NHS
Cheshire and Merseyside

ICB Board Public Questions

Month: March 2025

Question Received	By	Date received
Following the decision to close the Long Covid Clinics across Cheshire and Merseyside from 1 April 2025, Justin Madders MP has been contacted by constituents who will be affected by the changes and have expressed their severe concerns about the implications on their access to vital services that are currently offered under the clinic. It is our understanding that organisations that fund NHS care have to consult or engage with patients before significantly changing a service and this should be early on in this process. While it is noted that a consultation is now ongoing with the deadline for submission by 16 March 2025 and a review is also taking place, we understand the conclusions of both review will not be available until after the 1 April 2025 when the clinics will no longer operate. **Could the board confirm what notice they were given about the forthcoming changes and the process that was followed for such?** **Could the Equality Impact Assessment related to the decision be published publicly with full transparency of the procedure that was followed in this regard?** **What specific assessment of the suitability of the alternative services referenced to mitigate the loss of the Long Covid Clinics has taken place and what these services will be?**	Office of Justin Madders MP	27.02.25
Answer		
During 2024 there had been ongoing discussions with the six providers of adult long covid hubs in relation to falling referrals/caseload and the likelihood that the ringfenced national funding for long covid could end. As part of these discussions' providers were asked to submit proposals including how they could make efficiencies in their current model to reflect this context; the provider responses advised this would not be possible. (This was significantly influenced by the fact that most providers have very small teams of only 2 or 3 members).		

In December the ICB Executive Committee considered a paper on the issues and challenges faced with the long term sustainability of commissioning this model with the six separate services. This considered:

- *the expected loss of the ring-fenced national funding (this has now been confirmed by NHS England as part of the 2025-26 planning guidance),*
- *the significant drop in referrals and caseload*

The Executive Committee agreed it was no longer sustainable to commission the six hub based long covid services and to cease making referrals into these services. This included consideration of the EIA/QIA impacts that had been gathered through discussions between our Place based commissioners and hub providers during the Autumn.

As part of this decision it was agreed that the ICB should undertake a commissioning review to identify and agree the best way of supporting people with Long Covid in order to ensure they continue to receive the appropriate care and support in the future. Alongside this the six long covid hubs have been reviewing patients and determining onward referral for patients in need of further support to other existing services relevant to their clinical need, these services were listed on our website and include talking therapies, support for ME/CFS, pain management services, rehabilitation services and community therapies; these services are already available to support our residents and were identified clinically as being appropriate to support the clinical symptoms most associated with Long Covid. These were published alongside a number of self-help resources. Where the patient needs were assessed as having been met, they would be discharged from the service back to the care of their GP. As part of our commissioning review we are exploring what we can provide additionally to support people with Long Covid based on the feedback that we receive through our engagement.

At the January Board Meeting of the decision of the Executive Committee was publicly reported within the Chief Executives Report to Board.

The ICB is undertaking the review of future options for ensuring appropriate support is available for patients with Long Covid. It is planned that an options appraisal and recommendation will be brought to the ICB Board in May to make this decision.

In order to inform these options, we are undertaking significant engagement:

- *online survey between 14th Feb and 16th March. This has received 518 responses and 9 email response with responses from:*
  - *210 current long covid service users*
  - *83 previous long covid service users*
  - *40 people who have had long covid but didn't access long covid services*
  - *Additionally, we had feedback from 22 carers, and 51 staff (27 from within and 24 outside of long covid services).*

Additionally, we have also undertaken/undertaking the following:

- *our ICB commissioning leads for the review have also been holding a range of sessions to directly gather the views and experiences from providers, staff, patient groups, and charities with an interest in long COVID;*
- *we are liaising with a number of ICBs around England who are undertaking, or have undertaken similar reviews to understand their experiences of changing their support for people with Long COVID*
- *undertaking an evidence review of the latest research*
- *reviewing correspondence from both service users and staff outlining their experience of care for themselves/people with Long COVID.*

In advance of finalising the options appraisal we will form an "expert panel" to assess the options using an agreed assessment criteria (comprising a representative group of service users, clinical professionals with direct expertise in long covid and GPs). The final options and updated Equality and Quality Impact Assessments, will then be considered through the ICB governance process, including our Clinical Effectiveness Group in advance of the final options and recommendation being considered at a public ICB Board Meeting in May.

Further public information is available on the ICB website. Further communications with our public and local stakeholders will be undertaken throughout the process to keep them informed of progress.

Question Received	By	Date received
Channel 4 News recently revealed the gap between planned and actual numbers of nurses. **https://www.channel4.com/news/factcheck-englands-missing-nurses** Liverpool Women's: 17% shortfall in Maternity care (nurses + midwives) Alder Hey: 30% nursing shortfall in neonatal and 23% in critical care Royal Liverpool: 17% shortfall in critical care Arrowe Park: shortfalls of 27% neonatal, 24% critical care, and 17% maternity 1) What are the planned and actual numbers of Registered Nurses and (separately) Midwives for these hospitals and categories of care? 2) How will the ICB ensure that Registered Nursing and (separately) Midwifery staffing meets planned levels at these hospitals? 3) When will this be achieved?	Mr Greg Dropkin	24.03.25

Answer

The ICB recognises the critical role nurses and midwives play in maintaining and improving patient safety, and as such, NHS Trust staffing levels are one of the established mechanisms by which the ICB measures the quality and safety of the services it commissions.

The ICB also works its local providers and Higher Education Institutes to ensure there is an appropriate pipeline of multi-disciplinary professionals so that vacancy rates are minimised. The ICB is also involved in supporting and retaining the skilled workforce we have in place. This remains an ongoing challenge that sits within the wider national context.

There are a range of tools that each Trust uses to look at the variety of factors that will influence staffing requirements. These tools include ratio of patients to registered professional/s, the skill mix of the entire multi-disciplinary team (beyond nursing and midwifery numbers), the complexity of the patient caseload and the essential use of clinical judgement in a fast-moving and dynamic clinical

environment. The ICB and the NW NHS England workforce team have also recently undertaken a more detailed review of NHS provider staffing returns as a further means of assurance.

In view of the Channel 4 news coverage, both Alder Hey and University Hospital Liverpool Group provided a specific and detailed response to the issues raised which can be found below:

Alder Hey Statement
The suggestion that 'Alder Hey has one of the highest missing nurse rates of any neonatal ward in England' is inaccurate and to include this in your piece in this way could create unnecessary anxiety to our families. We refer you to our previous statement which clearly explains why the data provided to you does not accurately reflect the staffing on the Unit during this time frame and that we are confident all shifts across this time period were staffed appropriately.

The safety of our children and young people is paramount and maintaining optimum staffing levels is vital. The Trust has accurate data collection processes in relation to our workforce and robust systems and escalation protocols in place for monitoring safe staffing levels across the organisation each day. Staffing levels on our Neonatal Ward are also monitored by the North West Neonatal Operational Delivery Network who review staffing and occupancy data each quarter. There have been no concerns raised about staffing levels on our Neonatal Ward. We are confident all shifts across this time period were staffed appropriately and in line with national guidelines including those set by the British Association of Perinatal Medicine.

The data provided to you does not accurately reflect the staffing on the Unit during this time frame, as it has been collated in two parts, with the first set of data being pulled from the E-roster system and the planned hours populated based on current funded establishment. The 'actual staff hours' are based on the number of staff rostered to work clinically as per the E-Roster system. Between January 23 and November 24, the E-roster did not include bank staff or additional staff who were also able to work clinically, for example those on management days, study days and new starters in a period of supernumerary practice. This means that these staff are excluded from this Care Hours Per Patient Day data.

LWH statement
"Providing safe care to women and babies is always our main priority. We have robust processes in place for monitoring safe staffing levels across the organisation each day.

"We are confident that our staffing levels have been safe and appropriate during the period identified when taking into account factors that are not reflected in the data such as bed or cot occupancy levels, the use of bank or additional staff who provide clinical care, and

the specialist nature of the care we provide, particularly within our neonatal service, which can impact on demand and capacity at different times."

Additional information:

Our Neonatal unit staffing numbers are calculated using The Neonatal Nursing Workforce Tool (2020) and is based on recommended staffing ratios set by the British Association of Perinatal Medicine for babies requiring Intensive care, high dependency and low dependency nursing care. This means that the number of staff on duty each shift can vary depending on how many babies are under our care in a particular shift, as well as how much support these babies require which is dependent on their acuity, which is assessed for each of our babies individually.

In our Gynaecology ward staff ratio is maintained as 1 Registered Nurse to 8 Patients on day Shift and 1 Registered Nurse to 11 Patients on Night shift. In addition, Safe Care Nursing Tool audit of Dependency and Acuity has been undertaken and the data demonstrated that the Gynaecology Ward care was in the main at level 0 care as such the current staffing levels meet the requirements of the activity and acuity of the patients on the ward.

The data presented reflects the "planned staffing " which relates to number of staff needed for when the unit is at full utilisation and does not include other staff on-site, who may be redeployed as necessary. Our staffing levels are reviewed twice a day, with ongoing review by Clinical Leads and oversight by the Board of Directors. There is also external scrutiny provided by the North West Neonatal Operational Delivery Network and the Critical Care Network for Gynaecology. We are confident that Liverpool Women's Hospital has remained at appropriate Nursing staffing levels in line with national guidelines and have not had patient harm related to reported staff shortages.

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Question Received	By	Date received
In relation to Agenda item ICB /03/25/12 'Report on the October/November 2024 public engagement on Improving Hospital Gynaecology and Maternity Services in Liverpool' I note with concern: • Save Liverpool Women's Hospital Campaign now has 78,000 signatures opposing moving or dispersing LWH but the petitions and opposition receives just over 1 page in the 85 page report. • while 913 people responded to the survey, the 438 individuals who signed and addressed postcards, clearly opposing the engagement, moving or dispersing services receive 1 short paragraph. • instances in the public engagements of ICB paid staff dismissing the petitions, the campaign and their points. Hood & Woolf did not attend in person, relying on the notes and interpretation of these ICB staff. Intended bias? • while many completing the survey expressed support for 'change' , the change was clearly not spelled out in the ICB documents or at the engagements. **Q1** **a) Why was there no question asking directly do you want to move LWH from Crown St?** **b) Why was there no question if you wish it to move, where would you want to see the services moved to?**	Lesley Mahmood	25.03.25

Answer

The report summarises feedback received during the public engagement on Improving Gynaecology and Maternity Services in Liverpool, which ran from 15 October to 26 November 2024. This engagement asked people to respond to the case for change, and where relevant share their own experiences of care. It did not make any proposals for the future, including for moving or dispersing services.

Chapter 9 of the report covers both the petition, which has been running for several years, and the postcards that were received during the engagement period. In the case of both the petition and the postcards, the full text of each was provided in the report, in full, alongside the number of signatories of both at the close of the engagement period.

It is good practice for this type of engagement process to bring in an external organisation, so that analysis of data is carried out by a third party, and Hood & Woolf are an independent organisation which specialises in healthcare communications and engagement. They were engaged to design and host the engagement questionnaire, collate and analyse responses to it, and to undertake an analysis and report on the feedback across all the different strands of engagement activity. Their role did not include collecting feedback at engagement events. This is a task routinely carried out by our in-house team when we are undertaking public engagement, even when the analysis is being supported externally. Each original, full set of notes was provided to Hood & Woolf for them to analyse key themes and areas of discussion, so that these could be summarised in the report. NHS Cheshire and Merseyside had no role in the analysis of any of the feedback received, whether that came via the questionnaire or events.

The events were only one way in which we collected feedback during the engagement. Participants were reminded that even though they had attended an event, it was still important that they completed the engagement questionnaire. A QR code taking people to the questionnaire, and printed versions for those who weren't able to complete the questionnaire online, were made available at the events to support this.

The Case for Change sets out in detail the challenges facing services – it is about why change is required, not what this change might look like. Respondents were asked if they understood and supported the need for change, not about their level of support for a particular proposal. The work to develop potential options for how services could look in the future will come in the next phase of the programme and therefore has not yet taken place.

It is right that we engage with people around the issues facing services before we begin developing proposals, as the insights we have gathered will be used to inform this process. This is standard practice when the NHS identifies that services need to change. It would be misleading to seek people's views on scenarios for change which have not been scoped out. Any potential future engagement or public consultation with people about potential change to the location of services could only happen once these options had been subject to a robust clinical, operational and financial appraisal process.

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In relation to Agenda item ICB /03/25/12 'Report on the October/November 2024 public engagement on Improving Hospital Gynaecology and Maternity Services in Liverpool' We note that the survey does show numbers of participants have had poor experiences of care, most of the comments relate to understaffing, poor attitudes from staff, examples of problems with translation, interpretation, some examples of racism and long waits for treatment (e.g. gynae) a) How will these be resolved by moving, closing or dispersing LWH services as these have nothing to do with the site as such, but sadly are a common experience in the NHS and maternity as a whole (e.g. Donna Ockenden's reports)? b) Why were the ICB unwilling to attend 2 public events organized by 2 Liverpool MPS where the ICB was invited to explain their Case For Change? (To 198 members of the public in Granby, 40+ in Old Swan?) c) Why did only 25 members of staff attend the Case For Change event at LWH itself.	Teresa Williamson	25.03.25

Answer

No proposal has been made to move, close or disperse services provided at Liverpool Women's Hospital.

Listening to the experiences of people who use NHS services is a key part of delivering safe, effective services, and we're pleased that so many took the opportunity share their own stories with us during the public engagement. We of course want everyone to have positive experience of care, but we know this is not always the case, and it is important that we understand where issues exist, so that we can take steps to address them. Indeed, one of the themes to emerge from the engagement is that people regard patient experience, together with waiting times and reducing appointment delays, as priorities when considering the future of hospital gynaecology and maternity services in Liverpool.

Liverpool Women's will also be looking at the comments made during the public engagement through their own channels, as is the case with all patient experience feedback.

NHS Cheshire and Merseyside considered both these invitations carefully, however we felt that the timing meant that it wouldn't be appropriate for a representative to take part.

Because the report into the outcomes of the public engagement held during autumn 2024 was not published until 21 March 2025, at the same point the NHS Cheshire and Merseyside Board papers were published, we would not have been able to share any new information at either of these events. Our contribution would follow the same content shared during the public engagement period, including at the six engagement sessions we held. We were conscious that taking part in a public discussion about the future of Liverpool Women's could create the impression that a new development was being announced, which would not have been the case.

We are, of course, very keen to engage with MPs and the wider public around hospital gynaecology and maternity services in Liverpool, which was reiterated in our response to both invitations. We meet with local MPs regularly, in addition to sharing written briefings, and all local MPs were invited to a meeting about hospital gynaecology and maternity services in Liverpool in the month prior to the publication of the Case for Change. Last week we issued extensive communications about the publication of the report, both to the public, wider partners, and the media, and we will continue to look at how we involve people as work on the programme continues.

The online event held during the public engagement by Liverpool Women's was open to all staff, but individuals were – rightly – able to make a decision about whether or not to attend.

Although all members of staff were invited to attend, the event was primarily targeted those who were not already familiar with the challenges the hospital faces, or those who had questions about the case for change.

This event was just one opportunity for people working in gynaecology, maternity, and other services to get involved. There have been clinical engagement events throughout the programme, and staff receive briefings through the Trusts' regular communications channels, with opportunities to ask questions of senior leaders.

Staff engagement is an ongoing process, and NHS Cheshire and Merseyside will work with our local hospital trusts to ensure it remains central to the Women's Services Programme. It should be noted that 26% of respondents (more than 200 people) to the engagement questionnaire indicated that they worked in healthcare or social care.

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Question Received	By	Date received
The ICB is a "national incubator for the Federated Data platform (FDP) population health management product" (January Board papers). The FDP has five national products re population health management, in four of which Palantir is the processor. The controversial spy-tech firm also holds the overall FDP contract and seeks a “common operating system” linking healthcare data with sources including the Department for Work and Pensions. 1) Why should patients in Cheshire and Merseyside entrust their confidential medical data to systems processed and/or overseen by Palantir? 2) Why has the ICB embraced the FDP after previously preferring its own data system CIPHA (answer to question to Board 30 November 2023)	Andrea Franks	24.03.25

Answer

The ICB are obliged to conduct business under the scrutiny of NHS England and under the NHS England Framework have agreed to be an incubator for the NHS England FDP product for population health management. The product being incubated does not share confidential medical data with Palantir. It will share data in accordance with the existing Cheshire and Merseyside Information Governance arrangements agreed by its data controllers that ensures that only non-identifiable (anonymised) data is processed as part of the FDP product.

The ICB position has not changed from that previously given and discussed at Board. The existing population health products uses its own data system - CIPHA. This continues to be used and supported by data controllers and endorsed through extensive public engagement on the use of data. The FDP element of the population health management product in Cheshire and Merseyside is solely for planning purposes and that FDP element will only use non-identifiable (anonymised) data in accordance with existing information governance arrangements.

Where C&M Trusts are using the FDP platform and toolset to support operational processes such as theatre scheduling and patient discharge planning, those organisations remain the data controllers and directly manage access to the platform, data , applications and functionality through Purpose Based Access Controls. Use of the FDP solution in this way retains local control of data access but is moving C&M towards common ways of working across Trusts, and a more standard data model , which will ultimately help remove unwarranted variation and deliver cost optimisation in DigitaL.

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Answer

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Question Received	By	Date received
What plans does the ICB have to ensure a much better accident and emergency service next winter, 2025/6 given the restrictions on budget imposed by the government? a)How will the ICB avoid corridor care, unnecessary deaths and piteous situations that many patients endured? b) How will the ICB provide more space for such care? c) How will the ICB ensure sufficient staff to improve both staff and patient experience	Felicity Dowling	25.03.25
Answer		
The ICB has an improvement plan structured across 5 localities incorporating primary care and community services, acute and specialist hospitals, including paediatrics and mental health. The plan is predicated on patients being able to access those services according to their clinical need and reducing the demand upon on accident & emergency departments. *Each of the hospitals across C&M has a clear plan for escalation into other spaces based upon demand and clinical risk not only within the hospital itself but that of the community, for example the ability of ambulance to be able to respond to 999 calls appropriately.* *The improvement plan is purposed to reduce the frequency in which escalation capacity is utilised to ensure patient services are delivered in a safe manner and by teams which meets the safe staffing requirements.*		

Published: 27 March 2025