

## Questions Raised – March 2026 CM ICB Board

Question Received	By
<p>Billinge Medical Practice (BMP) has been given notice by their landlords to vacate their premises within six months. We are one month in to this notice and I would assume the GP practice would need at least one month to vacate all personnel and equipment plus one month to bring any new/temporary premises to standard before occupation. Therefore in reality BMP has two months to have premises available.</p> <ul style="list-style-type: none"> <li>• <b>So, who is leading this process from the ICB?</b></li> <li>• <b>Is the focus on what the 8500 patients of Billinge and Orrell want (the practice to remain in Billinge) or is the plan to scatter patients amongst already stretched GP facilities miles from the villages of Billinge and Orrell?</b></li> <li>• <b>What is the ICB plan?</b></li> <li>• <b>Are there a team of people with sufficient authority to make decisions to support the leader?</b></li> <li>• <b>Are regular meetings in place? Chaired with agenda's and minuted?</b></li> <li>• <b>Are these minutes in the public domain and could I make a freedom of information request for copies of these?</b></li> </ul>	<p>Darren Gilchrist</p>
Response	
<p><b>So, who is leading this process from the ICB?</b>  The ICB Place Team are working with the practice, ICB Estates leads and NHSE estates leads to consider all suitable options for a long-term solution for the practice. This is a collaborative approach to understand and consider all options available for the practice</p> <p><b>Is the focus on what the 8500 patients of Billinge and Orrell want (the practice to remain in Billinge) or is the plan to scatter patients amongst already stretched GP facilities miles from the villages of Billinge and Orrell?</b>  Options are being reviewed with the priority aim of retaining a local solution for the practice. Due diligence is being undertaken to understand estates options. Dispersal of patients is not currently being considered with the immediate aim to find a feasible estates solution agreeable to the practice.</p> <p><b>What is the ICB plan?</b>  The plan is to establish feasible options for the practice working with estates specialists to appraise. This work is currently in progress, and time is required to go through formal due diligence.</p> <p><b>Are there a team of people with sufficient authority to make decisions to support the leader</b>  Yes</p> <p><b>Are regular meetings in place? Chaired with agenda's and minuted?</b>  Yes, weekly meetings are taking place with additional meetings taking place directly with the practice.</p>	

**Are these minutes in the public domain and could I make a freedom of information request for copies of these?**

The enhanced surveillance group is not a public meeting, commercially sensitive and confidential matters are discussed. If an FOI request is submitted, this will be reviewed by the relevant team.

Question Received	By
<p>Billinge Medical Practice has been issued with a six-month eviction notice by its landlords. Given that over one month of this notice period has already elapsed, and allowing for the time required to safely decant services and prepare any alternative premises to an appropriate clinical standard, it is clear that the Practice is operating within a significantly reduced and increasingly critical timeframe. On behalf of the 8,500 patients served across Billinge and Orrell, I would ask the Board to provide clarity on the following:</p> <ul style="list-style-type: none"> <li>• <b>Who is the named accountable lead within the ICB responsible for ensuring continuity of GP services for this patient population?</b></li> <li>• <b>What is the agreed, time-bound plan - with clear milestones - to secure appropriate premises within Billinge, rather than dispersing patients to already stretched neighbouring practices?</b></li> <li>• <b>What specific actions have been taken by the ICB since the eviction notice was issued, and what measurable progress has been made to date?</b></li> <li>• <b>Why has there been no clear and transparent communication of this plan to patients, and when will this be shared publicly?</b></li> <li>• <b>What formal options have been explored in relation to securing the existing premises - including purchase of the building -and why was this not pursued at an earlier stage as a means of safeguarding local provision?</b></li> <li>• <b>How is the ICB discharging its statutory duty to ensure the provision of safe, accessible, and continuous primary care services for this community during this period of uncertainty?</b></li> <li>• <b>How has the ICB engaged with the patients within our community in shaping its response, and how will patient views influence the final decision?</b></li> </ul> <p>This situation is of significant concern to local residents, particularly given the reliance on accessible, community-based GP services. I would appreciate a clear and substantive response from the Board.</p> <p>I have copied David Baines MP into this correspondence given the urgency of the situation and would welcome his support in ensuring the ICB provides a clear, accountable plan to protect GP services for Billinge residents.</p>	<p>Karen Hatch</p>
Response	
<p>As per answer one (Darren Gilchrist)</p>	

Question Received	By
<p>This question for the Board is posed by the Chairs and Secretary of the Billinge Medical Practice Patient Participation Group (PPG) who are Darren Gilchrist (PPG Chair, Billinge), Andrea Jack (PPG Chair, Orrell) and Marion Logan (PPG Secretary). This question is very time sensitive since, without prompt and decisive intervention, Billinge Medical Practice, a GP practice serving over 8,500 patients, will be without premises from which to deliver their services by early September this year ... which is only 5 months away!</p> <p>As we hope the board is aware, Billinge Medical Practice has been served notice by the landlords, who are the former GPs, to vacate the premises from which the GP service is currently delivered on Recreation Drive, Billinge. This situation regarding the premises insecurity has been developing, without meaningful NHS intervention and support as far as we can tell, for multiple years prior to the new team taking over. The practice has already had to vacate the Orrell branch of the practice when the ex-GP landlords previously served notice for them to leave those premises.</p> <p>Apart from the premises issue, this GP practice is an unbelievable success story that ought to be being championed and supported. The new GP contractors have delivered an unprecedented turnaround in service quality, in an extremely tight timeframe. They have taken it from CQC Inadequate to CQC Good within a year, and in addition are now a training practice too! A PPG patient survey, based on the questions used in the official annual IPSOS GP survey, found that patient satisfaction is now over 20% higher than the national average! With limited public transport options, the community needs this GP success story practice maintaining in their local, semi-rural neighbourhood.</p> <p>Now that the new GP contract holders have turned the practice around in nothing short of a spectacular fashion, our questions for the board <b>are how are the NHS supporting them, especially in such a short timeframe, to secure premises for the 8,500+ patients relying on their services? And who has been allocated from NHS Cheshire and Merseyside to lead and take responsibility for this?</b></p> <p>If there is anything that the PPG can do to support resolution of this situation then please ask.</p>	<p>Darren Gilchrist (PPG Chair, Billinge)</p> <p>Andrea Jack (PPG Chair, Orrell)</p>
Response	
<p>As per answer one (Darren Gilchrist)</p> <p>In addition we welcome the positive feedback supplied on practice performance and improvement as stated.</p>	

Question Received	By
<p>On p.61 the board papers state that 'the cost of delivering the current model (of maternal &amp; neonatal/women's services in Liverpool) contributes to the lack of system financial sustainability'.</p> <p><b>Q1. Is not the inadequate maternity tariff and underfunding of maternity and neonatal care as recognised in the initial Amos report and the NHSE NW licence letter one of the main drivers of the financial situation of Liverpool Women's Hospital?</b></p> <p><b>Q2. How will moving services to the Royal cost less as the biggest cost is staffing?</b></p> <p><b>Q3. What is the timeline for the publication of the Women's Services Business Case and the consultation?</b></p>	<p>Lesley Mahmood</p>
Response	
<p>The item on page 61 is outlining the strategic position and configuration of maternity services across all of Cheshire and Merseyside not just in Liverpool. The financial position of Maternity and neonatal services in Liverpool is complex with maternity tariff being just one of a number of contributory factors.</p> <p>The full costing of major service reconfiguration of maternity and gynaecology services in Liverpool has not yet been finalised. Staffing costs are a significant area of spend for all NHS services however there are a range of other factors that also need to be taken into consideration.</p> <p>Subject to the development of the draft business case, and the Board of NHS Cheshire and Merseyside approving the engagement plan, we hope to begin public engagement on proposed improvements to hospital gynaecology and maternity services in early June 2026. This will run for six weeks.</p> <p>The engagement feedback will be used to inform the final business case for this proposal, which will then be presented to the Board of NHS Cheshire and Merseyside for decision-making. We currently expect this to take place in autumn 2026.</p>	

Question Received	By
<p>Re page 16:            This is the third year of winter crisis corridor care reported by the ICB in Cheshire and Merseyside. Such "care" is hated by patients, their families, and the staff caring for them. It is known to increase mortality and to lack dignity, however kind, caring and competent staff might be.  <i>"The Committee reviewed the position on winter pressures and noted significant concern regarding acute bed occupancy, which had reached 96%, exceeding the recommended threshold."</i>  <b>Q1. When will it return to the safe level of 85%?</b>   <i>"The Committee reviewed detailed information on corridor care and noted that the number of instances had reduced over the Christmas period despite an overall increase in A&amp;E attendance"</i>   <b>Q2. Was this because the hospitals had cleared beds before Christmas due to fewer elective surgeries and fewer planned treatments other than emergencies?</b>  <b>Q3. Did these figures for bed occupancy include those patients who were in the corridor or other unusual settings? Or were these patients not counted?</b>  <b>Q4. What percentage of patients treated in Corridors were 70years old and more?</b>  <b>Q5. How many children were there?</b>  <b>Q6. Given this high occupancy, were extra cleaners employed? Does the ICB require higher hygiene measures?</b>  <b>Q7. How many hospital-acquired infections were there amongst this cohort of patients?</b>  <b>Q8. How many falls were there in this group of patients?</b>             Having noted the difficulties shown in the financial reports for 2025-26 on the whole system finances in the board papers for March 2026;  <b>Q9. Were the figures printed in this Health Service Journal article, as indicated in the attached chart, correct for this ICB?</b>  <b>Q10. Will the real-terms increase in funding for this ICB in 2026-7 be just over 0.5%?</b>  <a href="https://www.hsj.co.uk/expert-briefings/following-the-money-the-losers-from-nhses-great-redistribution/7041095.article">https://www.hsj.co.uk/expert-briefings/following-the-money-the-losers-from-nhses-great-redistribution/7041095.article</a> </p>	<p>Felicity Dowling</p>
<b>Response</b>	
<p><b>The Committee reviewed the position on winter pressures and noted significant concern regarding acute bed occupancy, which had reached 96%, exceeding the recommended threshold." When will it return to the safe level of 85%?</b>            This is reflective of a wider national situation. Acute Trusts in England have not routinely operated at 85% occupancy for many years, and currently for England occupancy is typically in the region of 95%. Locally we have determined that if trusts were able to operate at around 92% occupancy this would facilitate improved flow and patient experience, and this is the level we aim to achieve in our winter plans, especially in the run up to Christmas in order to mitigate against the impact of the increased demand we typically see in January.</p>	

**The Committee reviewed detailed information on corridor care and noted that the number of instances had reduced over the Christmas period despite an overall increase in A&E attendance" Was this because the hospitals had cleared beds before Christmas due to fewer elective surgeries and fewer planned treatments other than emergencies?**

In part yes, there are typically fewer elective procedures over the Christmas period. However, a broad range of actions were taken within our winter plans, all of which aimed to contribute to a safer winter.

**Did these figures for bed occupancy include those patients who were in the corridor or other unusual settings? Or were these patients not counted?**

No however corridor care is captured in other data reporting

**What percentage of patients treated in Corridors were 70years old and more?**

The ICB does not hold this information.

**How many children were there?**

The ICB does not hold this information.

Whilst corridor care should never be seen as acceptable or normalised, as a C&M system, extensive work has been undertaken to develop quality standards called the "Red lines Toolkit, (that have since been nationally adopted) to ensure we maintain safety and give the best experience as possible when patients are nursed in those environments.

Assurances on these quality standards are sought via the NHS standard contract and are reported via QPC on a quarterly basis. All Trusts are embedding and developing these standards, with Healthwatch also using the toolkit as a prompt for their visits.

HCAI and falls rates specific to these areas are difficult to monitor, however clinical teams are continuously addressing the recognised IPC risks through the use of a range of IPC measures across the emergency departments

**Difficulties shown in the financial reports for 2025-26 on the whole system finances**

Yes. The HSJ calculated the figure using the core allocation net increase of 2.56% less the cost uplift of 2.03% which equates to a 0.53% real terms increase in funding. The allocations assume an efficiency requirement of 2% which is the same as 2025/26 and include a further reduction of 0.21% (reduced from 0.5% in 2025/26) as the ICB is currently spending more than its fair share of funding.

Question Received	By
<p>My MP Matthew Patrick wrote to the board on 01.08.2025 asking for assistance with a number of Subject Access Requests. I've been requesting medical information through the Subject Access Request process and escalating via the Information Commissioners Office. Despite this the following hospitals continue to act unlawfully within our region. Namely Mersey Care, The Walton Centre and more recently Liverpool University NHS Trust. If we take the example of Mersey Care I have been asking for a full disclosure for over 3 and a half years now.</p> <p>I cannot believe that this is an isolated case, because the hospitals are so adept at evading disclosure regardless of who is involved. In my case, this board has received an escalation from my MP, and still I'm no further forward 7 months on.</p> <p><b>Is this something that the board finds acceptable, and if not how will you assist patients and their representatives, who are facing this ongoing challenge? Does the board have any legal powers to enforce lawful disclosure of patient records and laboratory readings?</b></p> <p>Please note I would also be happy to share my personal experiences as a carer with the board, should they wish for an insight into my serious concerns about the local health system.</p>	<p>Alison Moglione</p>
Response	
<p>While Integrated Care Boards must comply with UK GDPR, NHS Cheshire and Merseyside only holds and processes information required for the ICB's statutory functions. We do not hold, manage or access the clinical records of NHS provider organisations.</p> <p>Like the ICB, all NHS trusts are legally required to comply with Subject Access Requests under the UK General Data Protection Regulation and the Data Protection Act 2018. It is also important to note that ICBs do not have legal powers to compel or enforce the disclosure of patient records or laboratory results held by NHS trusts. These responsibilities sit solely with the provider organisations as the data controllers for their clinical records.</p> <p>Recognising the importance of people receiving timely responses and access to their information, we have contacted each of the three provider organisations you identified to raise your concerns and request updates. Based on the information they have provided to us, we are assured that each organisation has received, reviewed and acted on your enquiries.</p> <p>We hope this provides you with the clarity and information you were seeking, and we are grateful to you for bringing this matter to our attention.</p>	

Question Received	By
<p>The 5 Year Strategic Clinical and Commissioning Plan 2025-2031 is to be commended in its desire to shift from hospital to community care and from sickness and treatment to prevention and well-being, and narrowing health inequalities. However delivering on these ambitions appears to run up against the financial and workforce capacity constraints presented in other reports on the ICBs agenda, chiefly the adverse financial position reported at month 11 2025/26, the required undertakings to NHSE, the workforce reductions expected by the end of March, and the risk assessment admission that "delivery of the requested reduction in the running cost allocation may have a significant impact on the ICBs ability to deliver against our commissioning intentions" (P10)</p> <p><b>Given such qualifications shouldn't the 5 year strategic plan carry a clear honest warning to residents/stakeholders that its delivery and sustainability is working under severe external and internal resource constraints?</b></p>	<p>Paul Dolan</p>
Response	
<p>We acknowledge the risks you have put forward. We consider that the 5 Year Clinical and Strategic Commissioning Plan set out a number of actions which act as mitigations within the areas you have identified. As follows:</p> <ul style="list-style-type: none"> <li>• How we will work differently with partners (including residents) (p 6-8) to focus our efforts on priorities that are based on a structured needs assessment (p 12-17 with further specifics throughout the plan)</li> <li>• We know as an organisation the role of ICBs is changing and we need to develop our skills and ways of working which will include a commitment to OD and how we work with partners to work more effectively and efficiently as a system (p9-10)</li> <li>• There is a need to shift the proportion of expenditure in line with the three shifts and this can't happen overnight.             <ul style="list-style-type: none"> <li>○ We reference how we will start to do this on page 32 of 5 Year CSCP with further detail in the Population Health Improvement Plan on shifting investment (left shift on p7-8 of PHIP) and also by</li> <li>○ Applying a population health approach to targeting resources at "higher need" populations which will have the greatest impact by reducing their need for specialist (hospital) based care and enable a further shift in resources as we start to see this reduction e.g. frailty, people nearing the end of life (p 3-6 of PHIP)</li> </ul> </li> </ul>	