NHS
Cheshire and Merseyside

28 September 2023 ICB Board Meeting - Questions received in advance

All questions raised to the Board, or the Annual General Meeting will be answered in writing to the individual who raised them and published on the ICB website.

Question Received	Raised by
Can the following question please be answered at the ICB's annual general meeting. Given that: • **the Cheshire and Merseyside integrated care system is set to carry out £58m CIPs (Cost Improvement Plans = cuts) this year, the various NHS Trusts and Foundation Trusts plan to achieve (i.e., cut) a further £331m in CIPs, and the ICS is expected to lose £350m funding in the next few years (according to the Review of Liverpool Clinical Services commissioned by the ICB); and that:** • **the impact of these cuts will be to inflict further damage on people's lives on top of a decade of cuts in access, beds, available staff; and that:** • **the forty-two integrated care systems are modelled closely on the American accountable care system and their establishment dealt a death blow to the irreplaceable and effective (before deliberate cuts, fragmentation and privatisation) NATIONAL health service; and that:** • **some Board members apparently took an oath to "first do no harm" (not to "first look after the bottom line" or "follow a plan devised in Minneapolis" or "allow patients' data into the hands of a CIA operative"); and that:** • **the public do not want a privatised system:** **are you now going to tell the people of Cheshire and Merseyside the truth about what is being done to the NHS?**	Kevin Donovan
ICB Response	
Each and every provider is committing to CIPs based on clinically lead decisions. Each trust Board has both medical and nursing clinical representation who will have scrutinised and supported any CIP have considered and published the quality impact of decisions. As a system we have no services being cut through this CIP process. The clinicians on the board of NHS Cheshire and Merseyside as well as every constituent trust have a clear commitment to uphold quality of care for patients. This is explicit in their job description, their roles in quality and safety governance, their appraisal as well as the most profound commitments and oaths sworn at the start of their careers. All of our clinical and data systems go through an independent Information Governance process to ensure data is managed safely and in line with the UK GDPR, the Data Protection Act 2018, Caldicott Principles and the Common Law Duty of Confidentiality.	

NHS
Cheshire and Merseyside

Question Received	By
Given that stroke is a leading cause of death and disability, with stroke survivors leaving hospital with an average of 7 disabilities, many needing complex and life-long care and contributing to delays in discharge and pressures across the health and social care system, how does Cheshire and Mersey ICB plan to appropriately fund and resource Cheshire and Mersey Integrated Stroke Delivery Network as the essential delivery mechanism for meeting guideline level standards of care and achieving the Long Term Plan's stroke commitments? **What protection and security can you provide to the committed and valuable stroke network staff who are working tirelessly to improve the quality and safety of local services for this clinical priority?**	Jennifer Gardner

ICB Response

We recognise that the Stroke ISDN is a valuable resource that has been critical to the improvements we have already put in place for stroke services such as the North Mersey Hyper acute stroke unit at Aintree Hospital. They also remain critical to our future plans for improving the thrombectomy pathway and reducing the variation in provision of integrated community support services for patients after a stroke. We also recognise and thank the Stroke Association for their input into the work of improving stroke services.

At this point the Stroke network team are resourced and employed by NHSE, as they have been since they were created, and are therefore subject to the staff restructuring exercise that is currently taking place within the regional NHSE team. We were hoping that when ICBs were established, all of the clinical network teams would be transferring from NHSE to ICBs however this has not happened and as a result we are not able to influence the structure of the team.

We await the outcome of the staff restructure at NHSE but whatever that is we are committed to continue working with the network to ensure we can jointly progress improvements in stroke services for the population of Cheshire and Merseyside.

NHS
Cheshire and Merseyside

Question Received	By
Re the expected CIPs (plus making good non recurrent savings from last financial year). From which areas of expenditure are you expecting trusts to make these " cost improvements"? Final budget decisions within the budget set must rest with trusts but in your planning for these targets, you must have scoped the possibilities of savings against increased risk to patients and staff. **How have you come to the conclusion that this level of CIPs are feasible? How have you ensured this is safely achievable? Are staff numbers protected? Are staff wages protected? Is staff workload protected? Is safety critical equipment protected? Will the number of patients be expected to reduce? Will certain treatments be limited?** **How will these cuts be risk assessed? Which vacancies will be filled? Will hospitals already experiencing Opel 3 levels of difficulty even in the summer early autumn still be expected to make cuts?**	Felicity Dowling
ICB Response	
Trust Boards review and agree their own cost improvement plans and have robust processes for quality and equality impact assessments to check that there is no adverse impact on patient safety or health equalities. For 2023/24, this will also include continuing to review any COVID-19 related arrangements which are no longer needed; reducing these costs forms part of the efficiency target set nationally. Our system and its partners use a range of benchmarking and productivity indicators to identify opportunities for efficiencies. Examples of CIP schemes across our 16 NHS providers include schemes in procurement, back office savings, theatre productivity and improvements in prescribing practices. The impact on patient safety, access to services, staffing and equipment etc. are considered as part of the Trusts Quality Impact Assessment and Equality Impact assessment reviews which are signed off by senior clinicians in each Trust. Trust boards are responsible for gaining assurance that these processes are robust and the ICB seeks its own assurance through its quality monitoring arrangements with each Trust.	

NHS
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Question Received	By
Liverpool Women's Hospital Appointment of a joint chief executive with Liverpool University Hospitals NHS Foundation Trust **What was the timeline for this decision and what role did the ICB play in it? Why was the women's committee of the ICB not involved or if it was, why were we told the opposite?** **Please point us to the paper trail for making this decision.** **Was the person spec for the original role also applied to the joint role?** **Why was this not considered through ICB papers or meetings? Why was the public not consulted? Why were representatives of the Campaign to Save Liverpool Women's Hospital misled at a meeting at representatives of the board invited us to?** **Can you provide reassurance that the well documented difficulties at LUHFT are now so well under control that the management can take on responsibility for the largest women's maternity hospital in the country without detriment to Cheshire and Merseyside's women and babies?**	Felicity Dowling

ICB Response

The appointment process for Director posts in NHS Trusts and NHS Foundation Trusts, unless they are under any conditions as set by NHS England, are a matter for the Board of those organisations. It is custom and practice for all senior appointments within the NHS to have the involvement of an external professional advisor in all parts of the recruitment process. Historically this has come from the relevant regional team but following the establishment of the ICB we now support the recruitment and selection process with Trusts within our region. As such the Chair and Chief Executive of the ICB provided support to both of the Chairs of LUFHT and Liverpool Women's Hospital to help determine the best way forward through collaboration to fill the Chief Executive position at Liverpool Women's.

The Liverpool Women's board have understood for some time that they would need to find a solution to both clinical isolation and the sustainability of their organisational form and finances. A Joint Chief Executive is one option that had been considered some years ago and has been part of the conversation in setting the strategy of the organisation. It was an established and understood direction of travel for Liverpool Women's going forward as an organisation to be part of another trust or a larger group of trusts.

Changes to organisational form of hospitals do not fall within the scope of the women's services programme, and the decision to progress appointing a Joint Chief Executive falls solely to that of the individual Boards and Council of Governors of each Trust, and as such any documentation on this matter will be held by each Trust. The appointment of a joint Chief Executive has the full support of the Liverpool Women's Board and has been welcomed by clinical staff at the hospital.

While it has been announced that James Sumner will take on the Joint Chief Executive role (subject to Council of Governor approval), the two trusts will continue to function as separate organisations. The Non-Executive Director Led Nomination & Remuneration Committee of Liverpool Women's has sought assurances and has been satisfied that the proposed Joint CEO has the requisite skills, experience, has met the necessary Fit and Proper Persons Test requirements and has the capacity to lead the organisation and fulfil their Accountable Officer duties.

The decision to stand down the external recruitment process was made the day before ICB colleagues met with representatives of the Campaign to Save *Liverpool Women's Hospital and these individuals were not privy to this information at the time of the meeting.*

NHS
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Question Received	By
How is the ICB preparing for Covid this winter? **How will hospitals make preparations:** • **given they are expected to make large cuts(CIPS) as described in the board paperwork.** • **given there are so many hospitals already on Opel level 3 in summer and early Autumn.** • **given Staff shortages and unfilled vacancies.** • **and the number of NHS staff relying on food banks, suggesting weakened responses.** **I refer you to the recent enquiry hearings which showed how badly the country was prepared for the first wave, with hospital infrastructure poor. SARS-CoV-2 frequently mutates and causes waves of infection and is to some extent seasonal. It is normal for The NHS to watch levels of Flu infections in the Southern Hemisphere Winter to plan for our Northern Hemisphere Winter infections. It would seem sensible to follow Covid levels similarly. Australia had a large and extended wave in its last winter, as reported in the BMJ 2023; Covid-19: Australia's future policies will be evidence led after "profound impact" of latest wave, says minister.** **How have you taken account of the Australian experience in your preparations for this winter?**	Dr Jim Hollinshead
ICB Response	
The ICB has produced a comprehensive winter plan which is constructed from locally determined knowledge and experience from the previous winter across health and social care sectors, as well as national clinical and operational guidance. Seasonal pressures such as flu and worldwide experience of new strains of covid impact are taken into account when planning additional capacity and response to mitigate the additional pressures associated with the winter period. These plans have been stress tested across each provider and locality by the ICB and in turn NHS England teams and both regional and national undertake further scrutiny.	

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ICB Response

The appointment process for Director posts in NHS Trusts and NHS Foundation Trusts, unless they are under any conditions as set by NHS England, are a matter for the Board of those organisations. It is custom and practice for all senior appointments within the NHS to have the involvement of an external professional advisor in all parts of the recruitment process. Historically this has come from the relevant regional team but following the establishment of the ICB we now support the recruitment and selection process with Trusts within our region. As such the Chair and Chief Executive of the ICB provided support to both of the Chairs of LUFHT and Liverpool Women's Hospital to help determine the best way forward through collaboration to fill the Chief Executive position at Liverpool Women's.

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Question Received	By
On 19 Sept, the Health Service Journal reported that National Data Advisory Group members have voiced concerns about the impact of NHSE's imminent contract award for the £480m federated data platform on opt-out numbers. **Lead bidders for the FDP are Palantir and IBM. Palantir is a US tech giant serving the US military and border control. IBM is a US tech giant operating in 175 countries with an annual turnover of $60billion, which helped develop US nuclear weapons and continues to service them.** **Why should patients in Cheshire and Merseyside allow their personal medical records to be passed to a platform supplied by Palantir or IBM?**	Greg Dropkin
ICB Response	
This is an important line of inquiry as the ICB's strategic ambition to use the power of data to derive insight with which to focus initiatives at a population level requires a going level of trust from patients around the safe and appropriate processing and control of their personal data. In this specific case the FDP programme is the subject of a live procurement and so commentary on potential bidders would be inappropriate. We will review the situation post-contract award as part of engagement with the national programme.	

NHS
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Question Received	By
The ICB holds a contract with Optum, concerning prescribing. In the US, Optum has been fined millions of dollars for violating laws on pricing of medicines. California charged Optum, other Pharmacy Benefit Managers and pharmaceutical companies with collaborating to rig the prices of Insulin. Optum is owned by UnitedHealth, the largest US health corporation, and is expected to merge with EMIS Health. **a) what due diligence did the Board conduct before awarding a contract to Optum?** **b) how will a merger with EMIS affect prescribing policy?** **c) how will the Board prevent UnitedHealth gaining access to individual patient medical records?**	Greg Dropkin
ICB Response	
Whilst there were historically contracts previously held with Optum Healthcare by some of the legacy CGG's in C&M for the Sciptswitch prescribing application, this is now no longer the case. Those users have now all migrated to an alternative product OptimiseRX provided by Data Bank UK Ltd. The only contractual relationship with Optum currently is for some short term resource support to assist the BI with the build of dashboards unrelated to prescribing.	

NHS
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Question Received	By
Cheshire and Merseyside ICS came into operation after the Health and Care Act was passed last year. The Treasury insists that ICS's should not go over budget. **How does the ICB intend to reduce its debt without imposing cuts to NHS services?**	Celia Kelly
ICB Response	
The deficit generated by providers in 2022/23 was mostly funded from their cash reserves and as such is not repayable. However, the system does have a recurrent financial gap which we need to address. We are in the process of developing strategies which address the systems' longer term financial sustainability whilst delivering the strategic priorities set out in our Health Care Partnership strategy	

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Question Received	By
In terms of the Advanced Cloud-Based Telephony Services mandate what/how is the current line of communication in addition to the 'HUB' in regard to the availability of funding and the end of year deadline for submission? **How many GP's do we expect/forecast to be in a position to switch services before this date?**	Nathanial Addison
ICB Response	
Communication regarding Advanced CBT is taking place through Place Digital Leads – there are regular agenda items on existing Digital and Primary Care forums providing updates and opportunity for discussions. Availability of funding to support transition is clear for those practices identified as analogue and/or evergreen contract. NHSE have allocated £1.1m to C&M ICB to support the transition for 40 practices which will cover exit fees and implementation costs. . Ongoing telephony costs related to contracts will continue to be funded by individual practices as this is funded through the existing Global Sum Allocation. . No further information has been provided by NHSE in relation to any further funding for this programme of work. The ICB's IT providers have list of practices due to transition and proactively contacting the initial 40 practices to ensure end of year deadline met. We have 40 analogue/evergreen practices so all will switch to CBT by 31st March 2024. In addition, any practices whose contract is due for renewal before 31st March 24 will also need to switch. Accurate number being determined (but maximum 223) Assessment of readiness to switch is underway.	

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Question Received	Raised by
1) The risks of deploying Physician Associates without adequate supervision by qualified GPs with sufficient time to do so, were highlighted by the recent tragic death of a patient twice misdiagnosed by a PA who did not carry out further investigation or seek medical opinion (GP practice stops employing physician associates after patient death - Pulse Today). In June 2022, BBC Panorama exposed the employment of PAs in Operose surgeries without adequate supervision (Operose Health: What I saw working undercover at a GP surgery - BBC News). Neither the ICB Board nor the Primary Care Committee appear to have discussed these risks. **a) how many PAs are currently employed in surgeries within Cheshire & Merseyside?** **b) what arrangements are in place in C&M to ensure that no PA is ever allowed to work without adequate supervision by a qualified GP who has sufficient time to carry out such supervision?** **c) the recent national Workforce Plan envisages a 300% rise to a total of 10,000 PAs by 2036/7 (NHS Long Term Workforce Plan (england.nhs.uk)). Do the Board plan to increase the deployment of PAs, and if so, what arrangements will ensure adequate supervision by qualified GPs with sufficient time to do so?**	Greg Dropkin

ICB Response

The ICB does not hold this information as GP practices are not required to report on the number or type of staff they directly employ. We do know that currently there are 76 Physician Associates employed across Cheshire and Merseyside through the ARRS scheme (Additional Roles Reimbursement Scheme).

As part of the ARRS scheme, Primary Care Networks (PCNs) are required to have arrangements in place to safely recruit and employ staff which includes ensuring staff are adequately trained and supervised in their role. It is the responsibility of the employing organisation to ensure adequate and appropriate supervision for all staff and this applies to individual GP practices who employ any staff including PAs.

The ICB are not responsible for the employment or deployment of staff; this is the remit of providers. This will include PCNs and GP practices deciding which ARRS roles or other non ARRS staff they wish to employ. The ICB will be responding to the long-term workforce plan which will define key action areas. The ICB will manage concerns raised with regards to any NHS professionals in line with usual policy. The ICB has a freedom to speak up process to allow staff across the system to raise concerns.

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Question Received	Raised by
In respect of the Board Papers for July: **Page 144. When did the Women's Committee meet? When is its next meeting? Where do we find minutes?** **Page 172 What steps are being taken to ameliorate these risks?** **Page 86 Why is the continuity of care model still being recommended after Ockendon?** **Page 268 Maternity. Given the severity of maternity issues locally and nationally why is this section not more detailed?** **Page 280 Liverpool Women's hospital is in Level 3 for financial concern yet cannot afford to provide full time consultant care at the Hospital. When will the ICB address the inadequacy of NHS funding for maternity as mentioned by Ockendon and other reports?** **Page 327 Partnership board" including independent healthcare providers" Who are these organisations involved with the partnership board? What will their role be? Will they have voting rights?**	Felicity Dowling

ICB Response

The Women's Services Committee has met on 28 February 2023, 24 April 2023 and the 01 August 2023. The next meeting is scheduled for the 26 September 2023. Minutes of the meetings are not published, however a Chairs report to the ICB Board is published on the ICB and which outlines the discussions and decisions undertaken. The ICB has also developed a section on its website https://www.cheshireandmerseyside.nhs.uk/latest/liverpool-women-s-services/ where further details on the discussions and outputs of this Committee will be published.

Following the Ockenden report NHSE wrote to all Trusts/LMNs/ICBs on 21st September 2022 to inform them to evaluate their current position with regard to the delivery of Midwifery Continuity of Care (MCOC). Trusts were asked to assess as follows:

- Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.

- Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.
- Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision.

Trusts are not expected to deliver against a target level of MCoC, and this will remain in place until maternity services in England can demonstrate sufficient staffing levels to do so.'

All providers in Cheshire and Merseyside assessed their position accordingly and prioritised MCOC for their most vulnerable cohorts of women/birthing people.

On 30 March 2023 NHS England published a three year delivery plan for maternity and neonatal services. Following several national plans and reports, including the reports by Donna Ockenden and Dr Bill Kirkup, the plan brings together the key objectives' services are asked to deliver against over the next three years. The plan identifies listening and responding to women and families as an essential component of safe and high-quality care: the importance of listening emerged strongly from both the Ockenden and Kirkup reports.

The first theme 'Listening to Women and Families with Compassion' is for all women to receive compassionate personalised care based on an ongoing dialogue between women and families and their clinicians. Within this objective all trusts are asked to:

- consider how to achieve midwifery continuity of carer in line with safe staffing principles

Funding has been provided via the Maternity Transformation Funding to trusts and the C&M Local Maternity and Neonatal System (LMNS) to support the provision or rollout of Midwifery Continuity of Carer where safe staffing is in place; lead implementation of enhanced Midwifery Continuity of Carer teams where pilots have been agreed; and elsewhere focus on retention and growth of the workforce, putting in place the building blocks for MCoC and developing plans that will work locally, in order to move the system towards a point where the Midwifery continuity of carer model can be safely implemented.

C&M LMNS is working with all Trusts and NHSE to support the further development of the midwifery workforce and provide safe staffing levels and personalised care to all women, birthing people and babies.

A detailed maternity update is provided to the Quality & Performance Committee each month and items that are discussed are escalated through the chairs report to bring to the awareness of the Board. Board members have the opportunity to request further information at and following each Board meeting.

The ICB continues to work with Liverpool Womens' hospital to support the development of its clinical and financial strategies. National funding has recently been made available for maternity services to support improvements in care e.g., Ockenden Funding, and we have worked with our Local Maternity Services group to determine the best application of this investment.

Further details about the Cheshire and Merseyside Health and Care Partnership can be found at https://www.cheshireandmerseyside.nhs.uk/about/cheshire-and-merseyside-health-and-care-partnership/ and https://www.cheshireandmerseyside.nhs.uk/get-involved/meeting-and-event-archive/cheshire-and-merseyside-health-and-care-partnership/