

Questions Raised - September 2026 CM ICB Board

Question Received	By
At the previous Board meeting, there was reflection on the importance of good access to General Practice. Since then, the ICB has approved the temporary closure of a service intrinsic to Neighbourhood Health, and affecting a patient group identified as a priority for the ICB. This is not an isolated occurrence. When services close or stop accepting referrals, the workload and clinical risk do not disappear; they are displaced elsewhere in the system, predominantly into General Practice. What oversight does the Board have of temporary service closures and referral suspensions across Cheshire and Merseyside? When these decisions are approved, how does the ICB assess their wider system impact, including equality, patient safety (including for those who cannot be referred) and the consequential impact on General Practice capacity and access? Given the ICB's priorities around frailty, UEC, GP access and Neighbourhood Health, how will the Board ensure that future decisions are considered across the whole system, with appropriate mitigation in place before workload and clinical risk are displaced into General Practice?	Rachel Stead
Response:	
The ICB sadly does not recognise the scenario described. However, we would be happy to engage outside the public meeting if specifics can be shared. On occasion there is a need for the ICB to support urgent decisions brought about as a result of a safety or a regulatory requirement. In which case such urgency is governed by the relevant guidance.	

Question Received	By
The Financial Times reported on a pilot within the Strategic Commissioning tool in which the ICB “has overseen the sharing of patient data from five local GP practices into its version of the Federated Data Platform (FDP), according to an internal NHS briefing note seen by the FT”. 1. How has the ICB informed patients in these practices of the pilot? 2. Why was the pilot not brought to the public Board before implementation? 3. Which GP practices are participating? 4. Do the ICB intend further pilots in which patient data will be shared with any instance of the FDP?	Greg Dropkin
Response	
Thank you for your question. The pilot referred to in recent media coverage involved a limited exploratory exercise with five GP practices in Warrington. The pilot used information from which names, NHS numbers and other direct identifiers had been removed before analysis. The purpose of the pilot was to explore whether combining information from secondary care and primary care NHS providers could help us better understand the health needs of local communities and support future NHS service planning. It was not used to make decisions about the care of individual patients. 1. How has the ICB informed patients in these practices of the pilot? The participating practices received information about the pilot, including its purpose, governance arrangements and the organisations involved in processing the data. The relevant privacy notices, data protection documentation and data sharing arrangements were made available through the ICB's established transparency arrangements. The ICB recognises the importance of maintaining public trust and being transparent about how health information is used to support the planning and improvement of NHS services. Each of the practices were responsible for informing their patients about the pilot, which they did through their established patient communication routes including privacy notices that provide detailed information to enable patients to exercise opt outs. More generally the ICB conducts extensive public engagement with patients and the public on the use of their data in health services and runs a regular digital Public Patient Advisory Group (PPAG).	

2. Why was the pilot not brought to the public Board before implementation?

The pilot was an operational and exploratory piece of work undertaken within established information governance, data protection and decision-making arrangements. As with many technical, analytical and service-planning activities undertaken across the NHS, operational approval was managed through the appropriate ICB governance routes, including the ICB Executive Committee, rather than through the public Board.

3. Which GP practices are participating?

We would not put this information into the public domain without the explicit agreement of practices. The pilot involved five voluntary GP practices in Warrington which entered into the relevant data-sharing arrangements. The participating practices are not named within the published privacy notices or data-sharing documentation, and it would not be appropriate for the ICB to disclose their identities.

4. Do the ICB intend further pilots in which patient data will be shared with any instance of the FDP?

The ICB is currently reviewing the position of the existing pilot through its governance arrangements. Any future activity would be subject to appropriate consideration of purpose, benefits, information governance requirements and organisational approval before proceeding however, there are no current plans for future pilots.

Question Received	By
Cheshire & Merseyside ICB gave explicit assurance in March 2026 that it would continue the collaborative work with Liverpool Hospice Action Group (LHAG), now known as Liverpool Hospice Pressure Group (LHPG) on the future procurement of inpatient hospice services — work that had already been underway since June 2025. Despite this, all communication from LHAG and LHPG since April 2026 has gone unanswered, including a message sent directly to the Executive Clinical Director using the contact number she provided. Given this prolonged absence of engagement, what explanation can the Board provide for the breakdown in communication, and what assessment has been made of the governance risks created by failing to respond to stakeholder groups who were formally recognised as partners in the development of future hospice provision? In particular, what assurance can the Board provide that specialist palliative care has not been allowed to drift into a deprioritised or unmanaged state, in light of: • the temporary and hospital-based nature of the Maple Suite beds, which do not constitute a commissioned inpatient hospice service • continuing reports of patients receiving end-of-life care in hospital corridors, indicating systemic pressure and potential breaches of dignity, safety, and quality standards • concerns from clinicians that the absence of commissioned inpatient hospice provision is leading to deskilling, erosion of specialist capability, and increased reliance on non-specialist settings What specific evidence can the Board provide — not general statements — to demonstrate that: 1. A structured and accountable programme of engagement with LHPG exists, with defined leads, timelines, and reporting routes 2. Risks to specialist palliative care skills, workforce confidence, and service continuity have been formally assessed and mitigated 3. The procurement of inpatient hospice beds is being progressed through a transparent governance pathway, with milestones, decision points, and responsible officers 4. No patient at the end of life is being left dependent on temporary arrangements or unsafe hospital environments due to commissioning delays Finally, when will the Board publish a clear, time-bound plan setting out how it intends to restore engagement, stabilise specialist palliative care capacity, and deliver a permanent inpatient hospice solution?	Caroline Chester

Response:

Thank you for your questions regarding stakeholder engagement, specialist palliative care provision, and the future procurement of inpatient hospice services for the city of Liverpool.

The ICB recognises the concerns expressed by the Liverpool Hospice Pressure Group (LHPG) and acknowledges the importance of maintaining effective communication with patients, families, clinicians, voluntary sector partners, and community representatives involved in the development of palliative and end-of-life care services.

Accountable programme of engagement

We acknowledge that correspondence from LHAG/LHPG has not received the timely response that stakeholders are entitled to expect. This has arisen during a period of organisational change, competing service pressures, and changes to programme leadership. While these factors provide context, they do not excuse the lack of communication, and we apologise for the frustration and uncertainty this has caused.

The ICB accepts that sustained engagement with recognised stakeholder groups is an important part of good governance. We have therefore asked that Leigh Thompson, Director of Health Care Commissioning for Liverpool City Region and Dr Sinead Clarke review communication arrangements and ensure that appropriate mechanisms are in place for regular engagement, clear points of contact, and timely responses to correspondence.

Governance and Oversight of Specialist Palliative Care

The ICB wishes to assure stakeholders that specialist palliative and end-of-life care remains a priority area and continues to be subject to executive and clinical oversight.

We recognise concerns regarding:

- The interim nature of current inpatient arrangements.
- Pressures affecting end-of-life care across the wider health and care system.
- The potential impact of prolonged uncertainty on workforce confidence, recruitment, retention, and maintenance of specialist skills.

Palliative End of Life Care for C&M ICB

C&M ICB have co-produced a population health-based needs assessment that provides the evidence to support our draft strategic plan and a list of 12 evidenced based interventions that will help support sustained improvements in outcomes for patients and carers, including by systematically identifying, measuring and reducing health inequalities, and reducing unwarranted variation in access, experience and outcomes.

1. Identification of palliative care needs and care planning
2. Specialist palliative care provision for babies, children, young people and adults
3. Provision of integrated and holistic palliative and end of life care, by generalists and specialists working together
4. Continuity of Care: relational, management and informational continuity
5. Out of hours care
6. District and community nursing
7. Social care
8. Informal family support
9. Volunteers
10. Palliative rehabilitation
11. Cultural safety and competency
12. Bereavement

Our intention is that every person who needs palliative care or care at the end of life will have equitable access to high-quality support, shaped by what matters to them, their families and carers.

1. We will support our staff and our population to better understand palliative care, death and dying.
2. Provide a person-centred approach and ensure equitable access to earlier and more effective identification of needs, in all settings of care.
3. Prevent distress through proactive and equitable assessment and management of need closer to home.
4. Ensure equitable access to personalised palliative care.
5. Deliver palliative care response that is timely, effective and equitable, including access to out-of-hours telephone support, within this parliament.

Risks to specialist Palliative care

These risks that you identified have been considered through a revised C&M governance structure, including clinical quality & safety, workforce, skills and education, pathway redesign and commissioning oversight arrangements.

The ICB recognises that any prolonged reliance on temporary provision requires careful monitoring to ensure patient safety, dignity, quality of care, and continuity of specialist expertise.

To reassure colleagues the ICB with partners at UHLG agreed to extend the current contractual arrangements until 01.04.2027, allowing the trust to embed clinical policies and protocols, support staff and their development, educate and skill staff from other specialities in palliative end of life care and to specifically provide continuity of care to the patients and their families.

Regular contract review meetings and monitoring of all activity on the ward continues and any concerns raised have been addressed through the appropriate governance arrangements.

Corridor Care and unsafe hospital environments

In response to continuing reports of patients receiving end-of-life care in hospital corridors, indicating systemic pressure and potential breaches of dignity, safety, and quality standards, C&M ICB have explicitly stated that corridor care is unacceptable and should only occur in exceptional circumstances whilst systems work to eliminate it entirely. Evidence from both Royal Liverpool University Hospital and Aintree University Hospital indicates that corridor care has been used during periods of operational pressure. Whilst this historically was a phenomenon specific to winter pressures, this has now become an issue year-round as a direct response to a 12-15% increase in ED attendances. External scrutiny by the CQC, national media investigations, Liverpool City Council and patient testimonies have highlighted concerns relating to patient dignity, privacy, delayed assessment and treatment, and potential patient safety risks.

UHLG acute sites have clear actions to reduce and eliminate corridor care both in ED's and on wards and are reporting improvements through governance structures internally and through regulators. Programs of work are directly linked to local, regional and national policy. Evidence of improved care and a reduction in the overall numbers of patients being cared for in sub optimal areas such as corridors, specifically those patient who are palliative and end of life, has been associated with the introduction of the Maple Suite and the trust wide arrangements between sites including Woodland's hospice, the virtual ward and the Impact model.

Next Steps

The ICB agrees that transparency is essential. Subject to completion of the ongoing programme review and relevant governance approvals, we intend to publish, within the next 2-4 weeks, a clear update setting out:

- The arrangements for renewed engagement with LHPG and other stakeholders.
- The current position regarding specialist palliative care capacity.
- The programme timetable for the future development and procurement of inpatient hospice services.
- Key milestones and expected decision points.

Conclusion

The ICB accepts that stakeholder confidence depends upon open communication, visible accountability, and demonstrable progress. We are committed to re-establishing effective engagement, ensuring robust oversight of specialist palliative care services, and progressing work towards a sustainable long-term solution for inpatient hospice provision.

We will provide a further public update following completion of the requested review and presentation of the associated assurance report through the appropriate governance processes.

Question Received	By
Maternity services and the Ockenden, Amos and government reviews are mentioned in the minutes on p.13. Maternity 'assurances' and 'challenges' in the region are referred to on p.182 and 183 of the ICB papers, including delays in Induction of Labour across maternity units, issues round triage and suspensions of home birth services across the region, are these linked to staff shortages as referred to in these national reports? Where is the expected business case regarding Liverpool Women's Hospital and Liverpool women's services? At the joint board of the University Hospitals Liverpool Group on Thursday 17th a board member asked if there was a pause of the plans for LWH, the board was informed there was a 'review and reset' of the plans in the light of feedback from the engagement and the maternity reviews. Can the ICB clarify what is meant by this and what is the timetable?	Lesley Mahmood And Frank McEntaggart
Response:	
Maternity 'assurances' and 'challenges' in the region are referred to on p.182 and 183 of the ICB papers, including delays in Induction of Labour across maternity units, issues round triage and suspensions of home birth services across the region, are these linked to staff shortages as referred to in these national reports? The Maternity workforce is under pressure with increasing complexities in pregnancy and workforce morale being low due to associated work pressures and negative media coverage in the light of recent reports. Delays in care can relate in some cases to sickness absence however C&M has a low vacancy rate, and all trusts are compliant with BR+ (Birth rate plus), the national staffing safety tool for midwifery. Additional funding has been sent directly to trusts from NHSE nationally to increase their midwifery staffing following the Amos report. The national online staff conversation Your Voice: Building a Better Future for Maternity and Neonatal Care was launched on 21 September to hear directly from all those working in maternity and neonatal services to shape the improvements required by the National Maternity Taskforce. A thorough review of IOL delays has been conducted in C&M with recommendations to be presented to the ICB Quality and Performance Committee and learning shared from trusts who have reduced their delays across C&M.	

Home birth service suspensions can be due to staffing shortages which are usually last-minute sickness and/or availability of 2 x skilled and experienced midwives to attend the home. These decisions are made based on safety and suspensions are usually for a short time period.

Maternity Triage

C&M has a standard of triage within 15 minutes which was introduced and embedded across trusts over 3 years ago. (Nationally the standard was midwife triage within 30 minutes, but this has changed in the recent Ten-Point Plan following publication of the AMOS report and now aligns with the C&M standard of 15 minutes). Triage breaches have started to increase and the reason for this is unclear. LWH have seen the biggest increase but proportionately see the most women. LWH are over recruited for midwifery but are reporting that they have seen an increase in triage attendances and are looking into why that might be. Increasing complexity, greater awareness and media coverage may be contributing.

Where is the expected business case regarding Liverpool Women's Hospital and Liverpool women's services?

The hospital management team and executive colleagues at UHLG are continuing to work on the details for delivering the improvements outlined in Option 2 of the options appraisal document. This is taking longer than anticipated due to a change in leadership in the LWH site team and also additional work being done with clinicians to consider the optimal clinical model for delivering the improvements as well as additional consideration being given to the physical building works that are required for the enhanced care unit.

At the joint board of the University Hospitals Liverpool Group on Thursday 17th a board member asked if there was a pause of the plans for LWH, the board was informed there was a 'review and reset' of the plans in the light of feedback from the engagement and the maternity reviews.

Can the ICB clarify what is meant by this and what is the timetable?

The ICB is not able to speculate on what was meant by comments made by an unknown individual at UHLG board. The timetable has changed in light of the additional work outlined above and as soon as a confirmed timetable is agreed the Trust and ICB will make that known to all stakeholders and interested members of the public.

Question Received	By
We've seen a recent uplift in UDA rates in the North East. Is Cheshire & Merseyside ICB considering a similar uplift for practices across Cheshire and Merseyside, and can providers expect any changes to UDA values in the near future?	Cathy Murphy
Response	
There are no agreed plans to do this. Supporting better access to NHS Dentistry for our patients remains a commissioning priority for the ICB.	

Question Received	By
With NHS orthodontic contracts coming up for extension, is Cheshire & Merseyside ICB planning to extend the existing contracts or undertake a new procurement, and should current providers be preparing for the possibility of having to re-tender?	Connor Bryan
Response	
Cheshire & Merseyside ICB is currently reviewing the commissioning arrangements for NHS orthodontic services, including the contracts that are approaching their extension/end dates. At this stage, no final decision has been made as to whether the existing contracts will be extended or whether a new procurement exercise will be undertaken. Providers should therefore not assume that contracts will automatically be extended and should remain mindful that a competitive procurement process may be required. However, the ICB will follow the regulations of the procurement selection regime (PSR) and decisions will be made and approved in accordance with the ICB governance frameworks.	