NHS
Cheshire and Merseyside

Questions Raised – May 2026 CM ICB Board

Question Received	By
Regarding the report on maternity & gynae changes from p.22 onwards of the report Q. 1 Why are only 3 physical meetings being proposed, 1 each for the whole of Liverpool, Sefton & Knowsley? Q. 2 Why is there no detailed business case in the papers, as how can the public give a view if there is no detail of what is involved, including • details of exactly how the 9th floor of the New Royal would be staffed, where will those staff come from • what happens to the babies of the 30 or so surgical births, how can the 9th floor of the Royal offer wrap around services for mothers & babies e.g. neonatal care, breast feeding support, mental health support to name just a few • where are detailed costings for staff and equipment, support services etc. • where will the additional costs come from given the severe financial problems of both LWH and LUHFT due to the way maternity and other services are funded, and cuts imposed on the ICB and these trusts? • what is currently on the 9th floor and where will those services take place, e.g. where would admin be moved to in an already crowded Royal? • The local MP, many in the local community including 90,000 who have signed our petition and many of the Black, Asian & minority ethnic women are opposed to moving services out of Liverpool 8	Lesley Mahmood
Response	
The plans include 3 in person meetings covering the 3 local authority areas that are the main users of services at Liverpool Women's Hospital. This was felt to be the most cost-effective way to ensure there was opportunity for in person engagement. As detailed in the report there will be several other methods used to gain the views of the public and people with experience of using these services. The document in the board pack is to obtain the board's approval to progress with the plans for public engagement on short to medium term proposed changes to complex and high-risk maternity and gynaecology services due to start next month. The full business case that will contain the answer to the questions you have listed is still being developed by the clinical and operational teams at UHLG. Regarding the use of Floor 9 in the Royal hospital building, this was part of the proposal outlined in option 6 during the options appraisal. It may or may not be part of the plans to deliver this smaller proposed change for complex cases in the short to medium term. That detail will be in the final operational plans and business case. The ICB and UHLG both meet regularly with local MPS to keep them appraised of proposals and progress.	

Question Received	By
Regarding plans to treat high risk pregnancies and complex gynaecology surgeries at the Royal Liverpool University Hospital (RLUH), I would be interested if you could answer the following questions, I understand that, at present, pre-operative assessments with specialist teams determine the site most appropriate for the procedure, either RLUH or Liverpool Women's Hospital (LWH). 1. Do your current plans exclude LWH from delivering any of these procedures? 2. What will the provisional care be at RLUH if a newborn needs intensive care? 3. Given that the numbers needing very specialised care are small, approximately 130 per annum (your figures), is it appropriate to open a special unit on the 9th floor and who will staff it? Will these be additional posts based at the unit in RLUH? 4. If a woman with a high-risk pregnancy goes into spontaneous labour ahead of her elective surgery date, is she expected to present at RLUH's Accident and Emergency department?	Sheila Altes

Response

The clinical teams at UHLG continue to work on detailed operational plans to deliver these changes.

1. Plans will not exclude these procedures from happening at LWH site if it is felt that would be the most appropriate option for an individual patient. All patients will have an individual clinical plan agreed by the patient and their clinical team ahead of any treatment at the Royal site.
2. The detailed operational plans that continue to be refined by the UHLG teams will include planning for the care of newborns with additional medical needs. As occurs now, babies will be transferred by the neonatal intensive care transfer team to the most appropriate site for their ongoing care.
3. No decision has been made about where at the Royal site these patients will be managed. The clinical teams are working on detailed operational plans and considering which options are going to deliver the optimal care for this cohort of patients. The full business case will detail the staffing plan required to deliver this care safely.
4. No. Each woman who is selected as appropriate for receiving maternity care at the Royal site will have a personalised plan for what to do in the event of spontaneous labour.

Question Received	By
Re- page 28-42, Women's Services. 1. Why does the document not mention option 6 of the January paperwork, given that at the January meeting it was said most emphatically "There is no going back from option 6"? Option 6 gives a distinct profile to these proposals, quite different from the proposals as outlined here. 2. Why does this document, which is described as a business case, not include "...a case for change; articulating value for money; commercial viability; affordability; and a capability to deliver"? a) Why is there no mention of staffing, governance, monitoring, finance, equipment, and other resources? b) Why is there no mention of the necessary building work required to meet national standards as mentioned in the January paperwork 3. Will this process come from existing funding or be additional? 4. Will the staff working on this process constitute additional posts? Will this require additional intensive care facilities and surgery days at the Royal? Who will cover at Liverpool Women's while staff are at Liverpool Royal? How will unexpected complications be managed with staff working away in the Royal? 5. How does the hiatus in leadership at the Liverpool Hospitals group and Liverpool Women's Hospital affect this process? 6. How will this impact on the very serious financial situation at the Liverpool Women's Hospital and separately at LUFT?	Felicity Dowling

Response

1.The document in the board pack is to obtain the board's approval to progress with the plans for public engagement on short to medium term proposed changes to complex and high-risk maternity and gynaecology services due to start next month. The longer-term changes that would be required to deliver option 6 are not yet at a stage where meaningful public engagement could happen. When those plans are worked up in more detail there will be further public engagement required. There will however be the opportunity to talk about the outcome of the options appraisal and the high-level information about option 6 during the in-person events as part of this engagement work.

2. This document is not a business case for option 2. The UHLG team are continuing work on the draft outline business case and once that is worked up into a full business case then it will be presented to the ICB board. A full business case will include all of the element you have listed in your questions 2,3 and 4.

5.We do not expect the changes in leadership at UHLG to significantly impact on this process.

6. The full business case will address the detailed financial planning required to deliver the proposed changes.

Question Received	By
I understand that the ICB will be asked to agree to a plan to change the delivery of Women's services in Liverpool. Should this be agreed, a public engagement will begin on 2 June. How will the ICB guarantee that the public engagement of 6 weeks will reach all the people who will be affected (especially those who are digitally excluded) by the proposed plan, as there will be only one public meeting in Liverpool, with details to be disclosed on 2 June and what evidence will the IBC propose to prove the public engagement is effectively carried out?	Celia Kelly

Response

How will we ensure we reach the people who are affected?

Public meetings are one of a number of ways to reach people during an engagement period – but they're not the best way of ensuring we hear from those most directly impacted (especially when those directly affected is quite a small, specific cohort of patients)

That's why we're taking a much more targeted approach, and will be spending more time talking to patients who have personal experience of the kind of care that the proposal focuses on. We are doing this by:

- partnering directly with local community groups and networks (particularly women's groups) to host a range of more targeted meetings, events or focus group sessions
- talking to those with previous personal experience of receiving this kind of high risk or complex care – both in 1:1 interviews & through our lived experience panel

…Especially those who are digitally included

For those who are digitally excluded (or have other barriers to access), we're providing a single point of contact (via the PALS team phone line at Liverpool Women's) - so people can give feedback over the phone, and/or request paper-based versions of the questionnaire and supporting materials, and other formats and languages.

And what evidence will the ICB propose to prove the public engagement is effectively carried out?

We're applying a transparent, best practice approach to the engagement process (as we always do) which includes:

- publishing our full engagement plans in advance – this outlines in detail what an effective engagement looks like, and the ways we will measure our reach/effectiveness

- using an independent company to handle & analyse all of the feedback we receive, and put it into a report, which we will publish and proactively share with stakeholders

Question Received	By
The Cheshire & Merseyside Clinical & Strategic Commissioning Plan (CSCP) and Population Health Improvement Plan (PHIP) refer repeatedly to Accountable Care. The PHIP states that the priorities for 2028-31 are to "Commission community, mental health, secondary and tertiary care services from an Accountable Care Organisation". The PHIP refers to Alder Hey as an Integrated Health Organisation (IHO). The CSCP states that the ICB will "Work with Alder Hey NHS Foundation Trust, and system partners, to develop an Accountable Care Organisation approach to prevention, care and treatment for children and young people." According to the July 2025 Ten-Year Plan, IHOs will be free to form "new partnerships" and "to contract with other service providers, within and outside the NHS". The Oct 2025 Medium Term Planning Framework described IHO as a contracting model rather than an organisational form. 1) Will Accountable Care Organisations (ACOs) in Cheshire & Merseyside be NHS bodies? 2) Will ACOs in Cheshire & Merseyside be free to form new partnerships and to contract with other service providers, within and outside the NHS? 3) If an ACO in Cheshire & Merseyside wishes to form a partnership with a non-NHS service provider, will that decision be subject to public consultation? 4) How have you evaluated the experience of ACOs in Spain (Ribera Salud) and the US before formulating the CSCP and PHIP?	Greg Dropkin

Response

1) Will Accountable Care Organisations (ACOs) in Cheshire & Merseyside be NHS bodies?

The priorities outlined in our plans centre on how we can work with current NHS providers to achieve this. We have not defined the exact configuration of services, and the approach may vary depending on the nature of service provision and geographical considerations.

We are very much at the beginning of planning an approach as to how we can best use the contractual models that will help to improve outcomes for our residents through integration of services to simplify pathways, reduce variation in access, experience and outcomes and reduce duplication in order to improve cost effectiveness.

We are initially focused on how best we can address those areas identified as priorities in our Clinical and Strategic Commissioning Plan (which are described in more detail in our Population Health Improvement Plan) including Neighbourhood Health, Children and Young People and Mental Health, Learning Disability and Neurodiversity.

2) Will ACOs in Cheshire & Merseyside be free to form new partnerships and to contract with other service providers, within and outside the NHS?

At present the services provided in our neighbourhoods are delivered through both NHS and non NHS organisations so the extent to which services are contracted within an ACO will need to be considered as part of the scope of the care pathway in order to ensure integration and joined up care for our residents.
Existing services are provided in our neighbourhoods through a range of providers including:

- NHS Trusts,
- Primary Care providers such as GPs, Optometrists, Dentists and Pharmacies (which are generally not delivered by NHS Trusts),
- Voluntary Community Faith and Social Enterprise providers,
- Hospices,
- Private provision, e.g. Care Homes,
- Local Authority commissioned services.

Further information you may be interested in is published at the links below; these outline different potential models of contracting related to:

- Single Neighbourhood Providers
- Multi Neighbourhood Providers
- Integrated health organisations (This will also include lead provider collaboratives/organisations)

Neighbourhood health framework – GOV.UK
It may also be helpful to outline the role of Advanced Foundation Trusts in the 10-Year Plan NHS Plan. In 2025 8 Foundation Trusts were invited to apply to become Advanced Foundation Trusts initially and this included Alder Hey NHS Foundation Trust. I would draw your attention to the statement below and this outlines the importance of both local and national assessment of organisational capability before the ICB and Provider would enter into a contractual agreement as an Accountable Care Organisation.
"Advanced foundation trusts will also have the opportunity to be designated as eligible to hold an integrated health organisation (IHO) contract to oversee the health budget for a defined local population. This will require an additional assessment of capability and readiness."
NHS England » Advanced foundation trusts
3) If an ACO in Cheshire & Merseyside wishes to form a partnership with a non-NHS service provider, will that decision be subject to public consultation?
We are committed to the principle of codesign of services which includes proactive engagement with service users and our communities alongside our partners in not only the NHS but also partners including Local Authorities and the VCFSE Sector.
Statutory duties hold both NHS commissioners and providers legally accountable for when formal public consultation is appropriate and you can find further information here.
4) How have you evaluated the experience of ACOs in Spain (Ribera Salud) and the US before formulating the CSCP and PHIP?
As described in your question ACOs/IHOs (Integrated Health Organisations) are referenced as a key enabler in the NHS 10 Year Plan and has been widely advocated over many years in both national Government and NHS strategic documents but differing models have also been assessed through various academic health and care organisations including Kings Fund, Nuffield Trust and The Health Foundation.
This analysis of national and international best practice, including the examples you reference, have formed the basis of both this national strategic approach and why we are exploring these approaches in Cheshire and Merseyside. In considering how we proceed we will work with partners to design the objectives and outcomes we are intending to focus on and then assess which models will work best to achieve them.

Question Received	By
Can the Board explain the legal basis on which Right to Choose autism assessment referrals have been restricted or paused within Cheshire and Merseyside, given that the NHS Constitution and the Choice Framework set out a statutory patient right to choose any qualified provider for a first outpatient appointment, and financial pressures are not listed as lawful grounds for limiting this right. In addition, can the Board clarify why GP practices across the region have not been provided with clear, accurate guidance on which providers they are permitted to refer to under Right to Choose. Many surgeries are currently unable to advise patients who they can legally be referred to, resulting in inconsistent information, confusion, and patients being denied access to services they are entitled to. Finally, what steps will the ICB take to ensure that all GP surgeries receive immediate, unambiguous instructions confirming the full list of eligible Right to Choose providers for autism assessments, and when will unrestricted access to these services be reinstated for all patients in Cheshire and Merseyside.	Laura Lyons

Response

There are no restrictions on making Right to Choose Adult autism referrals, in Cheshire and Merseyside. The ICB is in the process of agreeing Indicative Activity Plans with any Right to Choose Provider that has or intends to provide Adult Autism assessment activity in Cheshire and Merseyside. This is with the intention of balancing equitable access with financial sustainability, and the approach is supported by the national Choice team.

We recognise that this will mean some patients may need to wait longer for assessment and a number of mitigating actions are being taken to support these individuals. This includes adding information to the ICB website regarding the Right to Choose process as well as supporting resources that individuals can utilise prior and post assessment.

In addition, we are undertaking a small pilot in primary care to test out a different pathway that may enable more care and support to be delivered in the community, similar to the successful work already undertaken with Adult ADHD.

Finally, we will be looking to expand community-based support across Cheshire and Merseyside for those who have Autism or are experiencing challenges associated with autism, including peer-led support.

Also to note, there are no Indicative Activity Plans in place at the current time for Right to Choose Providers offering child autism assessments.

Question Received	By
East Cheshire has over 1,000 people living with Parkinson's (130 new diagnoses annually). Despite a recommended caseload of 300 per Parkinson's Nurse Specialist (PNS), the area is served by only two Parkinson's Nurses, causing long wait times. The two community-based PNS are managed by the Northern Care Alliance (Salford Royal), preventing them from treating inpatients at East Cheshire Trust Hospitals. Furthermore, elderly patients under East Cheshire Trust's Care of the Elderly Consultants cannot access the PNS service because the nurses only support patients under Salford Royal Neurologists. This limited access is believed to contribute to East Cheshire NHS Trust's higher-than-average hospital admission rates for Parkinson's patients. In 2024/25, the East Cheshire Trust recorded 210 emergency Parkinson's admissions. The average length of stay for emergency admissions (14.4 days) significantly exceeded the national average (7.7 days). The cost of these emergency admissions to East Cheshire Trust in 2024/25 was nearly £1 million. Moreover, in January 2026, Minister of State for Health, Karin Smyth MP, informed us that "Local ICBs are responsible for planning and commissioning Parkinson's services. We expect every ICB to design services in line with national best practice and guidance. In particular, the National Institute for Care Excellence (NICE) guideline on Parkinson's disease in adults sets a clear expectation that every person with Parkinson's should have an accessible point of contact with specialist services. In practice, this means patients should have access to a Parkinson's specialist nurse, who can be their expert point of contact for advice, care coordination and monitoring. NICE guidance states that all individuals with Parkinson's should be offered the services of specialist nurses to support their ongoing care." Given this compelling need, we respectfully request the ICB clarify plans to fund an additional Parkinson's Nurse Specialist to support people living with Parkinson's in East Cheshire.	Kim Snape

Response
C&M ICB is a co-commissioner to the Greater Manchester ICB contract with Northern Care Alliance which covers services provided by NCA to East Cheshire Trust as part of the Manchester Centre for Clinical Neurosciences. It is our understanding that the contract for 26/27 is still being negotiated by colleagues in GM ICB. From a strategic perspective C&M ICB is considering how Long-Term Condition management, including for neurological conditions, could be included in a neighbourhood health model to invest in specialist nursing support with the aim to reduce unplanned hospital admissions. Regarding issues related to NCA PD specialist nurses not being able to care for patients under the care of East Cheshire Trust, this is an issue that the ICB would suggest could be resolved through provider-to-provider conversations. To support this, we will share your questions and this response with colleagues at the provider and the contracts team in GM ICB.

Question Received	By
Physician Associates/Assistants I am concerned about the ways physician associates/assistants are used as this can seriously risk patient safety. I would like to ask: 1. a) Has Cheshire & Merseyside ICB implemented the Leng review recommendations for Physician Associates (Physician Assistants), in all local hospitals and in local primary care? b) If not, what is the timescale for implementation? 2. a) Has Cheshire & Merseyside ICB implemented the recommendations for Physician Associates (Physician Assistants) within the BMA Safe Scope of Practice for Medical Associate Professionals (MAPs), in all local hospitals and in local primary care? b) If not, what is the timescale for implementation?	Dr Andrea Franks And Dr Alex Scott-Samuel

Response
Safe staffing is the responsibility of each health care provider. The decision about whether to employ Physician Associates is one for each individual hospital provider and Primary Care provider. The ICB would expect all Providers to have given due consideration to the documents you refer to when planning staffing.

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