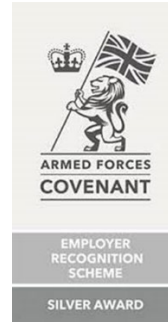
The Strategy outlines 4 key strands along with a broader commitment to creating the countess culture, with Equality, Diversity and Inclusion referenced within both Creating a sense of Belonging and creating the countess culture.

Our commitments within this strategy include that we will foster an inclusive and diverse workplace where every individual feels respected and valued, our people are treated fairly, and any inequalities are addressed. Key actions include strengthening our EDI strategies, ensuring representation at all levels and addressing disparities in recruitment, pay, progression and experience, and increasing awareness campaigns and culture events that highlight and celebrate the diversity of our workforce.



6. External Accreditations and/or Charter Marks

The Trust currently holds the following Equality, Diversity and Inclusion related accreditations and/or charter marks.



7. Key Achievements – 2025/26

- Launched and embedded a Trust approach to Flexible Working
This included a new policy and electronic process, ensuring all staff (including those with a disability or LTC) have access to flexible working to help them stay healthy in work. Over 500 staff have now utilised the new process to formerly request flexible working arrangements.
- Embedding and Extending the Trusts Health and Wellbeing offer for staff with Protected Characteristics
 - Launch of Stream, a financial wellbeing tool, further supporting staff to manage their finances.
 - Continued provision and promotion of the Trusts Employee Assistance Programme
- Targeting Workforce Health Inequalities
A calendar of health and wellbeing events have been delivered in 2025/26, targeting specific workforce health inequalities. These have included the following.
 - Recognizing the disproportionate impact of Diabetes on black and Asian communities, over 600 targeted emails were sent out to staff, with 115 diabetic assessments completed as part of a Diabetes Awareness Event targeting BAME colleagues.
 - Mental Health First Aid Training - Over the past year, our in-house trainer has equipped 43 colleagues with Mental Health First Aid skills. Mental health is embedded in the staff network activities, the Enabled Network held a Mental Health Day event
- Delivery of EDI Training and Awareness Sessions
 - Our overall Trust Equality, Diversity and Human Right Training compliance has remained consistently above target and as of February 26 is at 92%, demonstrating our staff commitment to learning about EDI.
 - Training compliance for LD and Autism Training e-learning has remained consistently above target and as of February 26 is currently at 93%
 - Sexual Safety e-learning has been launched across the Trust for all staff to complete.
 - Ongoing delivery of EDI Training and Awareness Sessions as part of management and leadership development
 - Bespoke sessions on EDI, bystander and unconscious bias training provided to teams and staff groups including to therapies, Ellesmere Port Hospital Staff, and Trust Apprentices.



- The Trust supported 11 members of staff to complete the ethnically diverse leadership course (the Elevate Programme), with a commitment to support a further cohort in line with programme availability.

- Further development of our Trust Staff Networks *staff networks*
 - 7 staff networks now established including the REACH network (formerly the BAME Network), the Women's network, the LGBTQ+ network, the ENABLED network, the Parents and Carers network, the Faith and Belief Network and the Armed Forces and Veterans Staff Network.
 - Increased membership across all staff networks in year
 - Key Staff Network Achievements in year have included the following.
 - Enabled Network – In 2025 the network designed and launched an ENABLED Staff passport, supporting their members to have conversations with their managers regarding adjustments in the workplace to support them in staying healthy in work. The network keep there members up to date via a regular newsletter and have also hosted a Mental Health Awareness Day.
 - The Womens network has recruited new chairs and hosted there first Trust wide event celebrating International Womens Day
 - The Faith and Belief Network have been active in supporting all faiths throughout the year, including the Trusts Muslim staff through facilitating increased. In addition, the Faith and Belief network facilitated increased access for Muslim brothers and sisters to prayer facilities during Ramadan and providing Iftar bags to those staff who are shift for the break of fast.
 - The Armed Forces and Veterans Staff Network has been established with a chair recruited. The network encouraged staff from across both the Countess and Cheshire and Wirral Partnership to mark the Armistice. Working in partnership with the Faith and Belief Network, this was led by the Trusts Chaplain.

- Tackling Violence and Aggression against Staff
Launch of the Trust Violence and Aggression Policy and a refreshed approach to staff support process, including reference to staff with protected characteristics recognising that these staff can be more likely to experience violence, aggression or abuse in the workplace.

- Improved Governance for Workforce EDI
The Trust has developed an integrated EDI Action Plan for workforce that has been designed to ensure a coordinated and visible approach to improving EDI across the workforce. This is reported and monitored via the People and Culture Sub-Committee with bi-annual reporting to People Committee in October and April.



8. Workforce Equality and Diversity Profile

8.1. Diversity Profile and Report Data – Principles

The data used in this report is sourced from Electronic Staff Record (ESR), the Office of National Statistics and the 2021 Census. Within ESR certain protected characteristics may have data quality gaps, where colleagues have been given the option not to disclose. This is a common dynamic across most NHS Organisations. The numbers of colleagues who have experienced formal procedures during their employment, is relatively low, meaning that any comparative analysis will not have high statistical value.

8.2. Workforce Breakdowns

This data below provides insights into how the workforce has changed over the previous twelve months.

8.2.1. Total Staff in Post (Substantive and Bank, including by Pay Grade)

Overall, staff numbers by headcount and pay grade by percentage have remained fairly stable in year. The overall staffing headcount as of 31st December 2025 was 5,853, which is a decrease of 39, (0.7%) from the previous year. The highest numbers of colleagues employed continue to be in Bands 1 & 2 and Band 4 pay bands.

Pay Grade by Headcount

Pay Grade	Headcount 2024	Headcount 2025
Apprentice	16	14
Band 1 & 2	1201	1408
Band 3	314	326
Band 4	1121	1123
Band 5	669	672
Band 6	454	455
Band 7	170	176
Band 8a	43	42
Band 8b	19	25
Band 8c	12	11
Band 8d	8	8
Band 9	19	17
Senior Manager	317	391
M&D - Career Grade	60	59
M&D - Consultant	298	302
M&D - Doctors in Training	1173	824
Trust Total	5894	5853

Pay Grade by Percentages

Pay Grade	Headcount 2024	Headcount 2025
Apprentice	0.27%	0.24%
Band 1 & 2	20.38%	24.06%
Band 3	5.33%	5.57%
Band 4	19.02%	19.19%
Band 5	11.35%	11.48%
Band 6	7.70%	7.77%
Band 7	2.88%	3.01%
Band 8a	0.73%	0.72%
Band 8b	0.32%	0.43%
Band 8c	0.20%	0.19%
Band 8d	0.14%	0.14%
Band 9	0.32%	0.29%
Senior Manager	5.38%	6.68%
M&D - Career Grade	1.02%	1.01%
M&D - Consultant	5.06%	5.16%
M&D - Doctors in Training	19.90%	14.08%



8.2.2. Total Staff in Post – Ethnicity Breakdown

Ethnicity by Headcount

Ethnicity	Headcount 2024	Headcount 2025
BAME	1060	1196
White	4738	4539
Not Stated	96	118

Ethnicity by Percentages

Ethnicity	Headcount 2024	Headcount 2025
BAME	17.98%	20.43%
White	80.39%	77.55%
Not Stated	1.63%	2.02%

Ethnicity declaration rates for the Trust Workforce was around 98% in 2025/2026. This provides increased assurance of accuracy throughout the workforce analysis; gaps in the known status in any of the protected characteristics can hinder statistical analysis.

When compared to the previous year, the percentage of colleagues from a BAME background in our workforce increased by 2.45% from 17.98% to 20.43%. This continues the previous years trend of increasing ethnic diversity within the organisation.

The Trusts workforce BAME representation at 20.43% is significantly higher than the local community percentage population of 4.6 % as per the 2021 Census.

BAME Groupings (Including White - Other)	Headcount 2024	Headcount 2025
Asian	40.93%	41.91%
Black	21.88%	23.16%
Mixed	6.35%	6.27%
Other	5.65%	6.02%
White - Other	25.19%	22.64%

The Asian BAME grouping remains the largest within the Black and minority ethnic profile, accounting for around 41.91% of all BAME staff, followed by Black grouping at 23.16%.

8.2.3. Total Staff in Post – Sex Breakdown

Gender by Headcount

Gender	Headcount 2024	Headcount 2025
Female	4583	4494
Male	1311	1359

Gender by Percentages

Gender	Headcount 2024	Headcount 2025
Female	77.76%	76.78%
Male	22.24%	23.22%

Whilst there has been a slight increase in the number of men employed by the organisation, women continue to make up a significant proportion of the workplace at 76.78%. This is in comparison to the local population where women make up 51.19% of the total population. This trend is not unusual for NHS Provider Trusts, however there is significant variation in the spread of male and female employees across the bands as highlighted within the Trusts Gender Pay Gap Report.



8.2.4. Total Staff in Post – Disability Breakdown

Disability by Headcount

Disability	Headcount 2024	Headcount 2025
No	5024	5000
Not Declared	522	508
Yes	348	345
Trust Total	5894	5853

Disability by Percentages

Disability	Headcount 2024	Headcount 2025
No	85.24%	85.43%
Not Declared	8.86%	8.68%
Yes	5.90%	5.89%

The number of colleagues who indicated they have a disability has remained static in year, with 345 staff declaring a disability equating to 5.89% of the total workforce. 8.68% of staff have not declared a disability, indicating that there may be further work to do to understand why disclosure rates within ESR or lower than some of the other protected characteristics.

In comparison, local population data identifies 17.9% disabled people living in Cheshire West and Chester, meaning that the workforce is potentially underrepresenting the community in its workforce profile relating to disability.

8.2.5. Total Staff in Post – Age Breakdown

Age Band by Headcount

Age Band	Headcount 2024	Headcount 2025
20 & Under	87	67
21-30	1221	1190
31-40	1654	1730
41-50	1248	1225
51-60	1147	1115
61-70	500	487
71 & Over	37	39
Trust Total	5894	5853

Age Band by Percentages

Age Band	Headcount 2024	Headcount 2025
20 & Under	1.48%	1.14%
21-30	20.72%	20.33%
31-40	28.06%	29.56%
41-50	21.17%	20.93%
51-60	19.46%	19.05%
61-70	8.48%	8.32%
71 & Over	0.63%	0.67%

The age profile of the Trust's workforce has remained fairly stable between 2024 and 2025 with slight decreases across all age bands apart from 31-40 and 71 and over age bands.

Local population data identifies the largest age group percentages in the ranges 50 – 64 years and 35 – 44 years that is broadly comparable to the Trusts workforce profile. 4.1% of the local population is aged 16-19 years, indicating that the Trust workforce of 20 & under may be under-representative of the local community.



8.2.6. Total Staff in Post - Religion & Belief Breakdown

Religious Belief by Headcount

Religious Belief	Headcount 2024	Headcount 2025
Atheism	1021	1014
Buddhism	33	35
Christianity	3092	3039
Hinduism	129	140
Islam	153	171
Jainism	1	2
Judaism	7	4
Not Recorded	965	977
Other	486	463
Sikhism	7	8
Trust Total	5894	5853

Religious Belief by Percentages

Religious Belief	Headcount 2024	Headcount 2025
Atheism	17.32%	17.32%
Buddhism	0.56%	0.60%
Christianity	52.46%	51.92%
Hinduism	2.19%	2.39%
Islam	2.60%	2.92%
Jainism	0.02%	0.03%
Judaism	0.12%	0.07%
Not Recorded	16.37%	16.69%
Other	8.25%	7.91%
Sikhism	0.12%	0.14%

Christianity remains the predominant religion or belief at 51.92% a slight decrease from 52.46% in 2024. Those who have not recorded has increased slightly from 16.37% to 16.69%, indicating that there is further opportunity to encourage disclosures relating to this protected characteristic. The 2021 census reports Christianity as the highest percentage religion, with a 54% stating it as their religious belief. 38% of the local population have declared no religion, with 1.0% reporting a Muslim faith and 0.4% reporting a Hindu faith. Whilst the Trusts workforce is representative of the community in relation to Christian faith, the Trust reports higher diversity in relation to Islamic faith and Hinduism.

8.2.7. Total Staff in Post – Sexual Orientation

Sexual Orientation by Headcount

Sexual Orientation	Headcount 2024	Headcount 2025
Bisexual	72	71
Gay or Lesbian	109	105
Heterosexual or Straight	5110	5062
Not Recorded	579	589
Other sexual orientation not listed	11	14
Undecided	13	12
Trust Total	5894	5853

Sexual Orientation by Percentages

Sexual Orientation	Headcount 2024	Headcount 2025
Bisexual	1.22%	1.21%
Gay or Lesbian	1.85%	1.79%
Heterosexual or Straight	86.70%	86.49%
Not Recorded	9.82%	10.06%
Other sexual orientation not listed	0.19%	0.24%
Undecided	0.22%	0.21%

The highest sexual orientation is 'Heterosexual' which has decreased slightly from 2024, 86.70% to 86.49%. There was a small increase noted in the percentage of colleagues who did not wish to disclose from 9.82% in 2024 to 10.06% in 2025. According to the 2021 census, 91.2% of people identify as Heterosexual in the local population, with 1.4% identifying as Gay or Lesbian and 1.1% identifying as bisexual, suggesting that there is slightly higher diversity within our workforce when compared to our local population.



8.3. Diversity Profile – Summary

Overall, the Trust's workforce profile has remained broadly stable during 2025/26, with some areas of positive movement and others where continued focus is required. Ethnic diversity within the workforce has continued to increase, with Black and minority ethnic representation now significantly higher than that of the local population, reflecting the Trust's ongoing success in attracting and retaining a diverse workforce.

The Trust remains a predominantly female workforce, consistent with the wider NHS, with variation in gender representation across pay bands reflected within the Gender Pay Gap analysis. The age profile of the workforce broadly mirrors the local working-age population, although there is some under-representation of younger staff aged 20 and under, indicating an opportunity to further strengthen early-career pathways.

Representation of staff declaring a disability has remained static and continues to be lower than local population levels, highlighting an ongoing challenge around both attraction and disclosure. While disclosure rates for most protected characteristics are relatively high, levels of non-declaration remain more pronounced in some areas, which can limit the depth of analysis and understanding of staff experience.

In relation to religion and sexual orientation, the Trust's workforce demonstrates higher levels of diversity than the local population, with representation broadly reflective of national NHS trends. The Trust recognises the importance of continuing to promote safe and inclusive environments that encourage disclosure and ensure all staff feel supported.

Taken together, the workforce profile demonstrates areas of strength alongside clear priorities for improvement. These findings continue to inform the Trust's EDI priorities and targeted actions for 2026/27, ensuring focus is directed to where it will have the greatest impact.



9. EDI Priorities for 26/27

Our priorities for 2026/2027 will build on the work undertaken in 2025/26, taking into account our People Strategy and the analysis and action planning that has been ongoing during this period. We will:

- Refresh the strategic direction for Workforce EDI that builds on the commitments made within the Trusts People Strategy. This includes
 - Strengthening our EDI Strategies, ensuring representation at all levels and addressing disparities in recruitment, pay, progression and experience
 - Increase awareness campaigns and cultural events that highlight and celebrate the diversity of our workforce
 - Expand and empower staff networks, ensuring diverse voices are heard and influence decision making.
- Take specific actions relating to the feedback from our staff and Trust self-assessment against statutory reporting requirements that will include the following.
 - Further develop and embed Equality Impact Analysis within Trust decision making
 - Further develop and embed a Zero Acceptance campaign in relation to staff experience of Violence, Aggression, Abuse, Racism and Unwanted Sexual Behaviour.

10. Governance and Accountability

The Trust assures itself that it is meeting its national and statutory Equality, Diversity and Inclusion obligations through established governance arrangements that reflect its duties under the Public Sector Equality Duty (PSED) as both an employer and a provider of services.

As an employer, workforce Equality, Diversity and Inclusion is overseen through the Trust's Board-level People Committee, where EDI is embedded within the Committee's cycle of business. Oversight is supported through the People & Culture Sub-Committee, ensuring that EDI is consistently mainstreamed within people governance. Clear executive accountability is in place for the delivery and assurance of workforce EDI priorities.

Accountable Officer for Workforce EDI: Vicki Wilson, Chief People Officer

As a service provider, responsibility for patient Equality, Diversity and Inclusion is overseen through the Trust's Quality Committee, ensuring alignment with quality, safety and patient experience governance. The Trust recognises that focus on patient EDI has been more limited to date and therefore strengthening our approach to patient equality, health inequalities and inclusive service delivery will be a priority area of focus during 2026/27.

Accountable Officer for Patient EDI: Sue Pemberton, Director of Nursing & Deputy Chief Executive

This report has been prepared with thanks to our EDI networks, Workforce Information colleagues, Recruitment colleagues and everyone at Countess of Chester Hospital NHS Foundation Trust.

Appendix 2 – WRES and WDES Reports 2025

2025 WRES Report

The table below shows the Trusts 2024/25 performance against each of the nine WRES indicators, compared to 2023/24 data at national, and Trust level. The RAG rating in the columns illustrates progress or deterioration in the Trust position as appropriate.

Indicator	National average 23/24	COCH 23/24	COCH 24/25	Difference: Trust 24/25 & 23/24.	Difference: Trust 24/25 & national avg 23/24.
1. Percentage of staff from racially minoritised groups.	28.6%	16.6%	18%	1.4%	-10.6%
2. Relative likelihood of white applicants being appointed from shortlisting compared to applicants from ethnic minority groups	1.27	1.47	1.61	- 0.14	- 0.34
3. Relative likelihood of staff from ethnic minority groups entering the formal disciplinary process compared to white staff	1.25	0.29	0.54	0.25	0.71
4. Relative likelihood of white staff accessing non-mandatory training and CPD compared to staff from ethnic minority groups.	1.25	0.80	0.94	0.14	0.31
5. Percentage of staff from ethnic minority groups experiencing harassment, bullying or abuse from patients, relatives, or the public in the last 12 months	23%	34%	34.5%	-0.5%	-11.5%
6. Percentage of staff from ethnic minority groups experiencing harassment bullying or abuse from staff in the last 12 months.	21.5%	32.4%	27.8%	4.6%	-6.3%
7. Percentage of staff from ethnic minority groups believing the Trust provides equal opportunities for career progression or promotion	49.7%	35.1%	37.7%	2.6%	-12%
8. Percentage of staff from ethnic minority groups experiencing discrimination at work from manager/team leader/other colleagues in the last 12 months	15.7%	27.5%	22.6%	4.9%	6.9%
9. Percentage difference between the Trust's Board membership, its overall workforce	16.5%	-17%	-18%	- 1%	28.5%

2025 WDES Report

The table below shows the Trusts 2024/25 performance against each of the 14 WDES indicators, compared to 2023/24 data at national, and Trust level. The RAG rating in the columns illustrates progress or deterioration in the Trust position as appropriate.

Metric	National average 2023/24	COCH 2023/24	COCH 2024/25	Difference: Trust 24/25 & 23/24.	Difference: Trust 24/25 & national avg 23/24.
1. Percentage of disabled staff	5.7%	4.9%	5.7%	0.8%	0%
2. Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants.	0.98	1.56	0.98	0.58	0
3. Relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff.	2.04	0	0	0	2.04
4. a) Percentage of disabled staff experiencing harassment, bullying or abuse(HBA) at work from the public in the last 12 months.	30%	31.3%	33%	1.7%	-3%
b) Percentage of disabled staff experiencing HBA from managers in the last 12 months.	14.6%	17.8%	16.26%	0.86%	-1.66%
c) Percentage of disabled staff experiencing HBA from other colleagues in the last 12 months.	23.8%	25.9%	26.8%	0.9%	3%
d) Percentage of disabled staff saying that the last time they experienced HBA they reported it.	52.5%	53%	51.5%	1.5%	-1%
5. Percentage of disabled staff who believe that the Trust provides equal opportunities for career progression or promotion.	52.2%	41.8%	42.7%	0.9%	-9.5%
6. Percentage of disabled staff who have felt pressure from their manager to come to work despite not feeling well enough.	26.6%	30.5%	27.55%	2.45%	-0.95%
7. Percentage of disabled staff who are satisfied with the extent that the Trust values their work.	36.9%	20.8%	27%	6.2%	-9.9%
8. Percentage of disabled staff saying that the Trust has made reasonable adjustment(s) to enable them to carry out their work.	74.5%	63.24%	65.31%	2.07%	-9.19%
9. a) The staff engagement score for disabled staff.	6.5	5.98	6.19	0.21%	-0.31%
9. b) Has your organisation taken action to facilitate the voices of your Disabled staff to be heard (yes or no)?	N/A	Yes	Yes	N/A	N/A
10. Percentage disabled Board membership.	6.2%	2%	0%	-2%	-6.2%

Committee Chair’s Report

Tuesday 10th February 2026, 13.30 – 16.30, Via Microsoft Teams

Committee	People Committee
Chair	Non-Executive Director, Ms W Williams

Key discussion points and matters to be escalated from the discussion at the meeting:

Alert (<i>matters that the Committee wishes to bring to the Board’s attention</i>)
<ul style="list-style-type: none"> No alerts to raise.
Assure (<i>matters in relation to which the Committee received assurance</i>)
<ul style="list-style-type: none"> Freedom to Speak Up (FTSU) - Request that future reports should detail actions taken, indicate whether concerns were appropriately addressed, and note if unresolved issues were escalated to ensure organisational accountability and transparency in addressing concerns. Further assurance is needed that while FTSU has appropriate processes, it remains unclear what organisational learning has resulted from concerns raised through FTSU. Received the Director of Medical Education Annual Report Received assurance of the implementation of the Resident Doctor 10point plan
Advise (<i>items presented for the Board’s information</i>)
<ul style="list-style-type: none"> Sexual Safety Charter Framework implementation. Sub committee reports were discussed in detail: <ul style="list-style-type: none"> Staff experience was discussed and reported to People Committee, confirming the 2025 approach has been implemented, and strategies to improve the process for 2026 have been identified and are being planned for implementation. Workforce Sub Committee. Acknowledgement of pressures within the organisation and the fragile services currently within the Trust. There are ongoing issues with regards to sickness levels and the need to fill these gaps, emphasising that, in addition to the existing medical risk, a nursing risk is in review. Joint Local Negotiating & Consultation (JLNC) sub committee. One alert from the Chair’s report was highlighted to the Committee regarding rate card application, and a further paper will be taken to Executive Directors Group (EDG) detailing actions to address concerns. Job planning risks and associated cost pressures are being managed. Staff wellbeing risks were noted in relation to the 10-point plan and associated support mechanisms.
Risks discussed and new risks identified
<ul style="list-style-type: none"> There is currently one high risk in relation to medical staffing, which has been upgraded due to challenges associated with changes to the medical rate card and the need to address staffing gaps. It is hoped that this risk can be downgraded in the future; however, this is not currently possible.

PUBLIC – Board of Directors
31st March 2026

Report	Agenda Item 24.	Standing Financial Instructions Review 2026					
Purpose of the Report	Decision	X	Ratification		Assurance		Information
Accountable Executive	Karen Edge			Chief Finance Officer			
Author(s)	Rose Garrod			Chief Financial Accountant			
Board Assurance Framework	BAF 1 Quality						
	BAF 2 Safety						
	BAF 3 Operational						
	BAF 4 People		X				
	BAF 5 Finance		X				
	BAF 6 Capital		X				
	BAF 7 Digital						
	BAF 8 Governance		X				
	BAF 9 Partnerships						
	BAF 10 Research						
Strategic goals	Patient and Family Experience						
	People and Culture						
	Purposeful Leadership						X
	Adding Value						X
	Partnerships						
	Population Health						
CQC Domains	Safe						
	Effective						
	Caring						X
	Responsive						
	Well led						X
Previous considerations	Audit Committee 3 rd February 2026.						
Executive summary	<p>The purpose of this report is to present the annual review of the Trust's Standing Financial Instructions (SFI's) to the Board for approval. The detailed update and full SFIs were ratified by the Audit Committee on the 3rd February for recommendation to the Board of Directors for approval.</p> <p>The SFI's are reviewed and amended annually by consulting various departments, including internal and external audit to ensure that they are current and relevant. This review ensures that the Standing Financial Instructions reflects:</p> <ul style="list-style-type: none"> • Current legislation • Team structure responsibilities. • Current terms of references <p>Once approved by the Audit Committee and Trust Board the new version of the SFI and VPP are uploaded onto the intranet. A mini guide will be updated and circulated to managers.</p>						

Recommendations	The Board of Directors is asked to Approve the changes to Standing Financial Instructions (SFI's) as recommended by the Audit Committee.
------------------------	---

Corporate Impact Assessment	
Statutory/regulatory requirements	Meets the Trust compliance with Foundation Trust Status
Risk	Ensures compliance of Trust rules and regulations by staff
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Document to be published on intranet.

Standing Financial Instructions Review 2026

1. Introduction

The Trust's Standing Financial Instructions (SFI's) set out the financial governance rules for the Trust and as such the Trust is required to review the Standing Financial Instructions on a regular basis to ensure that they remain current and relevant. SFI's have to be ratified and approved by the Trust Board, based on the recommendations from the Audit Committee.

Once approved and ratified by the Board the SFI's are updated on the Intranet to ensure that all staff have access. Training is delivered to all budget holders on a regular basis through the Finance Awareness Training and The Manager Essentials in which the key elements and importance of the SFI's are provided.

2. Background

The review is conducted by consulting with a number of stakeholders including Internal Audit and External Audit, Trust senior managers and Directors. The review also takes account of latest legislation, national guidance and internal audit recommendations.

3. Purpose

The purpose of the review is to ensure that the correct legislation is reflected throughout the document, that the correct roles and responsibilities are up to date and that all issues of financial governance are set out as to who is responsible and at what level.

4. Key changes within the SFI's

The full SFI's including tracked changes were reported to the Audit Committee. A summary of the changes are detailed below:

- The latest Terms of Reference for Audit Committee and Remuneration Committee (including data privacy);
- Changes have been made throughout the document to reflect latest legislation (e.g. Procurement Act 2023; Provider Selection Regime; Failure to Prevent Fraud requirements);
- Change of processes (including waiver processes; Business cases;
- Changes to the wording for External auditor responsibilities.
- Terminology updates (e.g. Department of Health and Social Care; People Committee; Global Internal Audit Standards); and
- Job title/ role changes (e.g. Executive Director portfolios).

The variable pay approval policy was also updated.

Full SFIs including tracked changes are available on request should Board members want to review these.

5. Recommendations

The Board of Directors is asked to **Approve** the changes to Standing Financial Instructions (SFI's) as recommended by the Audit Committee.

PUBLIC – Board of Directors
31st March 2026

Report	Agenda Item 25.	NHS Staff Survey 2025 – Results and High-Level Actions						
Purpose of the Report	Decision		Ratification	X	Assurance	X	Information	X
Accountable Executive	Vicki Wilson			Chief People Officer				
Author(s)	Vicki Wilson			Chief People Officer				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			X	BAF impact is BAF 4 – People Failure to maintain a positive staff experience and strong levels of engagement risks undermining recruitment, retention and staff advocacy. Poorer staff experience is also associated with reduced quality of care and negatively affects patient outcomes. Sustained deterioration may further impact the Trust’s CQC assessment under the Well-Led domain.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							X X X
CQC Domains	Safe Effective Caring Responsive Well led							X X X X
Previous considerations	Operational Management Board – 26 th March 2026							
Executive summary	<p>The 2025 NHS Staff Survey results provide an important indication of colleague experience at a time of sustained operational and financial pressure across the NHS. Five of the nine People Promise domains show no statistically significant movement compared with 2024, suggesting stability in several key aspects of staff experience. However, four domains (those relating to recognition, staff voice, health and wellbeing, and team climate) have deteriorated, reflecting the continued impact of workload, resource constraints and organisational strain. This pattern mirrors the national picture, where only 25 comparator Trusts reported year-on-year improvement.</p> <p>At question level, 84% of responses show no significant change, though notable declines are evident in areas relating to access to materials and equipment, organisational advocacy, health and wellbeing support, and opportunities for learning, development and career progression. By</p>							

	<p>contrast, improvements are seen in flexible working, the reduction in additional paid hours, and appraisal coverage, indicating positive movement in areas where targeted work has taken place.</p> <p>Feedback from staff highlights a mixed picture. There is evidence of strengthening line-management relationships, greater confidence to report incidents, and improvements in flexible working and aspects of inclusion. Alongside this, staff describe increasing work pressure and fatigue, reduced enjoyment, concerns about involvement in decision-making, and diminished confidence that the organisation prioritises patient care and invests in career development.</p> <p>Divisional patterns remain consistent with previous years. Non-patient-facing areas continue to report the most positive scores, while front-line clinical divisions face the greatest challenges in both engagement and morale, reflecting the day-to-day operational pressures in these services.</p> <p>In line with the national planning requirements for 2026/27, the Trust has identified four priority areas where dissatisfaction is greatest and where focused action is expected to have the most impact. These are:</p> <ul style="list-style-type: none"> • Make work feel manageable again • Strengthen staff voice, involvement and the standards we uphold together • Support individual, team and organisational learning • Ensure people feel valued every day <p>These priorities have been informed by detailed analysis of the survey results and shaped by two Trust-wide engagement sessions held with staff on the day the embargo was lifted. Divisional action planning, supported by HR Business Partners, is underway, with progress to be monitored through divisional and People governance arrangements. A consolidated action plan will be presented to People Committee in April 2026.</p>
Recommendations	<p>The Board of Directors is asked to:</p> <ul style="list-style-type: none"> • Note the Trust’s Staff Survey 2025 results • Note the analysis undertaken and areas for action identified. • Agree the Trust priorities identified in section 5 • Take assurance that the Trust continues to engage its staff in the completion of the staff survey, review and analysis of the survey results, and identification of appropriate actions, and will monitor progress via People Committee.

Corporate Impact Assessment	
Statutory/regulatory requirements	CQC/Constitution/other regulation/legislation
Risk	Poor staff experience (BAME and staff with disabilities) risk included on strategic risk register
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Document to be published on as part of agenda/papers pack.

NHS Staff Survey 2025 – Results and High-Level Actions

1 Introduction

The NHS Staff Survey provides an opportunity for NHS organisations to survey their staff in a consistent and systematic way. This makes it possible to build up a picture of staff experience and, with care, to compare and monitor change over time and to identify variations between different staff groups. The Trust recognises the importance of positive staff experience and the impact this has for patients. Our staff survey results provide valuable insight into the experience of staff working within our Trust and supports us in identifying priorities for improvement. The data from our staff survey is available in the public domain and is used by organisations such as the CQC as part of a wider suite of metrics to review and monitor performance.

2 Background

The survey was made available to all staff (including Bank Staff) for completion during the period September to November 2025 using a mixed survey mode of electronic and paper based. To maintain confidentiality, all Trusts are required to use an external survey provider, with the Trust continuing to use IQVIA for the 2025 survey. The results were subject to a national embargo that was lifted on 12th March 26, with benchmarking available for sharing from this date.

Since 2022, Staff Survey results have been mapped against the NHS People Promise, the promise that all NHS organisations and staff working within them make to each other to work together to improve the experience of working in the NHS for everyone. The people promise includes the following 7 elements, with the staff survey also mapped to two additional measures of engagement and morale.



Figure 1 – Visual summary of the NHS People Promise and the additional NHS Staff survey measures of Staff Engagement and Morale

3 Purpose

The purpose of the report is to highlight key observations from analysis of the Trust’s staff survey results and benchmark data, and to provide assurance that the Trust continues to engage its staff in the completion of the staff survey and has identified appropriate actions with the aim of further improving staff experience.

4 NHS Staff Survey 2025 Results

The 2025 Staff Survey results show that five of the nine measured domains (the seven People Promise themes plus Staff Engagement and Morale) showed no statistically significant year-on-year movement, indicating that in over half of the areas assessed, overall staff experience remained broadly consistent with 2024. These were:

- We are compassionate and inclusive
- We are always learning
- We work flexibly
- Staff Engagement
- Morale

The remaining four domains showed statistically significant deterioration, reflecting areas where staff perceptions have shifted more noticeably over the past year, specifically:

- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are a team

These are the areas that tend to be most sensitive to operational and financial pressures, as they reflect how staff feel about workload, recognition, voice in decision-making, and day-to-day team climate, all of which are affected when the system is under strain. These changes align with the national pattern of more challenging staff survey results across the NHS in 2025.

The following sections provide a high-level summary of results, and a full copy of the Trust Breakdown and Benchmark Reports are available via the links below:

<https://cms.nhsstaffsurveys.com/app/reports/2025/RJR-benchmark-2025.pdf>

<https://cms.nhsstaffsurveys.com/app/reports/2025/RJR-breakdown-2025.pdf>

4.1 Completion Rates

In 2025, the Trust achieved a completion rate of 44.34% (-0.2% from 2024, the highest response achieved in 11 years) which was an increase in the actual number of employees who responded compared with 2024. This compares to a national response rate for our comparator group of 47%.

4.2 Benchmarking with Comparator Group

For the purposes of national benchmarking the Trust is compared with 121 other organisations that are categorised as Acute and Acute and Community Trusts.

People Promise elements and themes: Overview Survey Coordination Centre **NHS**

People Promise elements, themes and sub-scores are scored on a 0-10 scale, where a higher score is more positive than a lower score.

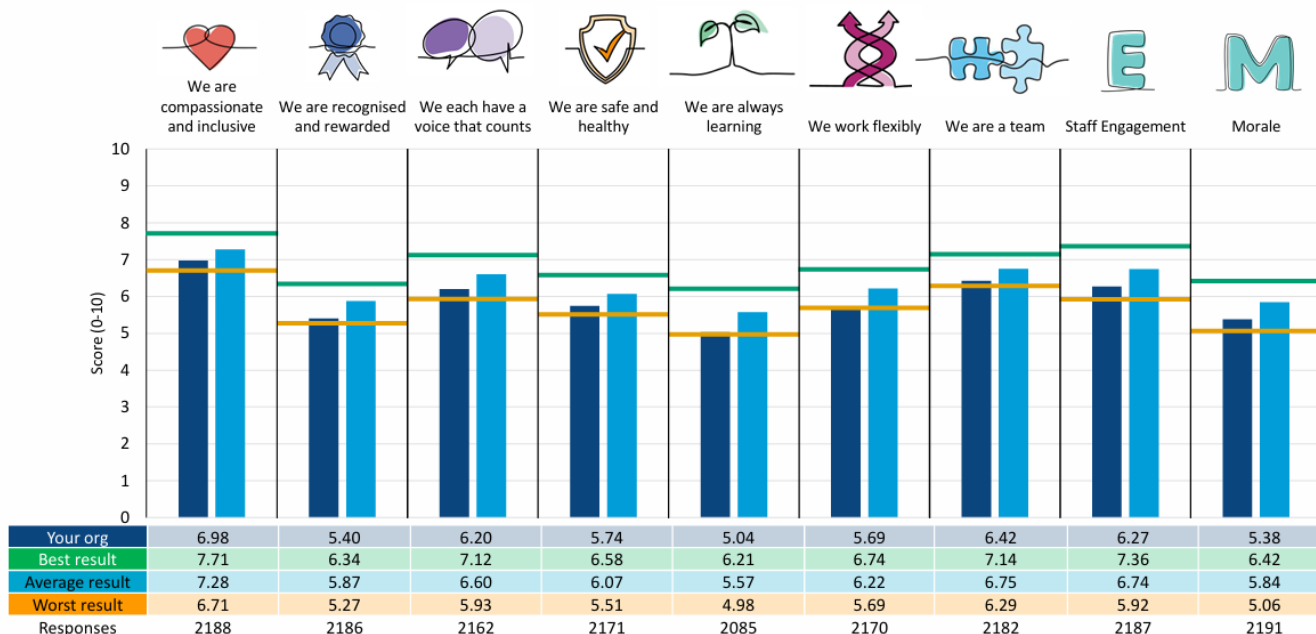


Figure 2. below provide a visual overview of Trust results against our comparator group.

The Trust continues to be below the average for our comparator group across all People Promise elements and themes and is aligned to the lowest score for 1 theme “we work flexibly” however this is the theme where we have seen greatest improvement. The 2025 results overall present an improved benchmarking position from 2023 results where we were the worst performing Trust for 7 out of 9 elements/themes.

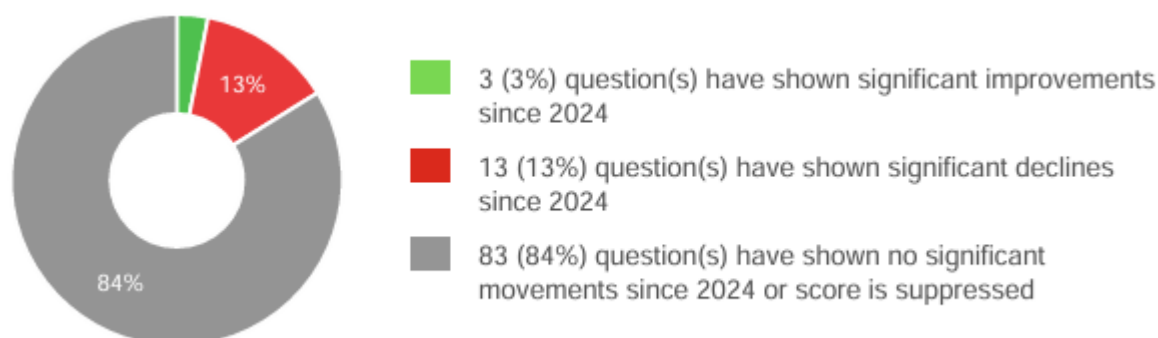
The Trust made progress contrary to the national trend in 2024, however results for 2025 show deterioration in line with the national picture of worsening results across the NHS. Only 25 comparator Trusts nationally saw an increase with the vast majority seeing scores deteriorate, reflecting the significant challenges facing the NHS and the impact these financial and operational pressures inevitably have on staff experience.

4.3 Trust performance compared with 2024 results

The Trust made progress against the national trend in 2024; however, the 2025 results reflect the wider national picture of deterioration across the NHS. Only 25 comparator Trusts nationally reported improvement, with the majority experiencing declining scores, highlighting the continued operational and financial pressures influencing staff experience.

While benchmarking provides helpful context, the Trust maintains a focus on year-on-year change to inform our improvement activity. Comparing 2025 results with 2024 shows that five of the nine People Promise domains recorded no statistically significant movement, while four domains demonstrated statistically significant deterioration, indicating areas where staff perceptions have shifted more noticeably.

At a question level, the picture is similarly consistent, with 84% of questions showing no significant change compared with 2024.



There were 3 questions where a statistically significant improvement has been achieved:

- I can approach my immediate manager to talk openly about flexible working (+3.3%)
- I work additional PAID hours, over and above my contracted hours. (-3.6%)
- In the last 12 months, I have had an appraisal or development review (+3.3%)

and 13 questions that have seen a significant decline, most notably:

- I have adequate materials, supplies and equipment to do my work (-8.6%)
- I would recommend my organisation as a place to work (-6.6%)
- My organisation takes positive action on health and well-being (-6.5%)
- There are opportunities for me to develop my career in this organisation (-6.2%)
- I have opportunities to improve my knowledge and skills (-6.2%)
- Care of patients / service users is my organisation's top priority (-6.2%)

4.4 Feedback Themes

The feedback themes provide helpful context to understand the underlying drivers of staff experience. Positive themes highlight areas where staff feel supported, including improvements in aspects of line management, diversity and equality, and elements of flexible working and work-life balance. Importantly, the increase in reported incidents of violence, bullying and abuse is viewed positively, as it reflects greater confidence among staff to report concerns rather than an increase

in behaviours themselves. This suggests that ongoing work to promote psychological safety and encourage speaking up is beginning to have impact.

Alongside these positives, several themes indicate areas where staff experience is becoming more challenging. Higher levels of work pressure and fatigue, reduced enjoyment, fewer opportunities to be involved in change, and concerns about career development and advocacy reflect the operational and financial pressures affecting the NHS. Together, these themes provide a balanced picture, highlighting where current approaches are working well and where targeted focus is needed.

Positive feedback themes	Negative feedback themes
✓ Improvements in line management scores	• Increased levels of work pressure and fatigue
✓ Improvement in specific diversity & equality measures	• Less enjoyment and enthusiasm
✓ Increased reporting of incidents of violence, bullying, abuse	• Less involved in changes and decisions & opportunities to develop
✓ Improvements in all 4 areas of flexible working and work life balance	• Decline in advocacy, especially linked to patient care being org top priority

4.5 Most Improved and Most Deteriorated Question

The question-level analysis shows notable variation in how staff experience has shifted over the year. The most improved questions relate to flexible working and day-to-day wellbeing, including increased confidence in approaching managers about flexible working, a reduction in additional paid hours worked, and more staff receiving an appraisal. These improvements suggest that changes in local practice and support structures are beginning to gain traction.

Conversely, the most deteriorated questions relate to foundational elements of the working environment: access to materials and equipment, organisational advocacy, perceptions of health and wellbeing support, and opportunities for learning and career development. These areas are typically most affected by operational and financial pressures, and this downward movement highlights where staff are feeling the strain most. This provides clear direction for targeted actions to strengthen the fundamentals of staff experience over the coming year.

Top 5 Improvements	Top 5 Deteriorations
Q6d – Able to talk to manager about flexible working (+3.3%)	Q3g – Meeting conflicting demands (–8.6%)
Q6b – Trust supports work–life balance (+2.5%)	Q25c – Recommend as place to work (–6.6%)
Q12f – Every working hour tiring (+2.1%)	Q25a – Care is top priority (–6.2%)
Q12e – Worn out at end of day (+2.0%)	Q24b – Career development opportunities (–6.2%)
Q12d – Exhausted at thought of another day (+1.8%)	Q23b – Appraisal helped improve job (–6.2%)

4.6 Question Types

Analysis of the seven question types shows a reduction in 'Your Organisation' scores, primarily linked to advocacy and perceptions of staff voice, and a decline in 'Your Personal Development', reflecting lower outcomes across the 'We Are Always Learning' sub-themes. In contrast, 'Your Managers' shows an improvement, indicating strengthening confidence in line manager relationships which was an area of focus following the 2024 results.

Question Type	2024 Overall %	2025 Overall %	Change in %
YOUR JOB	52.80%	51.39%	-1.41%
YOUR TEAM	65.24%	64.99%	-0.25%
PEOPLE IN YOUR ORGANISATION	63.90%	62.43%	-1.47%
YOUR MANAGERS	62.67%	63.12%	0.45%
YOUR HEALTH, WELL-BEING & SAFETY AT WORK	64.27%	63.77%	-0.50%
YOUR PERSONAL DEVELOPMENT	49.45%	46.93%	-2.52%
YOUR ORGANISATION	51.44%	47.88%	-3.56%
OVERALL	59.33%	58.32%	-1.01%

4.7 Staff Engagement & Morale Scores

In relation to the engagement and morale elements, prevalence of stress, anxiety & burnout amongst staff is contributing to lower scores. Staff Engagement is generally higher in non-patient-facing areas, and for Morale, a similar picture emerges. This likely reflects the day-to-day realities of service demand, resourcing, and fatigue in front-line environments. Further work is needed to tackle the root causes of stress, anxiety and burnout.

Staff Engagement	Morale
Corporate Non-Clinical 7.44	Finance & Performance 6.41
Finance & Performance 7.13	Corporate Non-Clinical 6.31
Nurse Management 6.85	Nurse Management 5.95
IMT 6.67	IMT 5.93
TICC 6.57	People Services 5.55
Women's & Children's 6.50	TICC 5.44
People Services 6.32	Planned Care 5.35
Urgent Care 6.24	Women's & Children's 5.30
Planned Care 6.16	Diagnostics & CSS 5.27
Diagnostics & CSS 5.95	Urgent Care 5.23
Estates & Facilities 5.85	Estates & Facilities 5.14

It is noted that the best performing areas are all non-patient facing divisions, mirrored by breakdown data for Staff Groups where A&C staff have the highest average across all areas.

Notably, Add Prof Scientific & Technical are the lowest by some distance for both Engagement and Morale. Feedback from recent staff sessions indicates that this is likely to be associated with

the planned organisational changes affecting their service and including how staff have been engaged in the process.

Staff Engagement	Morale
Healthcare Scientists 6.47	Administrative & Clerical 5.65
Additional Clinical Services 6.41	Additional Clinical Services 5.61
Administrative & Clerical 6.41	Healthcare Scientists 5.53
Nursing & Midwifery Registered 6.35	Medical & Dental 5.46
Allied Health Professionals 6.17	Estates & Ancillary 5.28
Medical & Dental 6.01	Nursing & Midwifery Registered 5.16
Estates & Ancillary 5.92	Allied Health Professionals 5.13
Add Prof Scientific & Technical 5.59	Add Prof Scientific & Technical 4.68

4.8 Divisional Breakdown

From a divisional perspective, the best staff experience (as measured by the 30 themes) is within Corporate non-clinical, IM&T and Finance & Performance. The divisional comparison between 2024 and 2025 shows a broadly consistent pattern in how staff across the Trust report their experience, with the relative position of divisions remaining largely unchanged year-on-year. Corporate (Non-Clinical), Finance & Performance, IM&T and Nurse Management continue to report the highest levels of Staff Engagement and Morale, mirroring their position in 2024. These areas are typically less exposed to the operational pressures experienced in clinical environments, which may contribute to the stability of their results.

Across patient-facing divisions, the comparison highlights continued challenges. Planned Care, Urgent Care, Diagnostics & CSS and Estates & Facilities again feature at the lower end of both Engagement and Morale, reflecting the operational intensity and day-to-day pressures experienced in these settings. While scores have shifted slightly across divisions, the overall pattern shows the same groups remaining under the most pressure in both years.

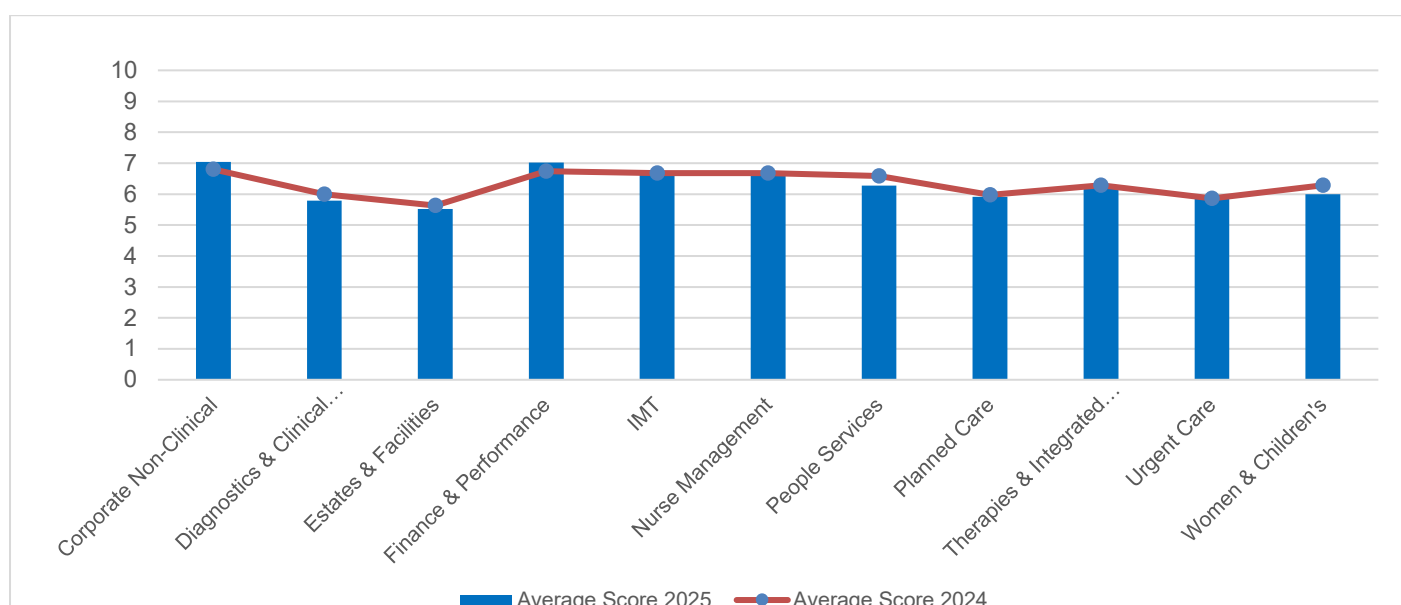


Figure 3.above provides a visual overview of Trust results by Division in 2024 and 2025.

4.9 Workforce equality indicators

Staff survey reporting also provides data for workforce equality indicators. WRES findings show a continued reduction in bullying, harassment and discrimination from colleagues and managers among staff in ethnic groups, although these staff still report fewer opportunities for career progression and continue to experience higher levels of harassment and abuse from patients and the public. WDES results highlight that staff with long-term conditions continue to have a less favourable experience than those without, particularly in relation to harassment and feeling valued, though positive movement is evident across most indicators, including increased reporting and higher levels of reasonable adjustments.

In relation to Workforce Race Equality Standards (WRES) key findings include:	In relation to Workforce Disability Equality Standards (WDES), key findings include:
<ul style="list-style-type: none"> Bullying/harassment and discrimination from staff continue to reduce for ethnic minority colleagues. Abuse from patients/the public remains a material issue across all groups. There's a slight increase for ethnic minority staff and only a small reduction for white staff Perceived fairness of career progression remains lower for ethnic minority staff than for white staff 	<ul style="list-style-type: none"> Colleagues with a long-term condition (LTC) report a less favourable overall experience than those without, including higher exposure to bullying/harassment (from staff and the public) and lower feelings of being valued. Positive movement across most WDES indicators versus prior years, notably more staff with LTCs receiving reasonable adjustments and higher reporting of incidents Engagement and satisfaction scores remain lower for staff with LTCs than for those without

5 Engagement with Staff

Divisional leaders have been working closely with HR and OD colleagues to review the feedback in detail and identify the most appropriate local actions. On the day the national embargo was lifted, we held two interactive staff sessions to share the results and invite colleagues to shape the Trusts priorities. Staff worked in groups, facilitated by the Chief People Officer and Head of OD to explore what actions would make the greatest difference and how they could actively contribute to improvement. The sessions were very positive and mark the start of a more proactive and collaborative approach to staff engagement.

6 NHS Staff Survey 2025 – Priorities

In line with the requirements of the 2026/27 Medium-Term Planning Framework and Standard Contract, Trust Boards must identify a minimum of three priority areas where staff experience data shows the greatest dissatisfaction. Following detailed analysis of the results, together with feedback from interactive staff engagement sessions, the proposed priority areas are set out below. Divisional action planning, supported by HR Business Partners, is already underway. Oversight will be maintained through divisional and People governance structures, with the consolidated action plan scheduled for initial reporting to People Committee in April 2026.

The proposed priorities reflect both the quantitative findings from the 2025 Staff Survey and the qualitative insights gathered through Trust-wide engagement sessions, ensuring that the areas selected align closely with what staff told us would make the greatest difference to their experience.

Priority	Specific focus
Make work feel manageable	Reduce: <ul style="list-style-type: none"> • stress, anxiety & burnout • unmanageable workloads and address workload inequity • violence and aggression
Strengthen staff voice, involvement and the standards we uphold together	Increase: <ul style="list-style-type: none"> • staff voice / engagement (in particular, in decision making & change) • psychological safety • the consistent upholding of standards and timely action on concerns
Support individual, team and organisational learning	Improve: <ul style="list-style-type: none"> • appraisal quality • personal learning, development & progression opportunities • organisational learning and improvement culture
Ensure people feel valued every day	Develop: <ul style="list-style-type: none"> • framework for local recognition • Executive and senior leadership visibility

7 Recommendations

The Board of Directors is asked to:

- Note the Trust’s Staff Survey 2025 results
- Note the analysis undertaken and areas for action identified.
- Agree the Trust priorities identified in section 6
- Take assurance that the Trust continues to engage its staff in the completion of the staff survey, review and analysis of the survey results, and identification of appropriate actions, and will monitor progress via People Committee.

PUBLIC – Board of Directors
31st March 2026

Report	Agenda Item 26.	Sexual Safety Charter Framework Implementation					
Purpose of the Report	Decision		Ratification		Assurance	X	Information
Accountable Executive	Vicki Wilson			Chief People Officer			
Author(s)	Liz Pritchard			Deputy Chief People Officer			
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			X	BAF impact is BAF 4 – People Fully embracing the terms of the sexual safety charter will support the Trust to move towards a safe and healthy culture so staff feel comfortable to raise concerns and behaviours can be challenged.		
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health						X X
CQC Domains	Safe Effective Caring Responsive Well led						X X X
Previous considerations	People and Culture Sub-Committee in November & December 2025; Operational Management Board in January 2026; People and Culture Sub-committee in January 2026 and People Committee in February 26.						
Executive summary	<p>This report provides the Board of Directors with assurance on the Trust's implementation of the NHS Sexual Safety Charter and the Sexual Safety Assurance Framework, and compliance with the legal duties introduced under the Worker Protection (Amendment of Equality Act 2010) Act 2023.</p> <p>The Trust has completed a comprehensive self-assessment against the framework and identified actions aligned to the ten principles of the Sexual Safety Charter. Trust-level data indicates that staff experience unwanted sexual behaviour, predominantly from patients and the public, with evidence of under-reporting and inconsistent escalation. The actions implemented to date directly respond to this position, strengthening prevention, reporting, investigation, support and governance arrangements, with oversight embedded through the People and Culture Sub-Committee.</p> <p>In total, 49 actions have been identified, reflecting both national requirements and subsequent national recommendations. Of these, 44 actions (90%) have been completed. The remaining five actions are ongoing, largely due to external national dependencies, including delays in guidance</p>						

	<p>and training. Mitigating arrangements are in place to manage risk in the interim.</p> <p>The Trust has complied with newly introduced quarterly reporting requirements for serious sexual misconduct cases and has completed the nationally mandated audit of Sexual Safety Charter implementation, providing external assurance of progress. To ensure completion of outstanding actions, embed practice and evaluate impact, the Sexual Safety Task and Finish Group will be extended for a further three months, with continued reporting through established People and Culture governance arrangements.</p>
Recommendations	<p>The Board of Directors is asked to:</p> <ul style="list-style-type: none"> • Receive assurance that the Trust has substantially met the requirements of the Sexual Safety Charter and Assurance Framework. • Note the residual risks relating to reporting confidence and specialist investigation capacity, and the mitigating actions in place. • Note the extension of the Sexual Safety Task and Finish Group for a further three months to embed and evaluate impact.

Corporate Impact Assessment	
Statutory/regulatory requirements	NHS England Education Contract
Risk	Failure to deliver actions identified could result in the Trust being in breach of its legal duty in relation to the Workers Protection Act 2023.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not confidential.

Sexual Safety Charter Framework Implementation

1. Introduction

This report provides the Board of Directors with assurance on the Trust's implementation of the NHS Sexual Safety Charter and the Sexual Safety Assurance Framework. It summarises progress against the ten principles of the Charter, highlights key risks and mitigations, and outlines the governance arrangements in place to ensure compliance with statutory requirements and national expectations.

2. Background

The Sexual Safety Charter was introduced across the NHS in September 2023 by NHS England in response to growing evidence that NHS staff are experiencing increased levels of unwanted sexual behaviour, alongside changes in legislation that place additional duties on employers to prevent sexual harassment in the workplace.

The Worker Protection (Amendment of Equality Act 2010) Act 2023 introduced a legal duty on employers to take reasonable steps to prevent sexual harassment by colleagues and third parties. In response, NHS England established the Sexual Safety Charter to support Trusts in adopting a zero-tolerance approach to unwanted, inappropriate and harmful sexual behaviour, and to promote a culture where staff feel safe and supported to raise concerns.

The Charter is underpinned by ten principles that set expectations for culture, prevention, reporting, investigation, support and governance. In August 2025, NHS England refreshed the Sexual Safety Assurance Framework, setting out recommended actions and outcomes to support Boards in assuring themselves that these principles are being delivered and that legal duties are being met.

In December 2025, the Trust set an internal ambition to complete the actions identified through the framework by 31 March 2026, with progress overseen through established People and Culture governance arrangements.

3. Purpose

The purpose of this report is to provide an update of the progress of the Sexual Safety Charter's implementation across the Trust via a progress report against Trust identified actions mapped to the Sexual Safety Assurance Framework.

4. Current Trust Position

4.1. Initial analysis of Trust data

Nationally, the NHS is reporting increased levels of unwanted sexual behaviour against staff, with this trend also seen locally. Our 2025 staff survey results indicate an increasing trend, with 12.33% of respondents (increase from 12.29% in 2024 and 10% in 2023) reporting that they have been the target of unwanted sexual behaviour in the workplace from patients, service users and members of the public. Whilst there has been a slight decrease to 2.9% (slightly down from 3.2% in 2024) of respondents reporting that they have been the target of unwanted sexual behaviour in the workplace from staff or colleagues, this figure is still of concern.

In relation to staff experiencing unwanted sexual behaviour from patients, service users or members of the public, since January 24 the Trust has recorded and categorised 30 incidents of abuse against staff of a sexual nature within Datix. Whilst 25 of these incidents have been recorded as no harm, 5

have been categorised as low – minimal harm caused. Whilst further work needs to be done to identify any additional categories within Datix that incidents of a sexual nature may be coded by, initial analysis indicates that reporting is significantly below expectations when compared with staff survey results.

In relation to staff experiencing unwanted sexual behaviour from colleagues/managers, the number of Trust formal Employee relations cases has increased in 2025/26 as per the table provided below. However, numbers being reported and investigated via a formal process are below expected when compared with 2024 Staff Survey results.

Table 1 – summary of formal ER casework related to incidents of a sexual nature.

Year	Formal complaints of sexual harassment/misconduct which have been subject to formal HR process.
2022/23	1
2023/24	1
2024/25	4
2025/26	6 (as at the 19 th March 2026)

This high-level analysis undertaken identifies the need at Trust level to encourage and support staff to report incidents, enabling us to take preventative action where possible and ensure that staff are fully supported. This is articulated in our action plan and is directly linked to principles 2, 4 and 8 of the assurance framework.

4.2. Progress of actions against the Sexual Safety Assurance Framework

The Trust has made good progress in delivering the Sexual Safety Charter action plan, with 44 of the 49 identified actions (90%) now completed. The total number of actions reflects the evolving nature of the framework and additional national recommendations introduced since initial reporting.

Completed actions include the establishment of clear governance and Board-level oversight; delivery of a Trust-wide communications campaign; publication and embedding of updated sexual misconduct policies, guidance and reporting routes; delivery of core and specialist training; strengthened Freedom to Speak Up and safeguarding arrangements; improved support and signposting for staff; and the introduction of dashboards to monitor prevalence, reporting and learning. An intersectional approach has been embedded throughout, supported by equality impact assessments, analysis of staff survey and workforce data by protected characteristic, and engagement with staff networks. Collectively, these actions provide assurance that robust arrangements are in place to prevent, identify and respond to sexual misconduct and to meet the Trust’s legal duties under the Worker Protection Act 2023.

Progress against the remaining actions has been impacted primarily by external national dependencies, with appropriate mitigations in place. A summary of the outstanding actions is set out below, with full detail reviewed through the People Committee.

Table 2 – Summary of actions not completed.

Action	RAG	Action Planned
To establish when a referral to DBS should be made when someone has been removed from the workplace due to concerns about conduct	Ongoing	This mandated action has been queried at a national level for appropriateness; recognising potential consequences of notifying the DBS where an investigation hasn’t been concluded and an outcome

		has not been confirmed. Awaiting further national guidance.
To ensure that the Trust identifies 2 People professionals to undertake the new national training for investigators of Sexual misconduct	Ongoing	<p>Awaiting nationally agreed training that was to be available in March 26. No current national update.</p> <p>The Trust is mitigating any risk in relation to lack of specialised training via expertise within HRBP team. Place-based and Trust specific scoping of training commenced based on a Trust level Training Needs Analysis, seeking to minimise impact and cost of delivery. This will continue to be progressed and updates continue to be requested from the national team.</p> <p>The Trust has processes in place to investigate when an unusual pattern of patient record access is flagged. A process for the proactive identifying of an unusual pattern of patient record access has been scoped and is currently being progressed by the Information Governance and Safeguarding Teams.</p>
To develop a pool of doctor investigators who are trained in Sexual misconduct investigations	Ongoing	
To implement Trust recommended specialist training, including training for managers as appropriate.	Ongoing	
To ensure that the Trust has a clear safeguarding process in place for identified unusual patterns of patient record access and ensuring escalation/reporting processes are in place.	Ongoing	

Whilst 90% of actions have been completed within the internal timescales set, work will continue to embed sexual safety across the Trust. Building on the involvement of staff from across the Trust in the delivery of the actions, a Sexual Safety Task and Finish Group has been established to drive forward this agenda. This group will be extended for a further 3 months to oversee the ongoing development of this work in the Trust, with reporting via the People and Culture Sub-Committee and exception reporting to People Committee as appropriate.

4.3. Trust compliance with regional escalation processes

A new escalation route to a nationally Executive led Improving Sexual Safety Group has been implemented, requiring NHS Trusts to ensure that cases of serious sexual misconduct committed by staff are seen by the Group, enabling them to take learning from cases to improve national policy and ensure that cases are being appropriately managed within the system.

The Trust is required to return a quarterly report to regional level using prescribed escalation criteria. For the period Oct – Dec 25, the Trust has recorded 4 cases. These have included 3 incidents reported of sexual misconduct staff against staff, and 1 case of staff against patient that has police involvement. 2 of the cases have been recorded as relating to sexual harassment, and 2 of the cases recorded as relating to sexual abuse. 2 of the cases have been concluded within the reporting period, one via informal resolution, and one with an outcome of a final written warning.

4.4. Audit of sexual safety actions and the impact of the sexual safety charter

The Trust is also required to submit a completed audit of the Sexual Safety Charter implementation, including the extent of Board assurance, a review of policy and processes and the impact of the charter and national policy framework at a Trust level. This was completed in February 26 and provided assurance that the Trust continued to make progress in the implementation of the charter.

5. Conclusion

The Trust has completed a comprehensive self-assessment against the Sexual Safety Assurance Framework and has implemented actions aligned to the principles of the Sexual Safety Charter to meet its legal duties under the Worker Protection Act 2023.

Trust data indicates that staff experience unwanted sexual behaviour, predominantly from patients and the public, with evidence of under-reporting. Actions have been implemented to strengthen reporting, investigation and governance arrangements, with oversight through the People and Culture Sub-Committee.

Of the 49 Trust actions identified, 44 (90%) are complete, with the remaining actions ongoing due largely to national dependencies. The Sexual Safety Task and Finish Group will be extended for a further three months to complete outstanding actions, embed practice and evaluate impact. The Trust has met its quarterly reporting requirements for serious sexual misconduct cases and has completed the national audit of Sexual Safety Charter implementation, providing external assurance that continued progress is being made.

6. Recommendations

The Board of Directors is asked to

- **Receive assurance** that the Trust has substantially met the requirements of the Sexual Safety Charter and Assurance Framework.
- **Note** the residual risks relating to reporting confidence and specialist investigation capacity, and the mitigating actions in place.
- **Note** the extension of the Sexual Safety Task and Finish Group for a further three months to embed and evaluate impact.

PUBLIC – Board of Directors
31st March 2026

Report	Agenda Item 27*.	Council of Governors Report – February 2026					
Purpose of the Report	Decision		Ratification		Assurance	Information	X
Accountable Executive	Karan Wheatcroft			Director of Governance, Risk & Improvement			
Author(s)	Nusaiba Cleuvenot			Head of Corporate Governance			
Board Assurance Framework	BAF 1 Quality		X	Relevant across all BAF areas.			
	BAF 2 Safety		X				
	BAF 3 Operational		X				
	BAF 4 People		X				
	BAF 5 Finance		X				
	BAF 6 Capital		X				
	BAF 7 Digital		X				
	BAF 8 Governance		X				
	BAF 9 Partnerships		X				
	BAF 10 Research		X				
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health						X
CQC Domains	Safe Effective Caring Responsive Well led						X
Previous considerations	Not applicable.						
Executive summary	The purpose of this report is to provide a summary of items discussed at the Council of Governors meetings.						
Recommendations	The Board of Directors is asked to note the report and the activity during this period.						

Corporate Impact Assessment	
Statutory/regulatory requirements	Meets the Trust compliance with Foundation Trust status.
Risk	Alignment with the Board Assurance Framework and Corporate Risk Register.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not confidential.

Council of Governors Report

1. PURPOSE

This report provides a summary update of recent activity related to the Council of Governors (CoG).

2. BACKGROUND

The Council of Governors meetings are held on a quarterly basis. In between, informal Governor meetings are held, led by the Chair.

3. CURRENT POSITION

3.1 Council of Governors Meeting

A full Council of Governors meeting was held on 4th February 2026, and key items included the following:

- A patient story was presented.
- An update was provided from the Chair and the Chief Executive Officer on key matters.
- Chair's reports were received from the Quality and Safety Committee, People Committee, Audit Committee and Finance & Performance Committee.
- Lead Governor update.
- Research Strategy.
- Patient and Family Experience Report.
- Medium Term Planning Update.
- NHS England Enforcement Notice Update.
- 'Innovation Fortnight' Feedback.
- The Trust System Oversight Framework (SOF) was provided setting out the Trust's performance in key areas from the NHS Oversight Framework Report including Operational Performance, Quality, Safety, Finance and People.
- Membership & Engagement Committee Chair's report.
- Draft CoG Annual Report 2025-26 Extract approved.
- Feedback from Non-Executive Director/ Governor Walkabouts.

Following the Council of Governors meeting held in public, a private meeting was held. The Council of Governors received papers detailing summary reports from the last Private Board meetings; reports setting out the Chair and Non-Executive Director Appraisal process for 2025-26; Lead Governor Succession and Appointment; and an Employment Tribunal Update.

An Extraordinary CoG was also held on 3rd December 2025 to review changes to the NED portfolios and approve an appointment and extension to a term of office.

3.2 Council of Governors Workshops and Informal Meetings

The Trust Chair has implemented regular informal meetings for Governors to promote engagement and facilitate information exchange. These sessions allow the Chair to share updates on current Trust activities between the quarterly Council of Governors meetings and offer Governors an additional forum to discuss issues beyond the set agenda, raise questions, and provide feedback.

Three further informal Chair and Governor meetings took place on 5th November, 3rd December 2025 and 4th March 2026.

4. RECOMMENDATIONS

The Board of Directors is asked to **note** the report and the activity during this period.

PUBLIC – Board of Directors
31st March 2026

Report	Agenda Item 28.	Provider Licence Compliance 2025/26					
Purpose of the Report	Decision	X	Ratification		Assurance		Information
Accountable Executive	Karan Wheatcroft			Director of Governance, Risk & Improvement			
Author(s)	Karan Wheatcroft			Director of Governance, Risk & Improvement			
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			X	BAF impact – Linked to all areas of the BAF but specifically the actions within BAF 8.		
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health						X X X X X X
CQC Domains	Safe Effective Caring Responsive Well led						X X X X
Previous considerations	The full annual Provider Licence self-assessment 2025/26 was reviewed and approved through the Audit Committee in February 2026 prior to the summary report being provided to the Board of Directors.						
Executive summary	<p>The self-assessment sets out compliance with the Provider Licence conditions.</p> <p>Assurance is provided in the context that during 2025/26 the Trust has continued to manage the recovery of waiting lists, alongside the challenges of operational pressures. These areas continue to have strong oversight through the Executive Team, respective assurance committees and the Board of Directors.</p> <p>The Trust received undertakings from NHS England (NHSE) which were accepted in November 2025 and correlate to key areas of Provider Licence conditions. This has been considered in the assessment with the undertakings mapped to the requirements and the mitigating plans and outputs reviewed.</p> <p>The assessment for 2025/26 confirms ongoing compliance with the Provider Licence, recognising that NHSE undertakings have been accepted and action plans have been delivered to meet the requirements. The key risk to delivery is the urgent and emergency care 12 hour and 4</p>						

	<p>hour constitutional targets. A final review will be undertaken at 31st March 2026 and any implications from this reported in the Trust's Annual Governance Statement and Annual Report.</p> <p>The main changes from the prior year assessment include:</p> <ul style="list-style-type: none"> • Use of C2AI health inequalities waiting list tool • Introduction of a 'quarterly checklist' to provide in year assurance on compliance with key aspects of the licence to the Audit Committee • Development of the Committee organogram • Progress against the Risk Management Improvement Plan • Continued focus on enhancing the financial control environment (grip and control mechanisms) • Continued focus on improving the NOF position (recognising the implementation of a new National Oversight Framework for providers during 2025/26) <p>Identified actions to be progressed including the link to the NHSE enforcement undertakings are:</p> <ul style="list-style-type: none"> • Continued focus on improving the Trust's NOF rating. • Delivery of the CQC UEC Section 29a warning notice action plan and any subsequent actions once the most recent inspection report is received. • Delivery of the financial plan including the 5 year integrated plan to eradicate the underlying Trust deficit. • Delivery of the UEC operational performance standards through our UEC and Flow action plans. • Effectiveness of Sub Committees and Divisional governance to be reviewed in 2026/27. • Consideration of an annual review against the NHS constitution. <p>The Audit Committee supported the self-assessment in February 2026 with a summary report to be presented to the Board for final approval.</p>
Recommendations	<p>The Board is asked to approve the Trust's current compliance against the Provider Licence, with a final review to take place as at 31st March and any implications from this to be included in the Trust's Annual Governance Statement and Annual Report.</p>

Corporate Impact Assessment	
Statutory/regulatory requirements	Meets the requirements of the Health and Social Care Act 2008 and in line with the Trust's Constitution, Code of Governance and regulatory requirements.
Risk	As outlined within the risk management policy document.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	To be communicated through a summary report to the Board of Directors and referred to in the Annual Report.

Provider Licence Compliance 2025/26

1. Executive Summary

The purpose of this paper is to provide assurance on compliance with the Provider Licence for 2025/26.

The Trust received undertakings from NHS England (NHSE) which were accepted in November 2025 and correlate to key areas of Provider Licence conditions. This has been considered in the assessment.

The assessment for 2025/26 confirms ongoing compliance with the Provider Licence, recognising that NHSE undertakings have been accepted and actions are being delivered to ensure we meet the requirements.

The Audit Committee was asked to approve the reported compliance with the Provider Licence for 2025/26, and the actions to be taken forward with a summary report to be provided to the Board of Directors.

2. Background

The Provider Licence sets out the obligations for providers of NHS services that will allow NHS England (NHSE) to fulfill its regulatory duties.

The licence has served as the main tool by which NHS England (NHSE) regulates providers of NHS services.

A new licence was implemented from 2023/24 to take account of the establishment of Integrated Care Systems and the new obligations for Foundation Trusts (FT) linked to system reform, collaboration and partnership working. These reforms change the emphasis of FT regulation.

3. Compliance 2025/26

This paper provides a detailed review of each condition within the licence and identifies, where relevant, the current controls that are in place to ensure compliance. Each licence condition is assigned to an accountable Executive Director (refer Appendix 1).

The actions delivered from the 2024/25 action plan and now reflected in the compliance are:

- Use of C2AI health inequalities waiting list tool
- Introduction of a 'quarterly checklist' to provide in year assurance on compliance with key aspects of the licence to the Audit Committee
- Development of the Committee organogram
- Progress against the Risk Management Improvement Plan
- Continued focus on enhancing the financial control environment (grip and control mechanisms)
- Continued focus on improving the NOF position (recognising the implementation of a new National Oversight Framework for providers during 2025/26)

A small number of actions continue to be progressed and have been carried forward along with any new actions in the action plan below:

Action	Responsibility	Timeframe
1. Continued focus on improving the Trust's NOF rating.	Chief Finance Officer/ Chief Operating Officer/ Director of Nursing, Quality and Safety/ Chief People Officer	2025/26 onwards
2. Deliver CQC UEC Section 29a warning notice action plan.	Director of Nursing, Quality and Safety/ Medical Director	To be completed by Q1 2026/27
3. Delivery of the financial plan including the 5 year integrated plan to eradicate the underlying Trust deficit.	Chief Finance Officer	2025/26 onwards
4. Delivery of the UEC operational performance standards through our UEC and Flow action plans.	Chief Operating Officer/ Director of Nursing, Quality and Safety/ Medical Director	2025/26 onwards
5. Effectiveness of Sub Committees and Divisional governance to be reviewed in 2026/27.	Director of Governance, Risk and Improvement/ Chief Operating Officer	To be completed by Q3 2026/27
6. Consider an annual review against the NHS constitution.	Director of Governance, Risk and Improvement	Deferred - To be completed by Q4 2026/27

During 2025/26 the Trust has continued to manage the recovery of long waiters on waiting lists, alongside sustained operational pressures. These areas have strong oversight through the Executive Team, respective assurance committees and the Board of Directors.

The assessment for 2025/26 confirms ongoing compliance with the Provider Licence, recognising that NHSE undertakings have been accepted and action plans have been delivered to meet the requirements. The key risk to delivery is the urgent and emergency care 12 hour and 4 hour constitutional targets. A final review will be undertaken based on the position as at 31st March 2026 and any implications from this reported in the Trust's Annual Governance Statement and Annual Report.

Regulatory risks are highlighted to the Board for consideration via the Board Assurance Framework (BAF) and regular cycle of Board assurance and Committee reporting.

4. Recommendation

The Board is asked to **approve** the Trust's current compliance against the Provider Licence, with a final review to take place as at 31st March and any implications from this to be included in the Trust's Annual Governance Statement and Annual Report.

PUBLIC – Board of Directors
31st March 2026

Report	Agenda Item 29.	Code of Governance Compliance 2025/26					
Purpose of the Report	Decision	X	Ratification		Assurance		Information
Accountable Executive	Karan Wheatcroft			Director of Governance, Risk & Improvement			
Author(s)	Karan Wheatcroft			Director of Governance, Risk & Improvement			
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			X	BAF impact – Linked to all areas of the BAF but specifically the actions within BAF 8.		
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health						X X X
CQC Domains	Safe Effective Caring Responsive Well led						X
Previous considerations	The full annual Provider Licence self-assessment 2025/26 was reviewed and approved (with agreed changes) through the Audit Committee in February 2026 prior to the summary report being provided to the Board of Directors.						
Executive summary	The assessment sets out compliance with the Code of Governance for NHS Foundation Trusts, including: <ul style="list-style-type: none"> • Board leadership and purpose • Division of responsibilities • Composition, succession and evaluation • Audit, risk and internal control • Remuneration <p>The Trust remains compliant with the majority of the areas set out within the code.</p> <p>The code is assessed on the basis of comply or explain. In 2024/25 the Trust declared partial compliance in 7 areas with mitigations and actions in place.</p>						

	<p>The actions now embedded from the prior year assessment include:</p> <ul style="list-style-type: none"> • (A.2.1) Continued system working and alignment of objectives including clinical strategy. • (A.2.5) use of Cheshire and Merseyside Data into Action tools C2AI to consider deprivation factors. • (A.2.8 and App B 2.12) Membership Engagement Group led through the Council of Governors re-established. • (B.2.5 and D.2.1) A new Audit Committee Chair was appointed in year and does not hold either the Deputy Chair or SID role. • (B.2.7) Board composition was reviewed in year and voting Directors clearly identified to ensure majority of Non-Executive Directors. • (C.4.13) Board diversity included within the EDI action plans and priorities. <p>For 2025/26 there are 2 conditions that do not meet full compliance which relate to:</p> <ul style="list-style-type: none"> • D.2.3 – External audit: The decision to extend the External Audit contract beyond 10 years. This decision was fully assessed and supported by the Council of Governors. • C.2.1 – Board succession planning: It is noted that whilst the Remuneration and Nomination Committee (Executive) has reviewed the succession plan there is more work to do to provide assurance on the effectiveness of Board succession planning within the Trust to mitigate the risks. A further meeting of the Remuneration and Nomination Committee (Executive) is planned for the 24th March 2026. <p>The Audit Committee supported the self-assessment of compliance against the Code of Governance provisions with the change applied to C.2.1 as set out above, with a summary report to be presented to the Board.</p>
Recommendations	<p>The Board of Directors is asked to approve the Trust’s current compliance against the Code of Governance, with a final review to take place as at 31st March and any implications from this to be included in the Trust’s Annual Governance Statement and Annual Report.</p>

Corporate Impact Assessment	
Statutory/regulatory requirements	Meets legislative requirements and is in line with the Trust’s Constitution, Code of Governance and regulatory requirements.
Risk	As outlined within the risk management policy document.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	To be communicated through a summary report to the Board of Directors and referred to in the Annual Report.