NHS
Cheshire and Merseyside

Questions Raised – Jan 2026 ICB Board

Question Received	By
Does the board believe it is acceptable that the complaints teams at hospitals and Cheshire and Merseyside, do not fully investigate complaints as they know the PHSO will refuse to investigate complaints if escalated, unless someone has come to harm. Therefore, avoiding admitting to errors or making improvements to services. Contrary to the trusts constitution.	P J Stott.
Response	
Thank you for your questions. In response, NHS organisations (NHS Providers and Commissioning Organisations) manage patient complaints in line with their local policies and procedures, which follow the requirements of The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 https://www.legislation.gov.uk/uksi/2009/309/contents . *The NHS Cheshire and Merseyside ICB complaint policy is publicly available at: https://www.cheshireandmerseyside.nhs.uk/contact/complaints/ . In accordance with the above Regulations, there are a number of exceptions which may result in a complaint not being accepted for investigation such as;* • *Complaints which have previously been investigated under these or previous complaint regulations and where no significant additional information is supplied.* • *A complaint that has already been raised directly with a service/organisation commissioned by the ICB. This includes complaints which are at the time, being investigated by the commissioned provider.* • *A complaint which is being or has been investigated by the Parliamentary Health Service Ombudsman.* *The full list of exceptions are contained within section 6 of the ICB Policy.* *Outside of the list of exceptions, NHS Cheshire and Merseyside ICB makes all efforts to fully investigate complaints which fall within scope of the statutory regulation to identify any required improvement and development of services which it commissions.*	

Question Received	By
Hello, I'm the director of a not-for-profit organisation working to improve health and wellbeing in one of the most deprived areas of Halton. Since the formation of the ICBs I fear that methods of interacting and communicating with the board regarding policy and delivery has become far more remote than it was with the old CCG structure (which itself was pretty remote). **Can you please explain how a very small project like ours can meet with or contact board members or other staff to discuss local and regional health issues?** For example, I have been asking for years at various levels including ministers for data on the level of mental illness within Halton (and regionally) but these totals are held only at a borough level and can't be drilled down any further. They also only include totals for those in treatment/contact with mental health services not those on prescriptions or another form of therapy and they do not offer any analysis on the different types of mental illness being treated. This type of information is crucial for projects like ours to demonstrate need for potential funders. I have attached a report that goes into more detail on this matter produced in 2024. I hope you can discuss this at the January board meeting.	Philip Thornton

Response

Thank you for getting in touch and for the important work your organisation continues to do across Halton. We recognise the importance of and the vital role that community-based projects play in improving health and wellbeing, and we're sorry that engagement with the ICB has at times felt more distant since the transition from CCGs. Strengthening local relationships is a key commitment within the Cheshire & Merseyside Public Engagement Framework, and your feedback helps us keep improving.

Engagement between the ICB and partners within Halton Place is ongoing, and insight from local organisations is brought regularly into system discussions via both the Halton Partnership Board and the Halton Health and Wellbeing Board. These forums are important routes for shaping priorities and ensuring community perspectives influence decision-making. If you are not already linked into these groups, they would be a very constructive way for you to engage further and share the experience and intelligence your project gathers.

You also raised important points about access to mental health data. We've shared your report with colleagues and have already sought advice from our Business Intelligence team to understand whether more detailed or granular data is available publicly, and to identify any alternative sources that may be able to support your work.

Your question—and this response—will be shared with Board members ahead of the January 2026 meeting. While it won't be discussed in depth on the day, this will ensure that all members are sighted on the issues you've raised and the importance of accessible data for local organisations.

To support a more direct conversation, we would be very happy to arrange a meeting with Anthony Leo, Place Director for Halton, who is keen to hear from local partners and explore how we can strengthen communication routes and better support projects like yours.
If you're willing, we can arrange this at a time that suits you.

Question Received	By
Under the periodic progress report on the Data Info Programme and its links with previous updates on Cyber Security could the Board give local assurance to the near 2.5 million NHS patients in the its footprint area that it is ensuring from routine contract reviews, providers incident alerts and independent verification of any data breaches over that Federated Data Platform operated by Palantir Analytica in some 10 Cheshire and Merseyside NHS Trusts as well as the ICB, including minimising the risks of patient data being leaked, anonymised, stored or inappropriately passed on for commercial or any illicit purposes. This follows recent concerns expressed by the Parliamentary Select Innovation and Technology Committee about outsourcing such a significant data contract to one overseas company with insufficient assurance its data handling and protection processes were sufficiently robust or verifiable.	Paul Dolan

Response

Thank you for your questions. In response, Palantir is the technology provider contracted to deliver the core infrastructure of the Federated Data Platform (FDP). Their role is to build and maintain the secure, cloud-based platform that enables NHS organisations to access and analyse data in a federated way — meaning data stays where it is but can be used collaboratively. Palantir does not control how the platform is used; NHS England and local NHS organisations retain full control over data access, use, and governance. For Cheshire and Merseyside this means the data stays within the information governance of Cheshire and Merseyside and is never outwardly shared. Each Trust the ICB has an incident reporting system and any IG breach is reported on that system - there are then processes locally to classify the breach in order of severity and report internally and if major to the Board. If it passes the threshold of major it will also be reported to the Information Commissioners Office (ICO)who will assess and take actions including fines . For every trust the DSPT toolkit compliance requires major breaches/incidents to be reported within 72 hours. All serious incidents are transparently reported through public boards.

Palantir cannot access patient-identifiable data. The FDP is governed by strict data protection rules, including UK GDPR and the Data Protection Act 2018. All of the IG documentation for FDP platform and products for trusts and ICB have been internally approved through their IG committees that include a SIRO and Caldicott guardian who are Executive board members. The FDP documents are nationally scrutinised and approved through NHSE IG specialists. For every trust or ICB these documents are available on public websites and referenced in privacy notices for the public
NHS organisations decide who can access what data, for what purpose, and under what legal basis. Palantir's role is limited to providing the technical environment — they do not determine how data is used or accessed. In Cheshire & Merseyside we have prepared information governance documentation to ensure that Palantir cannot access the patient identifiable data - it is identified only as a data processor in the technical environment on behalf of the NHS.

If a breach occurred then because the processor is Palantir and they are contracted by NHSE then both would be alerted through the local processes as 'interested parties' in the same way as if any supplier system was party to or responsible for a breach.

Question Received	By
For any NHS bodies within Cheshire & Merseyside 1) Is information on the immigration status of individual patients uploaded to the NHS Spine? 2) Can such information be accessed by the Federated Data Platform (FDP), either currently or as an option in future? 3) Is Message Exchange for Social Care and Health (MESH) used to upload such information to the NHS Spine? 4) Does the FDP have access to NHS communication via MESH, whether or not this information appears on the NHS Spine**?**	Greg Dropkin
Response	
Thankyou for your questions. In response, Immigration status is not something that's collected/stored in health records therefore the answer to all questions is no. There are occasions where a hospital may securely contact the Home Office to ask about an individual patient's status to confirm whether their care charges are recoverable or not, but it's not a data item that is part of any routine NHS data sets or associated data flows.	

Question Received	By
We are not opposed to closer working between hospitals, nor increased outreach to make women's services more accessible but the options to the ICB all seem to be about diminishing services at the Women's Hospital Given that the new Royal has several 100 fewer beds than the old Royal, has had over 90% bed occupancy, corridor care throughout winter (and some of summer), that the Royal A& E has had patients in chairs and trolleys for many hours, **where is the supposed capacity to treat up to 100 of the sickest women at the Royal rather than at the Women's Hospital?** **What will happen to the babies of those women giving birth? Where will an acute maternity unit fit in the Royal? What happens if the babies also need Neonatal Intensive Care? Will more be separated from their mothers?** **How is this to be achieved by displacing services on Level 9 at the Royal?** **What services are to be displaced & where would they go?** **Why are LWH gynae procedures being outsourced to a private hospital Aset, why are these resources not being put directly into the LWH to get the waiting list down?** **Given that approximately only 10-12 women per year are transferred to the Royal from LWH to ICU is all this the first steps to breaking up the Women's Hospital through the back door, as has happened in Leeds to the Children's hospital?** The local community is firmly opposed to any run down of the LWH Crown St site & any moving of services out of L8, including 85,000 signatures on the Save Liverpool Women's Hospital petition and the local MP. As Black, Asian & minority ethnic women are likely to have the worst maternal & neonatal outcomes, **where is the evidence that any of these options will give them a safer service?** **"The number of patients potentially impacted by option 2 is likely to be relatively low', what is meant by this and where is the evidence?** **"Risk 1 - Acutely deteriorating women cannot be managed on site at Crown Street reliably, which has resulted in adverse consequences and harm" RS> Q: Where is the evidence for additional harm to patients? How long is the usual wait to get a bed on any ICU (time interval between decision made and woman admitted to ICU)?** **"Risk 2 - Women presenting at other acute sites (e.g. A&E), being taken to other acute sites by ambulance, or being treated for conditions unrelated to their pregnancy or gynaecological condition at other acute sites, do not get the holistic care they need." Q: How will any of the Options rectify this?**	Lesley Mahmood

"Risk 3 - Failure to meet service specifications and clinical quality standards in the medium term could result in a loss of some women's services from Liverpool." Q: Can we see this evidence?

"Risk 4 - Recruitment and retention difficulties in key clinical specialties are exacerbated by the current configuration of adult and women's services in Liverpool." Where is the evidence for this? This is a national problem not related to being at Crown St.

"Risk 5 - Women receiving care from women's hospital services, their families, and the staff delivering care, may be more at risk of psychological harm due to the current configuration of services." Stress levels are no different to the national average.

RCN press release April 2024 states that "24.5% of nursing staff are off work with stress, anxiety and depression. It is so widespread it accounts for 1 week of absence per year for every practising nurse." Therefore, LWH is in line with the national average. Here's the link for the reference: NHS sickness data shows average nurse took entire week off sick last year due to stress-related illness | Royal College of Nursing

Response

Thank you for your questions. In response:

We are not opposed to closer working between hospitals, nor increased outreach to make women's services more accessible but the options to the ICB all seem to be about diminishing services at the Women's Hospital
The investments described in option 2 (many of which would be retained in options 6a - 6c) would be in addition to existing at Crown Street. They are service improvements to make care safer, not reductions.

Given that the new Royal has several 100 fewer beds than the old Royal, has had over 90% bed occupancy, corridor care throughout winter (and some of summer), that the Royal A& E has had patients in chairs and trolleys for many hours, where is the supposed capacity to treat up to 100 *of the sickest women at the Royal rather than at the Women's Hospital?*
The Board is being asked to consider whether to progress the option 2 proposal, which would include developing a business case and holding a period of public engagement ahead of final decision-making. Subject to the Board deciding to proceed, further details about how this proposal would be delivered would be set out in the engagement, giving people an opportunity to hear more and share their views.

What will happen to the babies of those women giving birth? Where will an acute maternity unit fit in the Royal? What happens if the babies also need Neonatal Intensive Care? Will more be separated from their mothers?
In option 2, a dedicated area for women's services would be created using existing clinical space at the Royal Liverpool University Hospital site. A neonatal team would be present for any births. If possible, the baby could stay with the mother. If the mother and / or the baby are too unwell

to stay together, the baby would be transferred to Liverpool Women's Hospital or Alder Hey Hospital depending on specific clinical circumstances.

How is this to be achieved by displacing services on Level 9 at the Royal?
Creating additional clinical space on level 9 has only been considered in option 6a at this stage. Non-clinical / administrative services are currently occupying level 9. In the event that a proposal (such as option 6a) was progressed, which would involve utilising this space, there would need to be a plan for alternative accommodation.

What services are to be displaced & where would they go?
Please see answer above.

Why are LWH gynae procedures being outsourced to a private hospital Aset, why are these resources not being put directly into the LWH to get the waiting list down?
LWH continues to work intensively to reduce waiting times across Gynaecology. The Trust has achieved a notable reduction in overall patients waits since October 2025, but additional capacity is still required to bring all pathways below 52 weeks. Much of this extra capacity is being delivered internally, and the use of insourcing specialist support has been essential in helping the Trust manage current demand. The Trust is also exploring the option of outsourcing a defined cohort of pathways to local NHS-partner providers to ensure patients receive timely treatment.

- *The Trust has recently filled several consultant vacancies, which will strengthen internal capacity and reduce reliance on outsourcing in the future.*
- *The opening of the new ambulatory unit was delayed by several months due to unforeseen construction issues; now that it is operational, it will further support the reduction of waiting times.*
- *The Trust is confident that the combined use of insourcing and short-term outsourcing will enable it to clear specific backlogs and achieve a sustainable position with the workforce and facilities now in place.*
- *LWH works with insourcing and outsourcing partners in a controlled and transparent way, and all transferred or internally delivered patient activity is closely monitored to ensure safety, quality, and continuity of care.*

Given that approximately only 10-12 women per year are transferred to the Royal from LWH to ICU is all this the first steps to breaking up the Women's Hospital through the back door, as has happened in Leeds to the Children's hospital
The Board is being asked to confirm support to progress a proposal aimed at improving safety in the medium term, including increasing resources at Liverpool Women's Hospital on Crown Street. This is about improving services.

The local community is firmly opposed to any run down of the LWH Crown St site & any moving of services out of L8, including 85,000 signatures on the Save Liverpool Women's Hospital petition and the local MP. As Black, Asian & minority ethnic women are likely to have the worst maternal & neonatal outcomes, where is the evidence that any of these options will give them a safer service?

The NHS is committed to the long-term future of the Crown Street site, which is an important asset. The options appraisal process involved multidisciplinary clinicians and people with lived experience who considered detailed clinical audit information and national service standards. They were clear in their assessment that the business as usual/ no change option was the worst option for addressing clinical risk.

"The number of patients potentially impacted by option 2 is likely to be relatively low', what is meant by this and where is the evidence?

We anticipate that between 20 and 30 maternity and up to 100 gynaecology inpatient procedures would take place each year. These are small numbers relative to total activity.

Risks below – with evidence / data – all detailed in the case for change.

- "Risk 1 - Acutely deteriorating women cannot be managed on site at Crown Street reliably, which has resulted in adverse consequences and harm" RS> Q: Where is the evidence for additional harm to patients? How long is the usual wait to get a bed on any ICU (time interval between decision made and woman admitted to ICU)?
- "Risk 2 - Women presenting at other acute sites (e.g. A&E), being taken to other acute sites by ambulance, or being treated for conditions unrelated to their pregnancy or gynaecological condition at other acute sites, do not get the holistic care they need." Q: How will any of the Options rectify this?
- "Risk 3 - Failure to meet service specifications and clinical quality standards in the medium term could result in a loss of some women's services from Liverpool." Q: Can we see this evidence?
- "Risk 4 - Recruitment and retention difficulties in key clinical specialties are exacerbated by the current configuration of adult and women's services in Liverpool." Where is the evidence for this? This is a national problem not related to being at Crown St.
- "Risk 5 - Women receiving care from women's hospital services, their families, and the staff delivering care, may be more at risk of psychological harm due to the current configuration of services." Stress levels are no different to the national average.
- RCN press release April 2024 states that "24.5% of nursing staff are off work with stress, anxiety and depression. It is so widespread it accounts for 1 week of absence per year for every practising nurse." Therefore LWH is in line with the national average. Here's the link for the reference: NHS sickness data shows average nurse took entire week off sick last year due to stress-related illness | Royal College of Nursing

Question Received	By
Why has there been so much waiting and suffering in A and E, so much corridor care, so many long trolley waits for admission to the wards, all of which costs lives, pain and indignity at the Royal, if there is spare capacity in the hospital available for Maternity, neonatal, and gynaecology on Level 9? **Why is there no mention of the opposition to these plans from the community, trade unions, and campaign groups?** We refer you to this comment from your own papers, 24 07 25 "*Dr Clare Baker, Public Health Registrar) says, "There is a significant difference between demographics and experiences common among senior decision-makers and common among our patients", and "We must acknowledge the gap between demographics and experiences common among senior decision-makers and common among our patients. Designing services for the white and well-off would focus on about 10% of our patients." (page 151 of the PDF for the cm-icb-board 240725-agenda and papers).* **Why are the financial (both capital and revenue problems) of LWH mainly based on the issues with the Maternity Tariff, not mentioned in these options?** ○ **How will any of this help the hospital's financial problems?** ○ **Will these options not increase the administrative load?** ○ **Why are there no costings, and why is there no mention of the likelihood of gaining significant capital spending for these options?** In earlier papers from the ICB and the hospital board, the additional cost of keeping the dedicated services on Crown Street was described as approximately £6million extra per year. The cost of a rebuild was defined as "up to £336 m-£549m". We pointed out that it would take up to 91 years for rebuilding to be cheaper than providing safe care at Crown Street. **Why is this paper not set in the context of the national Maternity crises, when hospitals with some of the configurations described here have had terrible outcomes for babies and mothers?** Professor Marian Knight, Director of the National Perinatal Epidemiology Unit and MBRRACE-UK maternal reporting lead, said: *'These data show that the UK maternal death rate has returned to levels that we have not seen for the past 20 years*." Clearly, this has not been helped by moving Maternity into general and acute hospitals. • **Why was the Save Liverpool Hospital Campaign excluded from this round of consultations, especially after previous assurances that we would be involved?** • **Why do you not mention midwife staffing?** • **How do we, as the public, present an alternative option?**	Felicity Dowing
Response	
Thankyou for your questions. In response: **Why has there been so much waiting and suffering in A and E, so much corridor care, so many long trolley waits for admission to the wards, all of which costs lives, pain and indignity at the Royal, if there is spare capacity in the hospital available for Maternity,**	

neonatal, and gynaecology on Level 9?

There is no spare clinical capacity on Level 9 at the moment. The area is currently occupied by non-clinical staff, who would need to be moved elsewhere, in the event that it was to be used for clinical services.

Why is there no mention of the opposition to these plans from the community, trade unions, and campaign groups? We refer you to this comment from your own papers, 24 07 25
"*Dr Clare Baker, Public Health Registrar) says, "There is a significant difference between demographics and experiences common among senior decision-makers and common among our patients", and "We must acknowledge the gap between demographics and experiences common among senior decision-makers and common among our patients. Designing services for the white and well-off would focus on about 10% of our patients." (page 151 of the PDF for the cm-icb-board 240725-agenda and papers).*

This extract was in reference to the fact that a significant proportion of our patient population is likely to be at risk of unfair and avoidable differences in health outcomes as a result of factors such as ethnicity and deprivation, which means this needs to be a central consideration when planning future services. The views of patients and the public will be gathered during the engagement period.

Why are the financial (both capital and revenue problems) of LWH mainly based on the issues with the Maternity Tariff, not mentioned in these options?

- **How will any of this help the hospital's financial problems?**
- **Will these options not increase the administrative load?**
- **Why are there no costings, and why is there no mention of the likelihood of gaining significant capital spending for these options? In earlier papers from the ICB and the hospital board, the additional cost of keeping the dedicated services on Crown Street was described as approximately £6million extra per year. The cost of a rebuild was defined as "up to £336 m-£549m". We pointed out that it would take up to 91 years for rebuilding to be cheaper than providing safe care at Crown Street**.

The potential options described are about resolving the long-term future and sustainability of hospital-based gynaecology and maternity services in Liverpool, by addressing the clinical risks currently associated with delivering this care, and not about financial issues facing individual trusts or the wider NHS.

While high level financial modelling of potential options has taken place to inform the options appraisal process, more detailed work would be required for a business case.

Why is this paper not set in the context of the national Maternity crises, when hospitals with some of the configurations described here have had terrible outcomes for babies and mothers? Professor Marian Knight, Director of the National Perinatal Epidemiology Unit and MBRRACE-UK maternal reporting lead, said: *'These data show that the UK maternal death rate has returned to levels that we have not seen for the past 20 years*." Clearly, this has not been helped by moving Maternity into general and acute hospitals.

The case for change is clear that outcomes would be improved by co-location with adult acute services. Continuing to deliver services in the current configuration, even with the proposed developments in option 2, would not resolve the clinical risks that come from geographical isolation as described in the case for change.

Why was the Save Liverpool Hospital Campaign excluded from this round of consultations, especially after previous assurances that we would be involved?
The options process outlined in the Board papers took place during summer 2025 – this is the same piece of work we referred to in September 2025 in response to questions about involvement in the Women's Hospital Services in Liverpool programme.

Members of our Lived Experience Panel were involved the options development process, taking part in face-to-face workshops with clinicians, where they actively participated in detailed discussions about how hospital gynaecology and maternity services in Liverpool might look in the future. Because of the complex nature of this work, we believe that giving individuals the opportunity to take part in this way was the best method to allow meaningful input from those who have used services, whether as patients or family members.

We first recruited to the panel during summer 2024, ahead of launching a six-week public engagement in October 2024, but we opened recruitment up again in March 2025 with an open invitation for people to come forward if they were interested in the programme.

In September 2025 we made clear that further public involvement would take place if a business case setting out potential changes was put forward, and it is these next steps which are being discussed by the Board of NHS Cheshire and Merseyside on 29 January 2026.

Why do you not mention midwife staffing?
While we have been clear that recruitment and retention difficulties in key clinical specialities, particularly anaesthetics, are being made worse by the current configuration of services, this does not relate to midwife staffing. Isolation from adult acute services is the main driver for the work. LWH does not currently have a problem recruiting midwives.

How do we, as the public, present an alternative option?
At its meeting on 29 January 2026, the Board of NHS Cheshire and Merseyside is being asked to confirm support to progress a proposal to make a range of service improvements in hospital gynaecology and maternity care. Subject to the Board's agreement, a period of public engagement would then be planned, which would be an opportunity for people to hear more about the proposal and share their views. As part of this, people could put forward alternative proposals that they believe should be considered. The feedback received from the engagement process will then inform final decision-making. It is likely that this engagement would take place during summer 2026.

Question Received	By
Liverpool Women's Hospital (LWH) provides a range of core services according to its contract with NHSE. These are: • Obstetrics and Gynaecology • Neonatology • Fertility services • Genetics • Research and Innovation. Well Woman Centres or hubs are designed to provide certain clinical services such as: • Menopause support • Reproductive health and contraception • Gynaecology treatment for heavy painful or irregular periods and endometriosis • Screening and diagnostics • Sexual health • Pelvic health • Vulval clinics **However many of these services are available at LWH. If these services are then provided at these hubs, will LWH lose revenue as an enhanced service or are they part of the core services in their contract with NHSE?** **How will these hubs be staffed? Will consultants at LWH be deployed to some of these hubs?** **Will the delivery and operations of these hubs involve private providers?**	Sheila Altes - RGN.

Response

Thank you for your questions. In response:

Liverpool Women's Hospital provides a wide range of services for core conditions as a secondary and tertiary level hospital serving the local population and providing specialist services across Cheshire and Merseyside and further afield.

The NHS Neighbourhood model of care for women's health aims to:

- *Increase the proportion of diagnosis, treatment, and care of common gynaecological conditions (menstrual, menopause, continence, prolapse) managed in the community*
- *Reducing waiting times for specialist gynaecological care offered in acute referral settings*
- *Uncovering and supporting women and girls with unmet needs*
- *Improving the uptake of early detection and prevention opportunities across the population footprint*

- *Educating and upskilling health care professionals in hubs*
- *Improve population level women's health*

Some of those services are available at LWH but current data shows that waiting times for first appointments for gynaecology services are high nationally and local reason for referral audits show that a large proportion of women are waiting a long time for appointments for women's health services, who could be reviewed, diagnosed and treated in the community.

Successful partnerships between primary and secondary care and other services are operational in some localities already, with excellent feedback from women and health care professionals with suitable contracting arrangements.

Consultants from LWH have worked with the ICB Women's Health programme to support the training and development of GPs with a special interest in women's health to support this community model and work alongside sexual health and other Health Care Professionals to provide care closer to home. Professional MDT sessions, and advice and guidance are part of this ongoing network of support.

There are no plans to include private providers within this model which is focussed on prevention, diagnosis and appropriate treatment, freeing up secondary and tertiary care for those patients most in need

Question Received	
With regards to East Cheshire NHS trust, **what actions are the ICB taking to ensure provision at ECNT, is of a good standard**. With the percentage of people waiting more than 18 weeks increasing by 9% - the greatest increase of any trust in the country. With the trust making a deficit in the last financial year, whilst continuing to expand and refurbish its buildings. The trust also consistently fails to ensure proper IPC, with higher than average infection rates. **Is the ICB concerned that the current arrangement at ECNT is unsustainable? And what is being done to address the issues raised above?**	Dora Petty
Response	
Thank you for your question. *We should recognise that in the current climate several smaller District General Hospitals remain under continued pressure to balance financially and clinically safe and sustainable services. As an ICB we are working with colleagues in East Cheshire Trust and other tertiary care providers to review the model of care that meets the population need and addresses the drivers of the financial deficit. This work will build upon some of the key strengths that exists across the locality such as community and primary care, supporting a left shift model to enable demand to be better managed and maintained in out of the hospital environment and in patients own home. Capital investments should be aligned to this ambition.*	