NHS
Cheshire and Merseyside

Questions Raised – Nov 2025 ICB Board

Q1. Question Received
I am a patient in Cheshire and chair of a Patient Participation Group in Chester. ***How will the ICB reassure the patients of Cheshire and Merseyside, when they learn that their personal mental and physical health data is being given to the American spy and security agency, Palantir, that their private information is safe?*** At a time when we have succeeded in getting many more patients using NHS digital services, like the NHS app and appointment booking apps, will not giving all this information to this apparently unethical, foreign company to put on a "federated data platform " lead to a loss of trust in its use by patients?
Q2. Question Received
How will the ICB safeguard our data when it is shared with Palantir, a company whose technology was used to link multiple different FBI and CIA databases in the US, and who also have contracts with UK Border Control and police forces in the East of England?
Q3. Question Received
How are the ICB going to safeguard patients from Palantir, a company known for its human rights abuses?
Q4. Question Received
I am a retired GP in Wales but my local A&E unit is the Countess of Chester Hospital and for several specialties I can choose to be referred to England rather than to Wales. I have seen colleagues suffer immeasurably through being locked into PFI contracts on their premises when - out of their own control- financial safeguards disappeared with organisational changes within the NHS. (FPCs became FHSAs, which became LHBs.) **What is the ICB's exit strategy if costs escalate, unforeseen costs evolve or even if it becomes clear that the contract turns out to be poor value for money?**

Response
The ICB takes data privacy and security extremely seriously. The ICB will only ever use data in ways that are safe, legal, and in the best interests of patients and the public. When using the Federated Data Platform (FDP), including any involvement with Palantir, we operate under strict NHS England frameworks and robust local information governance arrangements. The use of the FDP is tightly controlled, with multiple layers of oversight and security to ensure your data is protected at all times. Only non-identifiable (anonymised) data is processed for population health management within the FDP. No confidential medical data is shared with Palantir for these purposes. *Data is a core part of how the NHS delivers care, transforms services, and improves outcomes for patients—using it well saves lives. The NHS Federated Data Platform (FDP) is designed to help the NHS better understand local populations and address health inequalities, ensuring equitable access to care for all. In summary, to safeguard data:***:** • ***Strict Governance:*** *The ICB operates under robust NHS England frameworks and local information governance arrangements. Only non-identifiable (anonymised) data is processed for population health management within the FDP. No confidential medical data is shared with Palantir for these purposes.* • ***Local Control:*** *When the FDP is used for operational processes (like scheduling or discharge planning), NHS organisations in Cheshire and Merseyside remain the data controllers. They directly manage access to the platform, data, and applications using purpose-based access controls.* • ***Legal Compliance:*** *All data use is governed by UK law, including the Data Protection Act and GDPR, and is overseen by our digital design authority, which sets and enforces high standards for data use and security.*

- ***Privacy by Design:*** *The FDP is built with privacy as a core principle. Data protection is prioritised from the outset, with robust security measures in place to safeguard patient information. Access to data is only granted to authorised users for approved purposes that benefit patients and/or the NHS.*
- ***Supplier Oversight:*** *NHS England ran an independent and transparent procurement process for the FDP, awarding the contract to a consortium led by Palantir in November 2023. All suppliers had to meet strict standards, including mandatory and discretionary exclusions relating to illegal activity, social and environmental breaches, and robust information governance requirements.*
- ***Palantir's Role:*** *Palantir only operates under the instruction of the NHS when processing data on the platform. They do not control the data, nor are they permitted to access, use, or share it for their own purposes. The contract includes strict stipulations about confidentiality, and there is governance in place to monitor delivery and usage of the FDP.*
- ***Transparency and Choice:*** *We are committed to ongoing public engagement and transparency. Patients always have the right to opt out of data sharing for specific projects or products.*

Q5. Question Received

The meeting papers refer to "hear and treat" on pdf p270 of the pack

1) Who will take the decision that a patient requesting an ambulance does not need conveyance to an Emergency Department?

2) What clinical qualification, training and experience will they have to take such a decision?

3) How has the safety of this process been evaluated?

4) NHS England discuss "hear and treat" (H&T) at https://www.england.nhs.uk/long-read/urgent-community-response-and-ambulance-referral-resource/ and state: "Ambulance control centre advice does not need to be clinical, it can be as a result of triage only that closes a call or refers to another service is counted as H&T."

5) In C&M, will "hear and treat" include triage which is not clinical?

6) What is the difference between "Call Before Convey" and "hear and treat"?

Response

Who will take the decision that a patient requesting an ambulance does not need conveyance to an Emergency Department?

The role of the ambulance service has changed significantly over time, as has the availability of care options in the community that are nearer to the patient, and avoid the need to attend hospital. In the context of 'Hear and Treat' the decision at that point is not about conveying to hospital, it is about the clinical need for / appropriateness of an emergency ambulance response. Patients managed under the hear and treat category do not receive a physical ambulance response. Decisions are reached collaboratively with the patient or the patient's representative either in the initial 999 call or in a subsequent call back from a clinician.

Decisions about conveyance to hospital, including which hospital, and whereabouts in the hospital are made in the main by the responding paramedic, sometimes supported remotely by other senior clinicians. All 999 calls are prioritised upon receipt using an NHS national standard system called NHS Pathways, which determines clinical acuity and the required urgency of response. Circa 40% of calls originating as emergency calls are categorised into lower urgency categories, which are then subject to clinical call back, and where possible redirection to other services. The way that the system is set up nationally is that for some of the very lowest acuity calls, the national directory of services suggests appropriate ways to access care during the first 999 call. For example, if a patient calls 999 with dental pain, the 999 call handler will immediately direct the patient to the appropriate emergency dental service in their area. In that scenario, the patient needs urgent care, but neither an emergency ambulance response nor a journey to the ED will meet their needs.

What clinical qualification, training and experience will they have to take such a decision?

Other than in a small number of examples such as the dental pain one above, hear and treat clinical call backs to patient are carried out by NWAS specialist practitioners who are all either registered paramedics or registered nurses. All staff are trained in technical systems in-house by NWAS and use that approved telephone triage software alongside their knowledge and experience to assist their clinical decision making. NWAS is increasingly integrating hear and treat into existing local community care services, such as Urgent Community Response. This means that in addition to NWAS registered clinicians, registered clinicians in the UCR services will also contribute to hear and treat of patients in their local communities.

How has the safety of this process been evaluated?
NWAS, in common with every UK ambulance service has been carrying out hear and treat for lower acuity 999 calls for at least 20 years. The internal governance around clinical supervision, clinical audit and incident review are extremely robust. In 2024/25 NWAS dealt with 1.2 million emergency incidents, and closed 163,000 under the hear and treat category without a need for a physical face to face response. NWAS utilises a nationally validated triage and consultation tool in NHS Pathways and Pathways Advanced Clinical Consultation Software (PACCS). Clinical quality compliance with these systems is managed through random and in-line audit and supervision, with regularly convened learning and feedback national groups reviewing decision trees, clinical advice and dispositions.

NHS England discuss "hear and treat" (H&T) at https://www.england.nhs.uk/long-read/urgent-community-response-and-ambulance-referral-resource/ and state: "Ambulance control centre advice does not need to be clinical, it can be as a result of triage only that closes a call or refers to another service is counted as H&T."
Again, this is partially covered in the example above where the 999 call very clearly does not need an emergency ambulance response, the 999 call hander is able to close the call after discussion with the patient, with a referral to the most appropriate NHS service for their clinical needs. In the vast majority of cases though, hear and treat is a clinical call back and a discussion and brokerage conversation with the patient. This can include the patient being directed to another place of care locally, and NWAS funding a taxi where no other alternatives exist.

In C&M, will "hear and treat" include triage which is not clinical?
Already answered above.

What is the difference between "Call Before Convey" and "hear and treat"?
Call before Convey refers to 999 incidents where there has already been a physical emergency ambulance response, and the on scene paramedic has access to local community services or the patient's own GP to have a clinical conversation about the best options for the patient rather than attending ED. For example, if there is a local Urgent Community Response Team, they will come to the patient within 2 hours, rather than the patient needing to access care at hospital. So they call that team before conveying the patient. For appropriate patients, conveying to the Emergency Department should only happen once all other more appropriate places of care have been ruled out. This only happens if the patient's clinical condition allows it. If the patient is seriously unwell, the decision to convey is equally obvious and happens without any delay or further reference to others.

Decisions not to convey patients are very much reached collaboratively between NWAS clinicians, the patient, and local NHS services (unless the patient has clearly recovered and no longer needs our help, or simply refuses care from us). These incidents are categorised as 'see and treat'. In 2024 /25 NWAS closed 308,000 of the 1.2 million incidents incidents at scene without the need to convey the patient to hospital.

Hear and treat refers only to incidents closed just by telephone (rather than face to face) assessment, as noted in answer 1 above.

Q6. Question Received

"The winter crisis, as seen in corridor care in A and E and in very long waits for beds once a decision to admit was made, spread throughout the year. The Winter Planning report, page 279, does not appear to reflect the experience of patients in this area, nor does it reflect the Royal College of Physicians' report this autumn. Cheshire and Merseyside ICS – Urgent Emergency Care strategy for 2025/26 also does not seem to reflect the situation from the public's point of view.

We recognise the dedication and hard work of staff in challenging situations, but they too seem angry about the problem, apologising to patients for having to treat them without privacy. We note the focus on particular critical incidents, but the wear and tear on patients in the routine winter crisis must also be addressed. A five-hour wait is seen to be a feature in patients who have poor outcomes, including deaths.
The deep sadness and anger from older people at being treated in corridors must be heard and responded to.

- **What will be done to help staff navigate the tough times ahead?**
- **What research has been done to find out why staff distrust the vaccines?**
- **How do NHS staff who want the Covid vaccine get one?**
- **What are the plans in case of a qualitatively higher level of illness than you currently expect (given the experience of the southern hemisphere this year)?**
- **What lee way is there for such an escalation?**

Response

What will be done to help staff navigate the tough times ahead?

Each provider will have a range of staff support and wellbeing offers available to their employees. For details you will need to contact the individual providers organisations.

What research has been done to find out why staff distrust the vaccines?

Over recent years the number of frontline Health Care Workers taking up winter vaccinations has been declining. In order to ensure that as many eligible NHS staff as possible take up their Flu Vaccine in 25/ 26 and better understand their views, earlier this year NHS Cheshire and Merseyside commissioned insight work with local Health Care Workers to ascertain what shaped their views about whether or not to accept the Covid-19 and/ or Flu vaccination in 24/ 25. The work identified barriers, motivators, and information gaps. The insight work highlighted key enablers are as follows:

- *Increase Capability – address knowledge gaps and misconceptions*
- *Increase Vaccination Opportunity – improve access, convenience and social norms*
- *Increase Motivation – rebuild trust, share positive stories, offer incentives*

The ICB tabled the following report at the July 2025 Board "Seasonal Vaccinations: 2024/25 look back and plans for 2025/26 with a spotlight on improving vaccination uptake in Health Care Workers on staff vaccination" A copy of the papers can be found here: cm-icb-board-240725-agenda-and-papers-v3.pdf. As per the report we advised that it is the ICBs expectation that all Providers will act on the findings of the insight work and develop credible staff vaccination plans with agreed trajectories for improvement to ensure their staff uptake rate improves on last years. The national ambition is a 5% improvement on last years staff vaccination rate; locally we have set a more ambitious target and have advised all Providers that as a minimum we expect them to strive to achieve at least 50% uptake.

How do NHS staff who want the Covid vaccine get one?

In previous campaigns being an NHS Frontline worker meant that you were eligible to receive the COVID-19 vaccine. This year NHS staff are not eligible unless they meet the eligibility criteria which can be found here: COVID-19 vaccine - NHS. Eligibility is nationally determined by the Joint Committee on Vaccination and Immunisation (JCVI). The JCVI is the expert scientific advisory committee that advises the UK government on vaccination and immunisation matters including which groups should be offered COVID-19 vaccination at each stage of the programme. The recommendations can and do change between campaigns because of several key factors, notably:

- *Changing risk levels*
- *Evolving evidence on clinical vulnerability*
- *Vaccine effectiveness and duration.*

What will be done to help staff navigate the tough times ahead?

"Each organisation has tried and tested escalation processes which will see the redeployment of staff to the most critically needed services should a higher level of illness manifest itself beyond expectation, complimented by a range of staff support and wellbeing offers. Similarly should demands on services present beyond the expected increase, or should pre winter planning not realise the expected decompression of the system then additional capacity has been identified in the form of additional hospital beds, community beds and social care provision for all parts of the Cheshire and Merseyside healthcare system."

Q7. Question Received

The ICB is set to discuss privately a critical report on the future of Women's Services and Liverpool Women's Hospital. The report originally scheduled for the public agenda is now being taken behind closed doors.
There is huge public interest in this issue, including **84,000** signatories to our petition. We have been shut out of the review process. Secrecy around major decisions affecting Women's services is unacceptable.
The ICB has a duty of candour and transparency to report on possible options for LWH in public with adequate notice.

Q1. Why is the ICB discussing this in private?
Q2. Will the item on p.287 re the WSLH committee be discussed in public today?
Q3. Will the ICB discuss in public at the ICB the estimated capital cost of moving the Women's Hospital to the Royal site? Potential capital costs are given as £336m-£549m, it would take 91 years before such a rebuild became more cost effective than keeping Liverpool Women's Hospital on site and paying for the required upgrades?

(See the UHLG ARC committee October's papers (page 597), the underlying problem with the Maternity tariff is again reported. In an "Extraordinary Item - Women's Services", the paper says; "*Potential solutions of the isolated site clinical risks: Capital Build /co-location/reconfiguration of the estate up to£336m-£549M. Recognition of the existing and potential further revenue costs of delivering services from isolated site compared to the Maternity tariff(c£23m invested in Maternity and other safety issues since 2014/150 further costs ofc£6m/year identified as required).*"
http://www.uhliverpool.nhs.uk/application/files/1117/6068/9478/UHLG_Assurance_and_Risk_Committee_9_October_25_-_PDF_Pack_1.pdf

Response

Why is the ICB discussing this in private?
Unfortunately, due to a number of other urgent items which require immediate discussion, the Women's Hospital Services in Liverpool item will now not be included on the agenda for this month's private Board meeting, and will instead be rescheduled. It is normal practice for the ICB Board to discuss this type of matter at a private meeting ahead of it being presented during a public meeting, and we were clear about this step in updates about the Women's Services programme that were provided on our website in both July and October 2025. We are following an open and transparent process, and we therefore felt it was important to be clear in our wider communications about the fact that this would be happening. It does not in any way take away from our commitment and duty to making decisions in public.

When it takes place, the private Board discussion will be focussed on how we move forward with the programme, taking into account the extensive options work that took place over the summer, and will not involve making final decisions about how services might look in the future.

Will the item on p.287 re the WSLH committee be discussed in public today?
The minutes of the Women's Services Committee are provided for information purposes. They will not be discussed unless a member of the Board raises a question with the Chair.

Will the ICB discuss in public at the ICB the estimated capital cost of moving the Women's Hospital to the Royal site? Potential capital costs are given as £336m-£549m, it would take 91 years before such a rebuild became more cost effective than keeping Liverpool Women's Hospital on site and paying for the required upgrades?

We anticipate that an item about Women's Hospital Services in Liverpool will appear on the agenda of the public Board of NHS Cheshire and Merseyside early in 2026. The figures quoted in relation to potential future costs were indicative calculations captured during the process of assessing the impact of different options, which is very much an ongoing piece of work. If in the future potential options are put forward for changing services, full details of what this would mean from a financial perspective would of course be presented.

Q8. Question Received

3.9 of the Finance Plan mentions that management consultants Price Waterhouse Cooper have been deployed alongside NHS England to undertake monthly reviews with high risk (financial) organisations. Given that Merseyside and Cheshire ICB and ICS systems now fall into the 'formal undertakings 'category could the Board, (directly or via NHSE)

1. estimate the likely cost to the local ICB/ICS of obtaining such consultation work for both the remaining financial year and projected into 2026/27
2. and whether the ICB Board considers such consultation to be of good value given that it has been one of the highest users of private management consultants without securing sufficient financial recovery that alternative approaches such as external peer review using public service-based knowledge and experience may have delivered."

Response

Estimated Cost of Consultancy Support:

The current projected spend for Price Waterhouse Cooper (PWC) consultancy support in 2025/26 is approximately £5 million. This figure may change depending on the outcome of ongoing discussions with NHS England regarding the scope of further required work, which will be costed as plans develop. Any additional consultancy requirements for 2026/27 will be subject to further review and approval, and the ICB will continue to monitor and report these costs transparently.

Value for Money and Alternative Approaches:

The decision to engage PWC was made in light of the significant financial challenge facing the ICS, with the system forecasting a deficit of around £368 million—£190 million off plan—and a number of NHS organisations, including the ICB, under formal enforcement undertakings within C&M. PWC brings experience and a track record of supporting financial improvement in other NHS systems such as Greater Manchester and Lancashire & South Cumbria. The work is being supported and overseen by ICB and NHS England staff with relevant expertise to minimise external costs and ensure knowledge transfer. The Board recognises the importance of value for money and will continue to review the effectiveness of consultancy input, including consideration of alternative approaches such as peer review and public sector-based support, as part of ongoing financial recovery planning. The Board is committed to ensuring that any external support delivers measurable improvement and that lessons learned are embedded within the system for future sustainability

Q9. Question Received
After a recent gp appointment I was told I have 4 out of the 5 elements to meet the criteria for the weight loss injections on the NHS but the doctor was restricted by the ICB in issuing a prescription after reading NICE recommendations of a June 2025 deadline. **How is the ICB addressing the inequalities in obesity in healthcare?**

Q10. Question Received
Under the NHS can Mounjaro be prescribed for other conditions other than the obesity specific criteria. I currently have high BMI over 40 High Cholesterol, Pre diabetic and also have MBL. Given that I am under Clatterbridge and undergo blood testing now at regular intervals, I feel that I should be given this drug under the NHS so I can be monitored instead of buying from a Pharmacy and having no wraparound care. I have lost 5.5 stone and still have a BMI over 40. **How would you then approach this with the GP so I can ensure my own safety.**

Response
NHS Cheshire and Merseyside is following national NHS England guidance (PRN01879) and NICE recommendations for the phased rollout of weight loss drugs. This approach is designed to ensure fair access, manage significant cost implications, and address limited workforce capacity to support people losing weight. Community weight loss prescribing services are being introduced gradually through Primary Care Networks, with a limited number of places available each year as part of a national programme that includes mandatory lifestyle support. *Because capacity is limited, priority is given to those who meet strict clinical criteria. Once the allocated number of places is reached, prescribing will pause until more capacity becomes available. This national process aims to address obesity inequalities by ensuring that those with the greatest clinical need are able to benefit from the services are supported, while building up the resources needed to expand access in the future.* *For more information, please see the FAQs at **Mounjaro (Tirzepatide) - NHS Cheshire and Merseyside** which includes information about other support options which are available to you, or speak to your GP about any other support options.*