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NHS
Cheshire and Merseyside

26 January 2023 ICB Board Meeting - Questions received in advance

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

Question Received	Raised by
The One Liverpool Partnership Board is mentioned repeatedly in the Carnall Farrar Review. a) Who are the members of the One Liverpool Partnership Board? b) Can I have access to the One Liverpool Partnership Board meeting minutes for all meetings which considered the Carnall Farrar Review from its inception to completion? c) On what basis and by whom were the One Liverpool Partnership Board given the role of deciding the "three critical priorities to take forward immediately"?	Greg Dropkin
ICB Response	
The membership of the One Liverpool Partnership Board (OLPB) is contained in the Terms of Reference (attached and available **CLICK HERE**). The Review was commissioned by NHS Liverpool Clinical Commissioning Group (CCG) on behalf of the ICS. The terms of reference for the review identified the One Liverpool Partnership Board as responsible for oversight of the review, with regular updates and reports provided to NHS Cheshire and Merseyside ICB. This was approved by NHS England. The three critical priorities were agreed by representatives from all NHS organisations in Liverpool, including primary care, local authority and Healthwatch. There was also significant clinical involvement.	

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Question Received	Raised by
On p 176 of the ICB Board papers, the Carnall Farrar Review states [*sic*] "LWH has the one of highest rate of transfers in the country for mothers and their babies with 11 transfers for every 1,000 discharges." a) Where is the evidence for this? b) Which other hospitals have comparable or higher rates of transfer per 1,000 discharges?	Greg Dropkin

ICB Response

This evidence comes from the national Hospital Episode Statistics (HES) database, containing details of all admissions, A&E attendances, and outpatient appointments at NHS hospitals in England. This data is collected during a patient's time at hospital as part of the Commissioning Data Set (CDS). This is submitted to NHS Digital for processing. More information regarding HES can be found here:

https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/hospital-episode-statistics

During the review, Carnall Farrar undertook some analysis using HES data which can be seen in the slide below. Other Core Cities providers that host maternity services and neonatal networks were used as comparators – see attached and available **CLICK HERE**.

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Question Received	Raised by
Public involvement: What has the public's involvement been so far in this process? How was it decided that the public were not involved in the decisions regarding setting of the 3 priorities? The Review does not include Annex 2, 3 and 4 (these include who was consulted and how and what they said), please can you provide?	Rebecca Smyth
ICB Response	
The clinical services review had a specific focus, which was to identify opportunities to improve clinical hospital-based services in terms of clinical quality, efficiency, and effectiveness. The review specification included the need to address the longstanding issue and position of the clinical risks in relation to women's services. The review was intended to produce recommendations for NHS Cheshire and Merseyside ICB to endorse. No decisions have been taken with regard to changing services at this stage. Patients and public will be involved in the next stage, which is to develop proposals and to strengthen collaboration. If any proposals represent a change to the way services are delivered, they will be subject to engagement and potentially formal public consultation. The annexes to the Carnall Farrar report were omitted in error. The annexes detailed who was involved in the review process – see attached and available **CLICK HERE**.	

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Question Received	Raised by
Co-dependencies: Which 7 are not currently met? How do LWH plan to mitigate for them over the next few years while still at Crown St?	Rebecca Smyth

ICB Response

The 7 co-dependencies not currently met are referenced within the Liverpool Clinical Services Review report (page 175 of the public board pack), which is accessible here:
cm-icb-board-public-260123.pdf (cheshireandmerseyside.nhs.uk)

Liverpool Women's Hospital has a number of actions already in place and some further programmes of work ongoing to reduce risks as far as possible, working closely with partners such as Liverpool University Hospitals NHS FT and Alder Hey Hospital for Children NHS FT. Reducing the risks caused by the isolated site is also a key focus within the Trust's strategy. The Trust Board maintains oversight of these risks; reports are available as part of the Trust's public Board papers - please see the links below.

P37:
20220303-trust-board-public.pdf (liverpoolwomens.nhs.uk)

P102:
2022-07-07-public-board-pack.pdf (liverpoolwomens.nhs.uk)

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Question Received	Raised by
Standards for Service Delivery: Which 118 are currently not met by the Liverpool Women's Hospital? Which are the 75 not met as a consequence of being on an isolated site?	Rebecca Smyth

ICB Response

Liverpool Women's Hospital has undertaken voluntary reviews of key clinical standards since 2014, to map compliance with evolving standards and inform work to reduce risks. These standards are drawn from a range of sources, including:

- NICE Guidance
- Royal College Guidelines and Standards
- NHS England Service Specifications
- British Association of Perinatal Medicine Quality Standards.

The 75 standards which are unmet as a consequence of being on an isolated site relate to:

- Lack of on-site access to critical care
- Lack of on-site access to blood transfusion services and haematology specialists
- Lack of on-site access to a range of other adult acute services (for example complex pelvic surgery and cardiology)
- Lack of on-site access to interventional radiology
- Lack of on-site access to diagnostics, including a range of radiology services and echocardiography
- Lack of on-site access to obstetricians for women inpatient at other acute hospitals.

An example of an unmet standard is included below:

Placenta Praevia and Placenta Accreta: Diagnosis and Management (Green-top Guideline No. 27a), RCOG, 2018
Delivery for women diagnosed with placenta accreta spectrum should take place in a specialist centre with logistic support for immediate access to blood products, adult intensive care unit and neonatal intensive care unit by a multidisciplinary team with expertise in complex pelvic surgery."

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Question Received	Raised by
Clinical negligence costs: What are the costs attributed to LWH being on an isolated site?	Rebecca Smyth
ICB Response	
Clinical Negligence Scheme for Trusts (CNST) costs for maternity services are calculated based on an organisation's overall risk profile (a combination of past claims and number of deliveries), therefore it is not possible to determine the proportion of costs which are caused by the isolated site, only that increased risks increase the likelihood of claims. Additionally, the maternity element of the CNST premium is by far the largest of any speciality. As maternity forms such a high proportion of Liverpool Women's Hospital's activity, it is CNST costs are disproportionately high when compared to other organisations.	

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Question Received	Raised by
Risk associated with transferring women out of LWH: Where is the evidence for additional harm to patients? How long is the usual wait to get a bed on any ICU (time interval between decision made and woman admitted to ICU)?	Rebecca Smyth

ICB Response

Women who require critical care remain under the care of consultant anaesthetists, who work outside of standard anaesthetic consultant responsibilities, while they await transfer to an appropriate care setting. This means that there is no support from intensive care specialists, or ability to support renal function for women prior to transfer. Additionally, this places pressures on availability of consultant anaesthetists, leading to standing down of elective lists for other patients.

The need to transfer women to another hospital for critical care leads to the separation of mother and baby which has a significant impact on families.

Delays occur because transfers must be agreed between multiple teams across at least 3 organisations (transferring Trust, receiving Trust and ambulance service). Pressures within the ambulance service have the potential to impact transfer times, as do pressures within the receiving Trust. There is no consistent amount of time to wait for admittance to ICU due to these variables.

The Trust undertook a review of Serious Incidents (SIs) which occurred within maternity services over the last 5 years which noted that the isolated site was a factor in 20% of the 48 SIs which occurred between 2017 and June 2022. The same review was recently conducted for gynaecology and clinical support services. This review found that the isolated site was a factor in 40% of the 25 SIs which occurred in the same period.

Additionally, the Trust has now implemented a system to record impacts of the isolated site in *all* incidents recorded, as well as Serious Incidents, and since summer 2022 has reported *all* critical care transfers as SIs. The Trust is working closely with Liverpool University Hospital NHS FT to improve data collection around transfer incidents and the impact to patients. The outcomes of this work will be reported to the Trust Board in due course and made available to the public.

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Question Received	Raised by
Carnell Farrar Report Liverpool Women's Hospital. Why are possible changes to Liverpool Women's Hospital being given priority over life threatening other priorities like cancer waiting lists, long waiting lists, staff shortages, desperate shortages of mental health provision and decreasing life expectancy and life expectancy in good health? Where is the research that says this will save lives? LWH has problems not with being an "isolate site", it is far nearer to the Royal than parts of LUH are to each other, rather its problems lie with its finances and with the previous structure of the NHS which made competition rather than cooperation between Trusts the norm. That law appears to be changing to make cooperation acceptable. Additional resources, staffing, and greater cooperation within the hospitals in the area, can resolve the issues at LWH. Bringing LWH up to the recommended MMC levels can be achieved without a merger, closure, or prohibitively expensive new build. Ockendon did not recommend new build as a solution to the problems of maternity, nor did the Women's Strategy. Both did, however, say "listen to women". The people of Liverpool have made it clear they wish to keep a women's hospital focussed on women and babies. Unfortunately for Liverpool Women's hospital, it sits on a prime valuable site.	Felicity Dowling (For the campaign to Save Liverpool Women's Hospital)

ICB Response

The review specification included the requirement to address the longstanding issue and position of the clinical risks in relation to women's services.

Addressing the clinical risks around the provision of women's services in the city does not preclude work to address waiting times, cancer outcomes, mental health and reducing health inequalities. The 2023/24 NHS Planning and Operational Guidance details the requirements on ICBs, which address all the above.
https://www.england.nhs.uk/wp-content/uploads/2022/12/PRN00021-23-24-priorities-and-operational-planning-guidance-v1.1.pdf

The Cheshire and Merseyside Integrated Care Partnership Strategy also commits to addressing these priorities:
https://www.cheshireandmerseyside.nhs.uk/media/vz2na242/cm-icb-board-public-260123.pdf

In addition, the city's health and care strategy, One Liverpool, incorporates a wide range of priorities, aligned to the ICP strategy.
https://www.liverpoolccg.nhs.uk/media/4145/000918_one_liverpool_strategy_v6.pdf

The One Liverpool Strategy will be refreshed in 2023.

A new sub-committee of the ICB will be responsible for determining options for the future of women's services in the city. It will be clinically led and will involve patients with lived experience of these services.

The Ockenden report resulted from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust. In addition to specific recommendations regarding the Trust, it identified that similar problems may occur in other trusts and, therefore, the actions identified should be implemented in all maternity services. The Ockenden review did not review maternity services at Liverpool Women's Hospital.

The engagement on the case for change for a new Liverpool women's hospital in 2016 did demonstrate that the majority of participants agreed that the issues around clinical risks due to being located on an isolated site were good reasons for change, although there was also a preference that solutions be found without having to develop a new hospital. The engagement report can be viewed here: https://www.liverpoolccg.nhs.uk/media/2861/liverpool_womens_precons_engagement_report_sep16_final_web.pdf

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Question Received	Raised by
Carnell Farrar Report Why was there not public consultation? When will there be consultation? How will you avoid waste of resources if issues of concern to the public cannot be raised? Why were alternatives to these plans, which are in wide circulation in the area, not reflected in the report? Why were all the annexes not published? Why were the many concerned groups active on NHS issues not consulted? Why does the report say in the first round of consultation some years ago, those consulted all agreed? We attended each of these meetings and photographed the results of consultation at the time, there was no such agreement.	Felicity Dowling (For the campaign to Save Liverpool Women's Hospital)
ICB Response	
The Clinical Services Review goes no further than making recommendations for NHS and wider partners to take forward collaboratively. These recommendations do not represent formal proposals at this stage. The next phase of proposal development for the critical priorities will incorporate co-production and patient and public engagement, in line with NHS England guidance[1] setting out engagement best-practice principles and legal requirements for Integrated Care Boards and other NHS organisations, as well as the Cheshire and Merseyside ICS Public Engagement Framework. [2] Public consultation may be required for any proposals that emerge in future which would lead to a change in the way services are delivered. [1] NHS England issued Working with People and Communities: statutory guidance, for ICBs and other NHS organisations.	

[2] https://www.cheshireandmerseyside.nhs.uk/media/jz1ip34u/cm-public-engagement-framework-draft-101022.pdf

Question Received	Raised by
Finances How can the retention of staff and the developments recommended by Ockendon be developed with further major cuts in funding? How can any significant improvement in any services be achieved with such cuts? For example; 1. Currently, NHS organisations in Liverpool are in financial deficit with an aggregated reported deficit position of £12.3 million at YTD (August 2022/23), which is expected to deteriorate further over the rest of the financial year." (Carnell Farrell Report). 2. The Cheshire & Merseyside ICS allocation per head to NHS organisations remains higher than all other core cities with the overall allocation due to decrease by c.£300 million over the coming years. Alongside this the new Specialised Commissioning allocation will mean that Cheshire and Merseyside will be allocated £50 million less income from specialised commissioning. Local government in Liverpool and across Cheshire and Merseyside has also seen one of the largest decreases in real terms spending power since 2010 with a decrease of £700 per head of the population". (Carnell Farrar Report). 3. "Liverpool has the greatest extent of deprivation in England as measured by the Index of Multiple Deprivation (IMD), with two in three people living in deprivation, and eight in every hundred people living 4th in the most deprived one percent of the country. With respect to income, Liverpool is the most deprived 5thlocal authority, and the most deprived with respect to employment and living environment." (Carnell Farrar Report). 4. The financial deficit for all Cheshire and Merseyside NHS, and unrealistic Cuts (CIPs) can only mean deterioration of services.	Felicity Dowling (For the campaign to Save Liverpool Women's Hospital)
ICB Response	
Cheshire and Merseyside Integrated Care System partners have combined budgets of £6bn. Whilst all partners are facing significant financial pressures, taking an integrated approach presents us with the best way to respond to this challenge and to deliver ICP priorities.	

Partners will work together to spend the limited resources available in the most efficient and effective way, to gain the best value and outcomes. This will be delivered through integration of budgets and plans at a Place level, as well as working on Cheshire and Merseyside-wide objectives and plans where this makes sense.

There will be a focus on allocating resources to help address health inequalities. Liverpool, along with some other parts of Cheshire and Merseyside, does have high levels of deprivation. The ICP has signed up to become a Marmot community and adopted eight Marmot principles to tackle Health Inequalities in outcomes, experiences, and access.

In terms of workforce sustainability, one of the main challenges for Liverpool Women's Hospital is to recruit and retain clinicians due to the identified risks of working on an isolated site. Some of the recent service enhancements have improved this position, but it remains a challenge.

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Question Received	Raised by
Maternity provision across Cheshire and Merseyside We also point out to the board that no report has been delivered about maternity issues in the ICB area, despite our requests neither is there a maternity responsibility designated to an individual on the board except as one responsibility amongst many. The statement on the ICB Partnership board does not even reflect Ockendon's recommendations, see page 43 of the partnership meeting paperwork. "We will ensure continuity of care is the default model of care for all women most at risk in pregnancy including those from ethnic minority population groups and from the most deprived groups." In contrast Ockendon says "Until proposed staffing levels are improved to recognise the increasing complexities of maternity care in the 21st century, NHS maternity services must not, and cannot, focus on the implementation of midwifery continuity of carer. Before continuity of carer is recommenced in any form there must be a thorough review of the evidence that underpins continuity of carer to assess if it is a model fit for the future. Further investment in enhancing staff numbers across the multidisciplinary team will go a long way to improve overall safety in maternity services." Cheshire and Merseyside has significant problems in maternity. There is a lack of facilities for women to give birth in the Macclesfield area since the closure of Macclesfield Hospitals Maternity Unit. The Maternity Unit at the Countess of Chester being described as inadequate. These problems are in the context of major problems of retention of midwives nationally, with many leaving because of workplace pressures, and others being made ill by pressures at work. We are also concerned at reports of worsening experience of birth, and the failure to match other countries in reducing still birth and maternal deaths and maternal harm	Felicity Dowling (For the campaign to Save Liverpool Women's Hospital)
ICB Response	
Christine Douglas MBE, the ICB Director of Nursing and Care, has been appointed as the Senior Responsible Officer for the programme to review future options for the delivery of women's services in Liverpool. The Cheshire and Merseyside ICP strategy sets out a commitment to improve Maternity Neonatology and Women's Health, informed by the Women's Health Strategy for England. The strategy states that the ICP will: • Develop a co-produced women's health strategy for Cheshire and Merseyside	

- Accelerate preventative programmes to reduce the risks to women, birthing people, and their babies from ethnic minority population groups, socially deprived, under-represented and protected characteristic groups.
- Continue to co-produce interventions and services with all women and birthing people across Cheshire and Merseyside and implement recommendations from the National Maternity Transformation Programme to improve the safety and outcomes for maternity and Neonatal services
- Continue to prioritise the restoration of gynaecological services, surgery and screening, post-pandemic
- Deliver actions identified in the national women's health strategy and continue to deliver key priority and preventative programmes in response to population need
- Support maternity providers to deliver the priorities outlined in national reviews of services and strategies, including Ockenden and East Kent, and the new single delivery plan to improve the safety and care of maternity and neonatal services, and digital strategy
- Further develop community hubs for maternity and women's health across Cheshire and Merseyside.